

AMENDED IN SENATE JUNE 21, 2012

AMENDED IN ASSEMBLY APRIL 17, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

**ASSEMBLY BILL**

**No. 2152**

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**Introduced by Assembly Member Eng**  
**(Principal coauthor: Assembly Member Huffman)**

February 23, 2012

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*An act to amend, repeal, and add Section 1373.65 of, and to add Section 1373.66 to, the Health and Safety Code, and to amend Section 10192.17 of, to amend, repeal, and add Sections 10123.12, 10601, and 10604 of, and to add Section 10133.57 to, the Insurance Code, relating to insurance health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2152, as amended, Eng. ~~Disability insurance.~~ *Health care coverage.*

*Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires a health care service plan to submit a block transfer filing to the department at least 75 days prior to the termination of its contract with a provider group or a general acute care hospital and to provide 60 days' notice of the contract's termination to enrollees assigned to the terminated provider. Existing law specifies that a health care service plan is not required to send this notice to enrollees of a preferred provider organization unless the terminated provider is a general acute care hospital.*

*This bill would, commencing July 1, 2013, make these provisions inapplicable with respect to a contract between a plan and a provider that provides benefits to enrollees and subscribers through a preferred provider arrangement. The bill would instead require the plan under those contracts to notify the department at least 30 days prior to terminating a contract with a provider group or general acute care hospital, and where the termination would affect 2,000 or more covered lives who have obtained services from the provider group or hospital, would require the plan to send a written notice at least 10 days prior to the termination date to all of those covered lives, as specified.*

*Because a willful violation of these requirements would be a crime, the bill would impose a state-mandated local program.*

Existing law provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health insurer may contract with providers for alternative rates of payment. Existing law requires those insurers to file a policy with the department describing how the insurer facilitates the continuity of care for new insureds under group policies receiving services for an acute condition from a noncontracting provider. Existing law also requires those health insurers to, at the request of an insured, arrange for the completion of covered services by a terminated provider if the insured is undergoing treatment for certain conditions, as specified.

*This bill would, commencing July 1, 2013, require a health insurer to notify the department at least ~~75~~ 30 days prior to terminating a contract with a provider group or general acute care hospital to provide services at alternative rates of ~~payment and~~ payment. Where that termination would affect 2,000 or more covered lives who have obtained services from the provider group or hospital within the preceding 6 months, the bill would, commencing July 1, 2013, require the insurer to send a written notice ~~within a specified time period~~ to all insureds who have obtained services from that provider within the last 6 months if the termination results in a material change to the insurer's provider network, as specified of those covered lives at least 10 days prior to the termination date, as specified.*

Existing law requires disability insurance policies to include a disclosure form that contains specified information, including the principal benefits and coverage of the policy, the exceptions, reductions, and limitations that apply to the policy, and a statement, with respect to health insurance policies, describing how participation in the policy may affect the choice of physician, hospital, or health care providers,

and describing the extent of financial liability that may be incurred if care is furnished by a nonparticipating provider.

With respect to health insurance policies, this bill would require the disclosure form to include additional information, including conditions and procedures for cancellation, rescission, or nonrenewal, a description of the limitations on the insured's choice of provider, and, with respect to insurers that contract for alternate rates of payment, a statement describing the basic method of reimbursement made to its participating providers, as specified. The bill would also require the first page of the disclosure form for health insurance policies to include other specified information. The bill would require a health insurer, medical group, or participating provider that uses or receives financial bonuses or other incentives to provide a written summary of specified information to any requesting person. *The bill would make these provisions operative on July 1, 2013.*

*The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.*

*This bill would provide that no reimbursement is required by this act for a specified reason.*

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: ~~no~~ yes.

*The people of the State of California do enact as follows:*

- 1     **SECTION 1.** *Section 1373.65 of the Health and Safety Code*
- 2     *is amended to read:*
- 3     1373.65. (a) At least 75 days prior to the termination date of
- 4     its contract with a provider group or a general acute care hospital,
- 5     the health care service plan shall submit an enrollee block transfer
- 6     filing to the department that includes the written notice the plan
- 7     proposes to send to affected enrollees. The plan may not send this
- 8     notice to enrollees until the department has reviewed and approved
- 9     its content. If the department does not respond within seven days
- 10    of the date of its receipt of the filing, the notice shall be deemed
- 11    approved.
- 12    (b) At least 60 days prior to the termination date of a contract
- 13    between a health care service plan and a provider group or a general
- 14    acute care hospital, the plan shall send the written notice described

1 in subdivision (a) by United States mail to enrollees who are  
2 assigned to the terminated provider group or hospital. A plan that  
3 is unable to comply with the timeframe because of exigent  
4 circumstances shall apply to the department for a waiver. The plan  
5 is excused from complying with this requirement only if its waiver  
6 application is granted by the department or the department does  
7 not respond within seven days of the date of its receipt of the  
8 waiver application. If the terminated provider is a hospital and the  
9 plan assigns enrollees to a provider group with exclusive admitting  
10 privileges to the hospital, the plan shall send the written notice to  
11 each enrollee who is a member of the provider group and who  
12 resides within a 15-mile radius of the terminated hospital. If the  
13 plan operates as a preferred provider organization or assigns  
14 members to a provider group with admitting privileges to hospitals  
15 in the same geographic area as the terminated hospital, the plan  
16 shall send the written notice to all enrollees who reside within a  
17 15-mile radius of the terminated hospital.

18 (c) The health care service plan shall send enrollees of a  
19 preferred provider organization the written notice required by  
20 subdivision (b) only if the terminated provider is a general acute  
21 care hospital.

22 (d) If an individual provider terminates his or her contract or  
23 employment with a provider group that contracts with a health  
24 care service plan, the plan may require that the provider group  
25 send the notice required by subdivision (b).

26 (e) If, after sending the notice required by subdivision (b), a  
27 health care service plan reaches an agreement with a terminated  
28 provider to renew or enter into a new contract or to not terminate  
29 their contract, the plan shall offer each affected enrollee the option  
30 to return to that provider. If an affected enrollee does not exercise  
31 this option, the plan shall reassign the enrollee to another provider.

32 (f) A health care service plan and a provider shall include in all  
33 written, printed, or electronic communications sent to an enrollee  
34 that concern the contract termination or block transfer, the  
35 following statement in not less than 8-point type: "If you have  
36 been receiving care from a health care provider, you may have a  
37 right to keep your provider for a designated time period. Please  
38 contact your HMO's customer service department, and if you have  
39 further questions, you are encouraged to contact the Department  
40 of Managed Health Care, which protects HMO consumers, by

1 telephone at its toll-free number, 1-888-HMO-2219, or at a TDD  
2 number for the hearing impaired at 1-877-688-9891, or online at  
3 [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov).”

4 (g) For purposes of this section, “provider group” means a  
5 medical group, independent practice association, or any other  
6 similar organization.

7 (h) *This section shall become inoperative on July 1, 2013, and,*  
8 *as of January 1, 2014, is repealed, unless a later enacted statute,*  
9 *that is enacted on or before January 1, 2014, deletes or extends*  
10 *the dates on which it becomes inoperative and is repealed.*

11 SEC. 2. Section 1373.65 is added to the Health and Safety  
12 Code, to read:

13 1373.65. (a) At least 75 days prior to the termination date of  
14 its contract with a provider group or a general acute care hospital,  
15 the health care service plan shall submit an enrollee block transfer  
16 filing to the department that includes the written notice the plan  
17 proposes to send to affected enrollees. The plan may not send this  
18 notice to enrollees until the department has reviewed and approved  
19 its content. If the department does not respond within seven days  
20 of the date of its receipt of the filing, the notice shall be deemed  
21 approved.

22 (b) At least 60 days prior to the termination date of a contract  
23 between a health care service plan and a provider group or a  
24 general acute care hospital, the plan shall send the written notice  
25 described in subdivision (a) by United States mail to enrollees who  
26 are assigned to the terminated provider group or hospital. A plan  
27 that is unable to comply with the timeframe because of exigent  
28 circumstances shall apply to the department for a waiver. The plan  
29 is excused from complying with this requirement only if its waiver  
30 application is granted by the department or the department does  
31 not respond within seven days of the date of its receipt of the waiver  
32 application. If the terminated provider is a hospital and the plan  
33 assigns enrollees to a provider group with exclusive admitting  
34 privileges to the hospital, the plan shall send the written notice to  
35 each enrollee who is a member of the provider group and who  
36 resides within a 15-mile radius of the terminated hospital. If the  
37 plan assigns members to a provider group with admitting privileges  
38 to hospitals in the same geographic area as the terminated hospital,  
39 the plan shall send the written notice to all enrollees who reside  
40 within a 15-mile radius of the terminated hospital.

1 (c) If an individual provider terminates his or her contract or  
2 employment with a provider group that contracts with a health  
3 care service plan, the plan may require that the provider group  
4 send the notice required by subdivision (b).

5 (d) If, after sending the notice required by subdivision (b), a  
6 health care service plan reaches an agreement with a terminated  
7 provider to renew or enter into a new contract or to not terminate  
8 their contract, the plan shall offer each affected enrollee the option  
9 to return to that provider. If an affected enrollee does not exercise  
10 this option, the plan shall reassign the enrollee to another provider.

11 (e) A health care service plan and a provider shall include in  
12 all written, printed, or electronic communications sent to an  
13 enrollee that concern the contract termination or block transfer  
14 the following statement in not less than 8-point type: "If you have  
15 been receiving care from a health care provider, you may have a  
16 right to keep your provider for a designated time period. Please  
17 contact your HMO's customer service department, and if you have  
18 further questions, you are encouraged to contact the Department  
19 of Managed Health Care, which protects HMO consumers, by  
20 telephone at its toll-free number, 1-888-HMO-2219, or at a TDD  
21 number for the hearing impaired at 1-877-688-9891, or online at  
22 [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov)."

23 (f) For purposes of this section, "provider group" means a  
24 medical group, independent practice association, or any other  
25 similar organization.

26 (g) This section shall not apply with respect to a contract  
27 between a plan and a provider that provides benefits to enrollees  
28 and subscribers through a preferred provider arrangement.

29 (h) This section shall become operative on July 1, 2013.

30 SEC. 3. Section 1373.66 is added to the Health and Safety  
31 Code, to read:

32 1373.66. (a) This section shall apply only with respect to a  
33 contract between a health care service plan and a provider that  
34 provides benefits to enrollees and subscribers through a preferred  
35 provider arrangement.

36 (b) At least 30 days prior to the termination date of a contract  
37 between a health care service plan and a provider group or a  
38 general acute care hospital, the health care service plan shall  
39 submit a written notice notifying the department of the termination  
40 and shall include with that notice the written notice the plan

1 *proposes to send to affected enrollees pursuant to subdivision (c),*  
2 *if applicable.*

3 *(c) Where the termination of a contract between a health care*  
4 *service plan and a provider group or a general acute care hospital*  
5 *would affect 2,000 or more covered lives who have obtained*  
6 *services from the provider group or general acute care hospital*  
7 *within the preceding six months, unless the department establishes*  
8 *a higher threshold by regulation, the health care service plan shall*  
9 *send the written notice described in subdivision (b) by United*  
10 *States mail to all of those affected covered lives at least 10 days*  
11 *prior to the contract termination date. A health care service plan*  
12 *that is unable to comply with the timeframe because of exigent*  
13 *circumstances shall apply to the department for a waiver. The*  
14 *health care service plan is excused from complying with this*  
15 *requirement only if its waiver application is granted by the*  
16 *department or the department does not respond within seven days*  
17 *of the date of its receipt of the waiver application.*

18 *(d) If an individual provider terminates his or her contract or*  
19 *employment with a provider group that contracts with a health*  
20 *care service plan and that termination would affect 2,000 or more*  
21 *covered lives who have obtained services from the provider within*  
22 *the preceding six months, unless the department establishes a*  
23 *higher threshold by regulation, the plan may require that the*  
24 *provider group send the notice required by subdivision (c).*

25 *(e) If, after sending the notice required by subdivision (c), a*  
26 *health care service plan reaches an agreement with a terminated*  
27 *provider group or general acute care hospital to renew or enter*  
28 *into a new contract or to not terminate their contract, the plan*  
29 *shall send a written notice notifying the affected covered lives that*  
30 *the provider group or hospital remains in their plan network.*

31 *(f) A health care service plan or a provider group shall include*  
32 *in the written notice sent pursuant to subdivision (c) or (d) the*  
33 *following information in not less than 12-point type:*

34 *(1) The name of the terminated provider group or general acute*  
35 *care hospital, or in the case of a notice sent pursuant to subdivision*  
36 *(d), the name of the terminated individual provider.*

37 *(2) The date of the pending contract termination.*

38 *(3) A brief explanation of the termination of the contract between*  
39 *the plan and the terminated provider group or general acute care*  
40 *hospital, or, in the case of a notice sent pursuant to subdivision*

1 (d), a brief explanation of the termination of the contract between  
2 the individual provider and the provider group.

3 (4) A description explaining how to access a list of contracted  
4 providers in the enrollee's plan network.

5 (5) A statement that the enrollee may contact the plan's customer  
6 service department to request completion of care for an ongoing  
7 course of treatment from a terminated provider and a telephone  
8 number for further explanation.

9 (6) A statement informing the enrollee that he or she may be  
10 required to pay a larger portion of costs if the enrollee continues  
11 to use the terminated provider.

12 (7) The following statement:

13 "If you have been receiving care from a health care provider,  
14 you may have a right to keep your provider for a designated time  
15 period. Please contact your plan's customer service department,  
16 and if you have further questions, you are encouraged to contact  
17 the Department of Managed Health Care, which protects HMO  
18 consumers, by telephone at its toll-free number, 1-888-HMO-2219,  
19 or at a TDD number for the hearing impaired at 1-877-688-9891,  
20 or online at [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov)."

21 (g) For purposes of this section, "provider group" means a  
22 group of 20 or more physicians and surgeons who are employees,  
23 partners, or shareholders of the group and who practice  
24 substantially full time as part of the group.

25 (h) The director may adopt regulations in accordance with the  
26 Administrative Procedure Act (Chapter 3.5 (commencing with  
27 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
28 Code) that are necessary to implement the provisions of this  
29 section. The director shall coordinate with the Department of  
30 Insurance in the implementation and enforcement of this section  
31 and Section 10133.57 of the Insurance Code.

32 (i) This section shall become operative on July 1, 2013.

33 SEC. 4. Section 10192.17 of the Insurance Code is amended  
34 to read:

35 10192.17. (a) Medicare supplement policies and certificates  
36 shall include a renewal, continuation, or conversion provision. The  
37 language or specifications of the provision shall be consistent with  
38 the type of contract issued. The provision shall be appropriately  
39 captioned and shall appear on the first page of the policy, and shall  
40 include any reservation by the issuer of the right to change

1 premiums and any automatic renewal premium increases based  
2 on the policyholder's age.

3 (b) Except for riders or endorsements by which the issuer  
4 effectuates a request made in writing by the insured, exercises a  
5 specifically reserved right under a Medicare supplement policy,  
6 or is required to reduce or eliminate benefits to avoid duplication  
7 of Medicare benefits, all riders or endorsements added to a  
8 Medicare supplement policy after the date of issue or upon  
9 reinstatement or renewal that reduce or eliminate benefits or  
10 coverage in the policy shall require a signed acceptance by the  
11 insured. After the date of policy or certificate issue, any rider or  
12 endorsement that increases benefits or coverage with a concomitant  
13 increase in premium during the policy term shall be agreed to in  
14 writing signed by the insured, unless the benefits are required by  
15 the minimum standards for Medicare supplement policies, or if  
16 the increased benefits or coverage is required by law. If a separate  
17 additional premium is charged for benefits provided in connection  
18 with riders or endorsements, the premium charge shall be set forth  
19 in the policy.

20 (c) Medicare supplement policies or certificates shall not provide  
21 for the payment of benefits based on standards described as "usual  
22 and customary," "reasonable and customary," or words of similar  
23 import.

24 (d) If a Medicare supplement policy or certificate contains any  
25 limitations with respect to preexisting conditions, those limitations  
26 shall appear as a separate paragraph of the policy and be labeled  
27 as "Preexisting Condition Limitations."

28 (e) (1) Medicare supplement policies and certificates shall have  
29 a notice prominently printed on the first page of the policy or  
30 certificate, and of the outline of coverage, or attached thereto, in  
31 no less than 10-point uppercase type, stating in substance that the  
32 policyholder or certificate holder shall have the right to return the  
33 policy or certificate, via regular mail, within 30 days of receiving  
34 it, and to have the full premium refunded if, after examination of  
35 the policy or certificate, the insured person is not satisfied for any  
36 reason. The return shall void the contract from the beginning, and  
37 the parties shall be in the same position as if no contract had been  
38 issued.

39 (2) For purposes of this section, a timely manner shall be no  
40 later than 30 days after the issuer receives the returned contract.

1 (3) If the issuer fails to refund all prepaid or periodic charges  
2 paid in a timely manner, then the applicant shall receive interest  
3 on the paid charges at the legal rate of interest on judgments as  
4 provided in Section 685.010 of the Code of Civil Procedure. The  
5 interest shall be paid from the date the issuer received the returned  
6 contract.

7 (f) (1) Issuers of health insurance policies, certificates, or  
8 contracts that provide hospital or medical expense coverage on an  
9 expense incurred or indemnity basis, other than incidentally, to  
10 persons eligible for Medicare shall provide to those applicants a  
11 Guide to Health Insurance for People with Medicare in the form  
12 developed jointly by the National Association of Insurance  
13 Commissioners and the Centers for Medicare and Medicaid  
14 Services and in a type size no smaller than 12-point type. Delivery  
15 of the guide shall be made whether or not the policies or certificates  
16 are advertised, solicited, or issued for delivery as Medicare  
17 supplement policies or certificates as defined in this article. Except  
18 in the case of direct response issuers, delivery of the guide shall  
19 be made to the applicant at the time of application, and  
20 acknowledgment of receipt of the guide shall be obtained by the  
21 issuer. Direct response issuers shall deliver the guide to the  
22 applicant upon request, but not later than at the time the policy is  
23 delivered.

24 (2) For the purposes of this section, “form” means the language,  
25 format, type size, type proportional spacing, bold character, and  
26 line spacing.

27 (g) As soon as practicable, but no later than 30 days prior to the  
28 annual effective date of any Medicare benefit changes, an issuer  
29 shall notify its policyholders and certificate holders of  
30 modifications it has made to Medicare supplement policies or  
31 certificates in a format acceptable to the commissioner. The notice  
32 shall include both of the following:

33 (1) A description of revisions to the Medicare Program and a  
34 description of each modification made to the coverage provided  
35 under the Medicare supplement policy or certificate.

36 (2) Inform each policyholder or certificate holder as to when  
37 any premium adjustment is to be made due to changes in Medicare.

38 (h) The notice of benefit modifications and any premium  
39 adjustments shall be in outline form and in clear and simple terms  
40 so as to facilitate comprehension.

1 (i) The notices shall not contain or be accompanied by any  
2 solicitation.

3 (j) (1) Issuers shall provide an outline of coverage to all  
4 applicants at the time application is presented to the prospective  
5 applicant and, except for direct response policies, shall obtain an  
6 acknowledgment of receipt of the outline from the applicant. If an  
7 outline of coverage is provided at the time of application and the  
8 Medicare supplement policy or certificate is issued on a basis  
9 which would require revision of the outline, a substitute outline  
10 of coverage properly describing the policy or certificate shall  
11 accompany the policy or certificate when it is delivered and contain  
12 the following statement, in no less than 12-point type, immediately  
13 above the company name:

14 “NOTICE: Read this outline of coverage carefully. It is not  
15 identical to the outline of coverage provided upon application and  
16 the coverage originally applied for has not been issued.”

17 (2) The outline of coverage provided to applicants pursuant to  
18 this section consists of four parts: a cover page, premium  
19 information, disclosure pages, and charts displaying the features  
20 of each benefit plan offered by the issuer. The outline of coverage  
21 shall be in the language and format prescribed below in no less  
22 than 12-point type. All Medicare supplement plans authorized by  
23 federal law shall be shown on the cover page, and the plans that  
24 are offered by the issuer shall be prominently identified. Premium  
25 information for plans that are offered shall be shown on the cover  
26 page or immediately following the cover page and shall be  
27 prominently displayed. The premium and mode shall be stated for  
28 all plans that are offered to the prospective applicant. All possible  
29 premiums for the prospective applicant shall be illustrated.

30 (3) The commissioner may adopt regulations to implement this  
31 article, including, but not limited to, regulations that specify the  
32 required information to be contained in the outline of coverage  
33 provided to applicants pursuant to this section, including the format  
34 of tables, charts, and other information.

35 (k) (1) Any disability insurance policy or certificate, a basic,  
36 catastrophic or major medical expense policy, or single premium  
37 nonrenewal policy or certificate issued to persons eligible for  
38 Medicare, other than a Medicare supplement policy, a policy issued  
39 pursuant to a contract under Section 1876 of the federal Social  
40 Security Act (42 U.S.C. Sec. 1395 et seq.), a disability income

1 policy, or any other policy identified in subdivision (b) of Section  
2 10192.3, advertised, solicited, or issued for delivery in this state  
3 to persons eligible for Medicare, shall notify insureds under the  
4 policy that the policy is not a Medicare supplement policy or  
5 certificate. The notice shall either be printed or attached to the first  
6 page of the outline of coverage delivered to insureds under the  
7 policy, or if no outline of coverage is delivered, to the first page  
8 of the policy or certificate delivered to insureds. The notice shall  
9 be in no less than 12-point type and shall contain the following  
10 language:

11 “THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE  
12 SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible  
13 for Medicare, review the Guide to Health Insurance for People  
14 with Medicare available from the company.”

15 (2) Applications provided to persons eligible for Medicare for  
16 the disability insurance policies or certificates described in  
17 paragraph (1) shall disclose the extent to which the policy  
18 duplicates Medicare in a manner required by the commissioner.  
19 The disclosure statement shall be provided as a part of, or together  
20 with, the application for the policy or certificate.

21 (1) Insurers issuing Medicare supplement policies or  
22 certificates for delivery in California shall provide an outline of  
23 coverage to all applicants at the time of presentation for  
24 examination or sale as provided in Section 10605, and in no case  
25 later than at the time the application is made. Except for direct  
26 response policies, insurers shall obtain a written acknowledgment  
27 of receipt of the outline from the applicant.

28 Any advertisement that is not a presentation for examination or  
29 sale as defined in *paragraph (5) of subdivision-(e) (a)* of Section  
30 10601 shall contain a notice in no less than 10-point uppercase  
31 type that an outline of coverage is available upon request. The  
32 insurer or agent that receives any request for an outline of coverage  
33 shall provide an outline of coverage to the person making the  
34 request within 14 days of receipt of the request.

35 (2) If an outline of coverage is provided at or before the time  
36 of application and the Medicare supplement policy or certificate  
37 is issued on a basis that would require revision of the outline, a  
38 substitute outline of coverage properly describing the policy or  
39 certificate shall accompany the policy or certificate when it is

1 delivered and contain the following statement, in no less than  
2 12-point type, immediately above the name:

3 “NOTICE: Read this outline of coverage carefully. It is not  
4 identical to the outline of coverage provided upon application and  
5 the coverage originally applied for has not been issued.”

6 (3) The outline of coverage shall be in the language and format  
7 prescribed in this subdivision in no less than 12-point type, and  
8 shall include the following items in the order prescribed below.  
9 Titles, as set forth below in paragraphs (B) to (H), inclusive, shall  
10 be capitalized, centered, and printed in boldface type.

11 (A) (i) The following shall only apply to policies sold for  
12 effective dates prior to June 1, 2010:

13 (I) The outline of coverage shall include the items, and in the  
14 same order, specified in the chart set forth in Section 17 of the  
15 Model Regulation to implement the NAIC Medicare Supplement  
16 Insurance Minimum Standards Model Act, as adopted by the  
17 National Association of Insurance Commissioners in 2004.

18 (II) The cover page shall contain the 14-plan (A-L) charts. The  
19 plans offered by the insurer shall be clearly identified. Innovative  
20 benefits shall be explained in a manner approved by the  
21 commissioner. The text shall read:

22 “Medicare supplement insurance can be sold in only 12 standard  
23 plans. This chart shows the benefits included in each plan. Every  
24 insurance company must offer Plan A. Some plans may not be  
25 available.

26 The BASIC BENEFITS included in ALL plans are:

27 Hospitalization: Medicare Part A coinsurance plus coverage for  
28 365 additional days after Medicare benefits end.

29 Medical expenses: Medicare Part B coinsurance (usually 20  
30 percent of the Medicare-approved amount).

31 Blood: First three pints of blood each year.

32 Mammogram: One annual screening to the extent not covered  
33 by Medicare.

34 Cervical cancer test: One annual screening.”

35 [Reference to the mammogram and cervical cancer screening  
36 test shall not be included so long as California is required to  
37 disallow them for Medicare beneficiaries by the Centers for  
38 Medicare and Medicaid Services or other agent of the federal  
39 government under 42 U.S.C. Sec. 1395ss.]

(ii) The following shall only apply to policies sold for effective dates on or after June 1, 2010:

(I) The outline of coverage shall include the items, and in the same order specified in the chart set forth in Section 17 of the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners in 2008.

(II) The cover page shall contain all Medicare supplement benefit plan charts A to D, inclusive, F, high deductible F, G, and K to N, inclusive. The plans offered by the insurer shall be clearly identified. Innovative benefits shall be explained in a manner approved by the commissioner. The text shall read:

“Medicare supplement insurance can be sold in only standard plans. This chart shows the benefits included in each plan. Every insurance company must offer Plan A. Some plans may not be available. Plans E, H, I and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

The BASIC BENEFITS included in ALL plans are:

Hospitalization: Medicare Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical expenses: Medicare Part B coinsurance (usually 20 percent of the Medicare-approved amount) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

Mammogram: One annual screening to the extent not covered by Medicare.

Cervical cancer test: One annual screening.”

[Reference to the mammogram and cervical cancer screening test shall not be included so long as California is required to disallow them for Medicare beneficiaries by the Centers for Medicare and Medicaid Services or other agent of the federal government under 42 U.S.C. Sec. 1395ss.]

(B) PREMIUM INFORMATION. Premium information for plans that are offered by the insurer shall be shown on, or immediately following, the cover page and shall be clearly and prominently displayed. The premium and mode shall be stated for all offered plans. All possible premiums for the prospective applicant shall be illustrated in writing. If the premium is based

1 on the increasing age of the insured, information specifying when  
2 and how premiums will change shall be clearly illustrated in  
3 writing. The text shall state: “We [the insurer’s name] can only  
4 raise your premium if we raise the premium for all policies like  
5 yours in California.”

6 (C) The text shall state: “Use this outline to compare benefits  
7 and premiums among policies.”

8 (D) **READ YOUR POLICY VERY CAREFULLY.** The text  
9 shall state: “This is only an outline describing your policy’s most  
10 important features. The policy is your insurance contract. You  
11 must read the policy itself to understand all of the rights and duties  
12 of both you and your insurance company.”

13 (E) **THIRTY-DAY RIGHT TO RETURN THIS POLICY.** The  
14 text shall state: “If you find that you are not satisfied with your  
15 policy, you may return it to [insert the insurer’s address]. If you  
16 send the policy back to us within 30 days after you receive it, we  
17 will treat the policy as if it has never been issued and return all of  
18 your payments.”

19 (F) **POLICY REPLACEMENT.** The text shall read: “If you are  
20 replacing another health insurance policy, do NOT cancel it until  
21 you have actually received your new policy and are sure you want  
22 to keep it.”

23 (G) **DISCLOSURES.** The text shall read: “This policy may not  
24 fully cover all of your medical costs.” “Neither this company nor  
25 any of its agents are connected with Medicare.” “This outline of  
26 coverage does not give all the details of Medicare coverage.  
27 Contact your local social security office or consult ‘The Medicare  
28 Handbook’ for more details.” “For additional information  
29 concerning policy benefits, contact the Health Insurance  
30 Counseling and Advocacy Program (HICAP) or your agent. Call  
31 the HICAP toll-free telephone number, 1-800-434-0222, for a  
32 referral to your local HICAP office. HICAP is a service provided  
33 free of charge by the State of California.”

34 For policies effective on dates on or after June 1, 2010, the  
35 following language shall be required until June 1, 2011, “This  
36 outline shows benefits and premiums of policies sold for effective  
37 dates on or after June 1, 2010. Policies sold for effective dates  
38 prior to June 1, 2010 have different benefits and premiums. Plans  
39 E, H, I, and J are no longer available for sale.”

1 (H) [For policies that are not guaranteed issue] COMPLETE  
2 ANSWERS ARE IMPORTANT. The text shall read: “When you  
3 fill out the application for a new policy, be sure to answer truthfully  
4 and completely all questions about your medical and health history.  
5 The company may have the right to cancel your policy and refuse  
6 to pay any claims if you leave out or falsify important medical  
7 information.

8 Review the application carefully before you sign it. Be certain  
9 that all information has been properly recorded.”

10 (I) One chart for each benefit plan offered by the insurer  
11 showing the services, Medicare payments, payments under the  
12 policy and payments expected from the insured, using the same  
13 uniform format and language. No more than four plans may be  
14 shown on one page. Include an explanation of any innovative  
15 benefits in a manner approved by the commissioner.

16 (m) An issuer shall comply with all notice requirements of the  
17 Medicare Prescription Drug, Improvement, and Modernization  
18 Act of 2003 (P.L. 108-173).

19 *SEC. 5. Section 10123.12 of the Insurance Code is amended*  
20 *to read:*

21 10123.12. Every health insurer, including those insurers that  
22 contract for alternative rates of payment pursuant to Section 10133,  
23 and every self-insured employee welfare benefit plan that will  
24 affect the choice of physician, hospital, or other health care  
25 providers shall include within its disclosure form and within its  
26 evidence or certificate of coverage a statement clearly describing  
27 how participation in the policy or plan may affect the choice of  
28 physician, hospital, or other health care providers, and describing  
29 the nature and extent of the financial liability that is, or that may  
30 be, incurred by the insured, enrollee, or covered dependents if care  
31 is furnished by a provider that does not have a contract with the  
32 insurer or plan to provide service at alternative rates of payment  
33 pursuant to Section 10133. The form shall clearly inform  
34 prospective insureds or plan enrollees that participation in the  
35 policy or plan will affect the person’s choice in this regard by  
36 placing the following statement in a conspicuous place on all  
37 material required to be given to prospective insureds or plan  
38 enrollees including promotional and descriptive material, disclosure  
39 forms, and certificates and evidences of coverage:

1 PLEASE READ THE FOLLOWING INFORMATION SO  
2 YOU WILL KNOW FROM WHOM OR WHAT GROUP OF  
3 PROVIDERS HEALTH CARE MAY BE OBTAINED  
4

5 It is not the intent of this section to require that the names of  
6 individual health care providers be enumerated to prospective  
7 insureds or enrollees.

8 If a health insurer providing coverage for hospital, medical, or  
9 surgical expenses provides a list of facilities to patients or  
10 contracting providers, the insurer shall include within the provider  
11 listing a notification that insureds or enrollees may contact the  
12 insurer in order to obtain a list of the facilities with which the  
13 health insurer is contracting for subacute care and/or transitional  
14 inpatient care.

15 *This section shall become inoperative on July 1, 2013, and, as*  
16 *of January 1, 2014, is repealed, unless a later enacted statute, that*  
17 *is enacted on or before January 1, 2014, deletes or extends the*  
18 *dates on which it becomes inoperative and is repealed.*

19 SEC. 6. Section 10123.12 is added to the Insurance Code, to  
20 read:

21 10123.12. (a) Every health insurer, including those insurers  
22 that contract for alternative rates of payment pursuant to Section  
23 10133, and every self-insured employee welfare benefit plan that  
24 will affect the choice of physician, hospital, or other health care  
25 providers shall include within its disclosure form and within its  
26 evidence or certificate of coverage a statement clearly describing  
27 how participation in the policy or plan may affect the choice of  
28 physician, hospital, or other health care providers, and describing  
29 the nature and extent of the financial liability that is, or that may  
30 be, incurred by the insured, enrollee, or covered dependents if  
31 care is furnished by a provider that does not have a contract with  
32 the insurer or plan to provide service at alternative rates of  
33 payment pursuant to Section 10133. The form shall clearly inform  
34 prospective insureds or plan enrollees that participation in the  
35 policy or plan will affect the person's choice in this regard by  
36 placing the following statement in a conspicuous place on all  
37 material required to be given to prospective insureds or plan  
38 enrollees including promotional and descriptive material,  
39 disclosure forms, and certificates and evidences of coverage:

1 PLEASE READ THE FOLLOWING INFORMATION SO YOU  
2 WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS  
3 HEALTH CARE MAY BE OBTAINED

4 It is not the intent of this section to require that the names of  
5 individual health care providers be enumerated to prospective  
6 insureds or enrollees.

7 If a health insurer providing coverage for hospital, medical, or  
8 surgical expenses provides a list of providers or facilities to  
9 patients or contracting providers, the insurer shall include within  
10 the listing a notification that insureds or enrollees may contact  
11 the insurer in order to obtain a list of the facilities with which the  
12 health insurer is contracting for subacute care and/or transitional  
13 inpatient care.

14 (b) Every health insurer that contracts for alternative rates of  
15 payment pursuant to Section 10133, shall include within its  
16 disclosure form a statement clearly describing the basic method  
17 of reimbursement, including the scope and general methods of  
18 payment, made to its contracting providers of health care services,  
19 and whether financial bonuses or any other incentives are used.  
20 The disclosure form shall indicate that if an insured wishes to  
21 know more about these issues, the insured may request additional  
22 information from the insurer, the insured's provider, or the  
23 provider's medical group regarding the information required  
24 pursuant to subdivision (c).

25 (c) If a health insurer, medical group, or participating health  
26 care provider uses or receives financial bonuses or any other  
27 incentives, the insurer, medical group, or health care provider  
28 shall provide a written summary to any person who requests it  
29 that includes both of the following:

30 (1) A general description of the bonus and any other incentive  
31 arrangements used in its compensation agreements. Nothing in  
32 this paragraph shall be construed to require disclosure of trade  
33 secrets or commercial or financial information that is privileged  
34 or confidential, such as payment rates, as determined by the  
35 commissioner, pursuant to state law.

36 (2) A description regarding whether, and in what manner, the  
37 bonuses and any other incentives are related to a provider's use  
38 of referral services.

39 (d) The statements and written information provided pursuant  
40 to subdivisions (b) and (c) shall be communicated in clear and

1 *simple language that enables consumers to evaluate and compare*  
2 *health insurance policies.*

3 *(e) This section shall become operative on July 1, 2013.*

4 ~~SECTION 1. Section 10123.12 of the Insurance Code is~~  
5 ~~amended to read:~~

6 ~~10123.12. (a) Every health insurer, including those insurers~~  
7 ~~that contract for alternative rates of payment pursuant to Section~~  
8 ~~10133, and every self-insured employee welfare benefit plan that~~  
9 ~~will affect the choice of physician, hospital, or other health care~~  
10 ~~providers shall include within its disclosure form and within its~~  
11 ~~evidence or certificate of coverage a statement clearly describing~~  
12 ~~how participation in the policy or plan may affect the choice of~~  
13 ~~physician, hospital, or other health care providers, and describing~~  
14 ~~the nature and extent of the financial liability that is, or that may~~  
15 ~~be, incurred by the insured, enrollee, or covered dependents if care~~  
16 ~~is furnished by a provider that does not have a contract with the~~  
17 ~~insurer or plan to provide service at alternative rates of payment~~  
18 ~~pursuant to Section 10133. The form shall clearly inform~~  
19 ~~prospective insureds or plan enrollees that participation in the~~  
20 ~~policy or plan will affect the person's choice in this regard by~~  
21 ~~placing the following statement in a conspicuous place on all~~  
22 ~~material required to be given to prospective insureds or plan~~  
23 ~~enrollees including promotional and descriptive material, disclosure~~  
24 ~~forms, and certificates and evidences of coverage:~~

25  
26 ~~PLEASE READ THE FOLLOWING INFORMATION SO~~  
27 ~~YOU WILL KNOW FROM WHOM OR WHAT GROUP OF~~  
28 ~~PROVIDERS HEALTH CARE MAY BE OBTAINED~~  
29

30 ~~It is not the intent of this section to require that the names of~~  
31 ~~individual health care providers be enumerated to prospective~~  
32 ~~insureds or enrollees.~~

33 ~~If a health insurer providing coverage for hospital, medical, or~~  
34 ~~surgical expenses provides a list of providers or facilities to patients~~  
35 ~~or contracting providers, the insurer shall include within the listing~~  
36 ~~a notification that insureds or enrollees may contact the insurer in~~  
37 ~~order to obtain a list of the facilities with which the health insurer~~  
38 ~~is contracting for subacute care and/or transitional inpatient care.~~

39 ~~(b) Every health insurer that contracts for alternative rates of~~  
40 ~~payment pursuant to Section 10133, shall include within its~~

1 disclosure form a statement clearly describing the basic method  
2 of reimbursement, including the scope and general methods of  
3 payment, made to its contracting providers of health care services;  
4 and whether financial bonuses or any other incentives are used.  
5 The disclosure form shall indicate that if an insured wishes to know  
6 more about these issues, the insured may request additional  
7 information from the insurer, the insured's provider, or the  
8 provider's medical group regarding the information required  
9 pursuant to subdivision (c).

10 (c) If a health insurer, medical group, or participating health  
11 care provider uses or receives financial bonuses or any other  
12 incentives, the insurer, medical group, or health care provider shall  
13 provide a written summary to any person who requests it that  
14 includes both of the following:

15 (1) A general description of the bonus and any other incentive  
16 arrangements used in its compensation agreements. Nothing in  
17 this paragraph shall be construed to require disclosure of trade  
18 secrets or commercial or financial information that is privileged  
19 or confidential, such as payment rates, as determined by the  
20 commissioner, pursuant to state law.

21 (2) A description regarding whether, and in what manner, the  
22 bonuses and any other incentives are related to a provider's use of  
23 referral services.

24 (d) The statements and written information provided pursuant  
25 to subdivisions (b) and (c) shall be communicated in clear and  
26 simple language that enables consumers to evaluate and compare  
27 health insurance policies.

28 SEC. 2.

29 SEC. 7. Section 10133.57 is added to the Insurance Code, to  
30 read:

31 10133.57. (a) At least ~~75~~ 30 days prior to the termination date  
32 of its ~~a contract with~~ *between a health insurer and* a provider group  
33 or a general acute care hospital to provide services at alternative  
34 rates of payment pursuant to Section 10133, ~~a~~ *the* health insurer  
35 shall ~~notify~~ *submit a written notice notifying* the department of the  
36 termination and ~~shall include with that notice~~ the written notice  
37 the insurer proposes to send to affected insureds ~~if the termination~~  
38 ~~of the contract results in a material change to the insurer's provider~~  
39 ~~network, as defined by the department by regulation. The insurer~~  
40 ~~shall not send this notice to insureds until the department has~~

~~reviewed and approved its content. If the department does not respond within seven days of the date of its receipt of the filing, the notice shall be deemed approved. For purposes of this section, “material change” shall be defined as a termination affecting 800 or more covered lives unless the department establishes a higher threshold by regulation pursuant to subdivision (b), if applicable.~~

~~(b) At least 60 days prior to Where the termination date of a contract between a health insurer and a provider group or a general acute care hospital to provide services at alternative rates of payment pursuant to Section 10133 would affect 2,000 or more covered lives who have obtained services from the provider group or general acute care hospital within the preceding six months, unless the department establishes a higher threshold by regulation, the health insurer shall send the written notice described in subdivision (a) by United States mail to all insureds who have obtained services from the professional or institutional provider within the preceding six months if the termination of the contract results in a material change to the insurer’s provider network, as defined by the department by regulation of those affected covered lives at least 10 days prior to the contract termination date. A health insurer that is unable to comply with the timeframe because of exigent circumstances shall apply to the department for a waiver. The health insurer is excused from complying with this requirement only if its waiver application is granted by the department or the department does not respond within seven days of the date of its receipt of the waiver application. If the terminated provider is a hospital, the health insurer shall send the written notice to all insureds who reside within a 15-mile radius of the terminated hospital.~~

~~(c) If an individual provider terminates his or her contract or employment with a provider group that contracts with a health insurer and that termination would affect 2,000 or more covered lives who have obtained services from the provider within the preceding six months, unless the department establishes a higher threshold by regulation, the insurer may require that the provider group send the notice required by subdivision (b).~~

~~(d) If, after sending the notice required by subdivision (b), a health insurer reaches an agreement with a terminated provider group or general acute care hospital to renew or enter into a new contract or to not terminate their contract, the insurer shall offer~~

1 ~~each affected insured the option to return to that provider send a~~  
2 ~~written notice notifying the affected covered lives that the provider~~  
3 ~~group or hospital remains in their provider network.~~

4 (e) A health insurer ~~and~~ or a provider group shall include in all  
5 ~~written, printed, or electronic communications sent to an insured~~  
6 ~~that concern the contract termination or transition plan, in the~~  
7 ~~written notice sent pursuant to subdivision (b) or (c) the following~~  
8 ~~statement information in not less than eight-point 12-point type:~~  
9 ~~“If~~

10 (1) *The name of the terminated provider group or general acute*  
11 *care hospital, or in the case of a notice sent pursuant to subdivision*  
12 *(c), the name of the terminated individual provider.*

13 (2) *The date of the pending contract termination.*

14 (3) *A brief explanation of the termination of the contract between*  
15 *the insurer and the terminated provider group or general acute*  
16 *care hospital, or, in the case of a notice sent pursuant to*  
17 *subdivision (c), a brief explanation of the termination of the*  
18 *contract between the individual provider and the provider group.*

19 (4) *A description explaining how to access a list of contracted*  
20 *providers in the insured’s provider network.*

21 (5) *A statement that the insured may contact the insurer’s*  
22 *customer service department to request completion of care for an*  
23 *ongoing course of treatment from a terminated provider and a*  
24 *telephone number for further explanation.*

25 (6) *A statement informing the insured that he or she may be*  
26 *required to pay a larger portion of costs if the insured continues*  
27 *to use the terminated provider.*

28 (7) *The following statement:*

29 *“If you have been receiving care from a health care provider,*  
30 *you may have a right to keep your provider for a designated time*  
31 *period. Please contact your insurer’s customer service department,*  
32 *and if you have further questions, you are encouraged to contact*  
33 *the Department of Insurance, which protects insurance consumers,*  
34 *by telephone at its toll-free number, 800-927-HELP (4357), or at*  
35 *a TDD number for the hearing impaired at 800-482-4833, or online*  
36 *at [www.insurance.ca.gov](http://www.insurance.ca.gov).”*

37 (f) For purposes of this section, “provider  
38 group” means a ~~medical group or any other similar organization~~  
39 *group of 20 or more physicians and surgeons who are employees,*

1 *partners, or shareholders of the group and who practice*  
2 *substantially full time as part of the group.*

3 (g) The commissioner may adopt regulations in accordance with  
4 the Administrative Procedure Act (Chapter 3.5 (commencing with  
5 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
6 Code) that are necessary to implement the provisions of this  
7 section. *The commissioner shall coordinate with the Department*  
8 *of Managed Health Care in the implementation and enforcement*  
9 *of this section and Section 1373.66 of the Health and Safety Code.*

10 (h) *This section shall become operative on July 1, 2013.*

11 SEC. 8. *Section 10601 of the Insurance Code is amended to*  
12 *read:*

13 10601. (a) As used in this chapter:

14 (a)

15 (1) "Benefits and coverage" means the accident, sickness, or  
16 disability indemnity available under a policy of disability insurance.

17 (b)

18 (2) "Exception" means any provision in a policy whereby  
19 coverage for a specified hazard or condition is entirely eliminated.

20 (c)

21 (3) "Reduction" means any provision in a policy which reduces  
22 the amount of a policy benefit to some amount or period less than  
23 would be otherwise payable for medically authorized expenses or  
24 services had such a reduction not been used.

25 (d)

26 (4) "Limitation" means any provision other than an exception  
27 or a reduction which restricts coverage under the policy.

28 (e)

29 (5) "Presenting for examination or sale" means either ~~(1)~~ (A)  
30 publication and dissemination of any brochure, mailer,  
31 advertisement, or form which constitutes a presentation of the  
32 provisions of the policy and which provides a policy enrollment  
33 or application form, or ~~(2)~~ (B) consultations or discussions between  
34 prospective beneficiaries or their contract agents and employees  
35 or agents of disability insurers, when such consultations or  
36 discussions include presentation of formal, organized information  
37 about the policy which is intended to influence or inform the  
38 prospective insured or beneficiary, such as brochures, summaries,  
39 charts, slides, or other modes of information in lieu of or in addition  
40 to the policy itself.

1     ~~(f)~~

2     (6) “Disability insurance” means every policy of disability  
3 insurance, self-insured employee welfare benefit plan, and  
4 nonprofit hospital service plan issued, delivered, or entered into  
5 pursuant to or described in Chapter 1 (commencing with Section  
6 10110), Chapter 4 (commencing with Section 10270), or Chapter  
7 11A (commencing with Section 11491) of this part.

8     ~~(g)~~

9     (7) “Insurer” means every insurer transacting disability  
10 insurance, every self-insured employee welfare plan, and every  
11 nonprofit hospital service plan specified in ~~subdivision (e)~~  
12 *paragraph (6)*.

13     ~~(h)~~

14     (8) “Disclosure form” means the standard supplemental  
15 disclosure form required pursuant to Section 10603.

16     ***(b) This section shall become inoperative on July 1, 2013, and,***  
17 ***as of January 1, 2014, is repealed, unless a later enacted statute,***  
18 ***that is enacted on or before January 1, 2014, deletes or extends***  
19 ***the dates on which it becomes inoperative and is repealed.***

20     SEC. 9. Section 10601 is added to the Insurance Code, to read:  
21     10601. (a) As used in this chapter:

22     (1) “Benefits and coverage” means the accident, sickness, or  
23 disability indemnity available under a policy of disability  
24 insurance.

25     (2) “Exception” means any provision in a policy whereby  
26 coverage for a specified hazard or condition is entirely eliminated.

27     (3) “Reduction” means any provision in a policy which reduces  
28 the amount of a policy benefit to some amount or period less than  
29 would be otherwise payable for medically authorized expenses or  
30 services had such a reduction not been used.

31     (4) “Limitation” means any provision other than an exception  
32 or a reduction which restricts coverage under the policy.

33     (5) “Presenting for examination or sale” means either (A)  
34 publication and dissemination of any brochure, mailer,  
35 advertisement, or form which constitutes a presentation of the  
36 provisions of the policy and which provides a policy enrollment  
37 or application form, or (B) consultations or discussions between  
38 prospective beneficiaries or their contract agents and employees  
39 or agents of disability insurers, when such consultations or  
40 discussions include presentation of formal, organized information

1 about the policy which is intended to influence or inform the  
2 prospective insured or beneficiary, such as brochures, summaries,  
3 charts, slides, or other modes of information in lieu of or in  
4 addition to the policy itself.

5 (6) "Disability insurance" means every policy of disability  
6 insurance and self-insured employee welfare benefit plan issued,  
7 delivered, or entered into pursuant to or described in Chapter 1  
8 (commencing with Section 10110) or Chapter 4 (commencing with  
9 Section 10270) of this part.

10 (7) "Insurer" means every insurer transacting disability  
11 insurance and every self-insured employee welfare plan described  
12 in paragraph (6).

13 (8) "Disclosure form" means the standard supplemental  
14 disclosure form required pursuant to Section 10603.

15 (9) "Small group health insurance policy" means a group health  
16 insurance policy issued to a small employer, as defined in Section  
17 10700.

18 (b) This section shall become operative on July 1, 2013.

19 ~~SEC. 3. Section 10601 of the Insurance Code is amended to~~  
20 ~~read:~~

21 ~~10601. As used in this chapter:~~

22 ~~(a) "Benefits and coverage" means the accident, sickness or~~  
23 ~~disability indemnity available under a policy of disability insurance.~~

24 ~~(b) "Exception" means any provision in a policy whereby~~  
25 ~~coverage for a specified hazard or condition is entirely eliminated.~~

26 ~~(c) "Reduction" means any provision in a policy which reduces~~  
27 ~~the amount of a policy benefit to some amount or period less than~~  
28 ~~would be otherwise payable for medically authorized expenses or~~  
29 ~~services had such a reduction not been used.~~

30 ~~(d) "Limitation" means any provision other than an exception~~  
31 ~~or a reduction which restricts coverage under the policy.~~

32 ~~(e) "Presenting for examination or sale" means either (1)~~  
33 ~~publication and dissemination of any brochure, mailer,~~  
34 ~~advertisement, or form which constitutes a presentation of the~~  
35 ~~provisions of the policy and which provides a policy enrollment~~  
36 ~~or application form, or (2) consultations or discussions between~~  
37 ~~prospective beneficiaries or their contract agents and employees~~  
38 ~~or agents of disability insurers, when such consultations or~~  
39 ~~discussions include presentation of formal, organized information~~  
40 ~~about the policy which is intended to influence or inform the~~

1 prospective insured or beneficiary, such as brochures, summaries,  
2 charts, slides, or other modes of information in lieu of or in addition  
3 to the policy itself.

4 (f) ~~“Disability insurance” means every policy of disability~~  
5 ~~insurance and self-insured employee welfare benefit plan issued,~~  
6 ~~delivered, or entered into pursuant to or described in Chapter 1~~  
7 ~~(commencing with Section 10110) or Chapter 4 (commencing with~~  
8 ~~Section 10270) of this part.~~

9 (g) ~~“Insurer” means every insurer transacting disability insurance~~  
10 ~~and every self-insured employee welfare plan specified in~~  
11 ~~subdivision (f).~~

12 (h) ~~“Disclosure form” means the standard supplemental~~  
13 ~~disclosure form required pursuant to Section 10603.~~

14 (i) ~~“Small group health insurance policy” means a group health~~  
15 ~~insurance policy issued to a small employer, as defined in Section~~  
16 ~~10700.~~

17 *SEC. 10. Section 10604 of the Insurance Code is amended to*  
18 *read:*

19 10604. (a) The disclosure form shall include the following  
20 information, in concise and specific terms, relative to the disability  
21 insurance policy:

22 (a)  
23 (1) The applicable category or categories of coverage provided  
24 by the policy, from among the following:

25 (1)  
26 (A) Basic hospital expense coverage.  
27 (2)  
28 (B) Basic medical-surgical expense coverage.  
29 (3)  
30 (C) Hospital confinement indemnity coverage.

31 (4)  
32 (D) Major medical expense coverage.

33 (5)  
34 (E) Disability income protection coverage.

35 (6)  
36 (F) Accident only coverage.

37 (7)  
38 (G) Specified disease or specified accident coverage.

39 (8)  
40 (H) Such other categories as the commissioner may prescribe.

1     ~~(b)~~

2     (2) The principal benefits and coverage of the disability  
3 insurance policy.

4     ~~(c)~~

5     (3) The exceptions, reductions, and limitations that apply to  
6 such policy.

7     ~~(d)~~

8     (4) A summary, including a citation of the relevant contractual  
9 provisions, of the process used to authorize or deny payments for  
10 services under the coverage provided by the policy including  
11 coverage for subacute care, transitional inpatient care, or care  
12 provided in skilled nursing facilities. ~~This subdivision~~ *paragraph*  
13 shall only apply to policies of disability insurance that cover  
14 hospital, medical, or surgical expenses.

15    ~~(e)~~

16    (5) The full premium cost of such policy.

17    ~~(f)~~

18    (6) Any copayment, coinsurance, or deductible requirements  
19 that may be incurred by the insured or his family in obtaining  
20 coverage under the policy.

21    ~~(g)~~

22    (7) The terms under which the policy may be renewed by the  
23 insured, including any reservation by the insurer of any right to  
24 change premiums.

25    ~~(h)~~

26    (8) A statement that the disclosure form is a summary only, and  
27 that the policy itself should be consulted to determine governing  
28 contractual provisions.

29    ***(b) This section shall become inoperative on July 1, 2013, and,***  
30 ***as of January 1, 2014, is repealed, unless a later enacted statute,***  
31 ***that is enacted on or before January 1, 2014, deletes or extends***  
32 ***the dates on which it becomes inoperative and is repealed.***

33    ***SEC. 11. Section 10604 is added to the Insurance Code, to***  
34 ***read:***

35    ***10604. (a) The disclosure form shall include at least the***  
36 ***following information, in concise and specific terms, relative to***  
37 ***the disability insurance policy, together with additional information***  
38 ***as the commissioner may require in connection with the policy:***

39    ***(1) The applicable category or categories of coverage provided***  
40 ***by the policy, from among the following:***

- 1     (A) Basic hospital expense coverage.
- 2     (B) Basic medical-surgical expense coverage.
- 3     (C) Hospital confinement indemnity coverage.
- 4     (D) Major medical expense coverage.
- 5     (E) Disability income protection coverage.
- 6     (F) Accident only coverage.
- 7     (G) Specified disease or specified accident coverage.
- 8     (H) Such other categories as the commissioner may prescribe.
- 9     (2) The principal benefits and coverage of the disability
- 10  insurance policy, including coverage for acute care and subacute
- 11  care if the policy is a health insurance policy, as defined in Section
- 12  106.
- 13     (3) The exceptions, reductions, and limitations that apply to the
- 14  policy.
- 15     (4) A summary, including a citation of the relevant contractual
- 16  provisions, of the process used to authorize, modify, delay, or deny
- 17  payments for services under the coverage provided by the policy
- 18  including coverage for subacute care, transitional inpatient care,
- 19  or care provided in skilled nursing facilities. This paragraph shall
- 20  only apply to health insurance policies, as defined in Section 106.
- 21     (5) The full premium cost of the policy.
- 22     (6) Any copayment, coinsurance, or deductible requirements
- 23  that may be incurred by the insured or his or her family in
- 24  obtaining coverage under the policy.
- 25     (7) The terms under which the policy may be renewed by the
- 26  insured, including any reservation by the insurer of any right to
- 27  change premiums.
- 28     (8) A statement that the disclosure form is a summary only, and
- 29  that the policy itself should be consulted to determine governing
- 30  contractual provisions.
- 31     (9) For a health insurance policy, as defined in Section 106, all
- 32  of the following:
- 33         (A) A notice on the first page of the disclosure form that
- 34  conforms with all of the following conditions:
- 35             (i) (I) States that the form discloses the terms and conditions
- 36  of coverage.
- 37             (ii) States, with respect to individual health insurance policies,
- 38  small group health insurance policies, and any group health
- 39  insurance policies, that the applicant has a right to view the
- 40  disclosure form and policy prior to beginning coverage under the

1 *policy, and, if the policy does not accompany the disclosure form,*  
2 *the notice shall specify where the policy can be obtained prior to*  
3 *beginning coverage.*

4 *(ii) Includes a statement that the disclosure and the policy should*  
5 *be read completely and carefully and that individuals with special*  
6 *health care needs should read carefully those sections that apply*  
7 *to them.*

8 *(iii) Includes the insurer's telephone number or numbers that*  
9 *may be used by an applicant to receive additional information*  
10 *about the benefits of the policy, or states where those telephone*  
11 *number or numbers are located in the disclosure form*

12 *(iv) For individual health insurance policies, and small group*  
13 *health insurance policies, states where a health policy benefits*  
14 *and coverage matrix is located.*

15 *(v) Is printed in type no smaller than that used for the remainder*  
16 *of the disclosure form and is displayed prominently on the page.*

17 *(B) A statement as to when benefits shall cease in the event of*  
18 *nonpayment of premium and the effect of nonpayment upon an*  
19 *insured who is hospitalized or undergoing treatment for an ongoing*  
20 *condition.*

21 *(C) To the extent that the policy or insurer permits a free choice*  
22 *of provider to its insureds, the statement shall disclose, consistent*  
23 *with Section 10123.12, the nature and extent of choice permitted*  
24 *and the financial liability that is, or may be, incurred by the*  
25 *insured, covered dependents, or a third party by reason of the*  
26 *exercise of that choice.*

27 *(D) For group health insurance policies, including small group*  
28 *health insurance policies, a summary of the terms and conditions*  
29 *under which insureds may remain in the policy in the event the*  
30 *group ceases to exist, the group policy is terminated, or an*  
31 *individual insured leaves the group, or the insureds' eligibility*  
32 *status changes.*

33 *(E) If the policy utilizes arbitration to settle disputes, a statement*  
34 *of that fact. If the policy requires binding arbitration, a disclosure*  
35 *pursuant to Section 10123.19.*

36 *(F) A description of any limitations on the insured's choice of*  
37 *primary care physician, specialty care physician, or nonphysician*  
38 *health care practitioner, based on service area and limitations on*  
39 *the insured's choice of acute care hospital care, subacute or*  
40 *transitional inpatient care, or skilled nursing facility.*

1 (G) Conditions and procedures for cancellation, rescission, or  
2 nonrenewal.

3 (H) A description as to how an insured may request continuity  
4 of care as required by Sections 10133.55 and 10133.56, and  
5 request a second opinion pursuant to Section 10123.68.

6 (I) Information concerning the right of an insured to request  
7 an independent medical review in accordance with Article 3.5  
8 (commencing with Section 10169) of Chapter 1.

9 (J) A notice as required by Section 791.04.

10 (b) This section shall become operative on July 1, 2013.

11 SEC. 4. ~~Section 10604 of the Insurance Code is amended to~~  
12 ~~read:~~

13 ~~10604. The disclosure form shall include at least the following~~  
14 ~~information, in concise and specific terms, relative to the disability~~  
15 ~~insurance policy, together with additional information as the~~  
16 ~~commissioner may require in connection with the policy:~~

17 ~~(a) The applicable category or categories of coverage provided~~  
18 ~~by the policy, from among the following:~~

- 19 ~~(1) Basic hospital expense coverage.~~
- 20 ~~(2) Basic medical-surgical expense coverage.~~
- 21 ~~(3) Hospital confinement indemnity coverage.~~
- 22 ~~(4) Major medical expense coverage.~~
- 23 ~~(5) Disability income protection coverage.~~
- 24 ~~(6) Accident only coverage.~~
- 25 ~~(7) Specified disease or specified accident coverage.~~

26 ~~(8) Such other categories as the commissioner may prescribe.~~

27 ~~(b) The principal benefits and coverage of the disability~~  
28 ~~insurance policy, including coverage for acute care and subacute~~  
29 ~~care if the policy is a health insurance policy, as defined in Section~~  
30 ~~106.~~

31 ~~(c) The exceptions, reductions, and limitations that apply to the~~  
32 ~~policy.~~

33 ~~(d) A summary, including a citation of the relevant contractual~~  
34 ~~provisions, of the process used to authorize, modify, delay, or deny~~  
35 ~~payments for services under the coverage provided by the policy~~  
36 ~~including coverage for subacute care, transitional inpatient care,~~  
37 ~~or care provided in skilled nursing facilities. This subdivision shall~~  
38 ~~only apply to health insurance policies, as defined in Section 106.~~

39 ~~(e) The full premium cost of the policy.~~

1     ~~(f) Any copayment, coinsurance, or deductible requirements~~  
2     ~~that may be incurred by the insured or his or her family in obtaining~~  
3     ~~coverage under the policy.~~

4     ~~(g) The terms under which the policy may be renewed by the~~  
5     ~~insured, including any reservation by the insurer of any right to~~  
6     ~~change premiums.~~

7     ~~(h) A statement that the disclosure form is a summary only, and~~  
8     ~~that the policy itself should be consulted to determine governing~~  
9     ~~contractual provisions.~~

10    ~~(i) For a health insurance policy, as defined in Section 106, all~~  
11    ~~of the following:~~

12    ~~(1) A notice on the first page of the disclosure form that~~  
13    ~~conforms with all of the following conditions:~~

14    ~~(A) (i) States that the form discloses the terms and conditions~~  
15    ~~of coverage.~~

16    ~~(ii) States, with respect to individual health insurance policies,~~  
17    ~~small group health insurance policies, and any group health~~  
18    ~~insurance policies, that the applicant has a right to view the~~  
19    ~~disclosure form and policy prior to beginning coverage under the~~  
20    ~~policy, and, if the policy does not accompany the disclosure form,~~  
21    ~~the notice shall specify where the policy can be obtained prior to~~  
22    ~~beginning coverage.~~

23    ~~(B) Includes a statement that the disclosure and the policy should~~  
24    ~~be read completely and carefully and that individuals with special~~  
25    ~~health care needs should read carefully those sections that apply~~  
26    ~~to them.~~

27    ~~(C) Includes the insurer's telephone number or numbers that~~  
28    ~~may be used by an applicant to receive additional information~~  
29    ~~about the benefits of the policy, or states where those telephone~~  
30    ~~number or numbers are located in the disclosure form.~~

31    ~~(D) For individual health insurance policies, and small group~~  
32    ~~health insurance policies, states where a health policy benefits and~~  
33    ~~coverage matrix is located.~~

34    ~~(E) Is printed in type no smaller than that used for the remainder~~  
35    ~~of the disclosure form and is displayed prominently on the page.~~

36    ~~(2) A statement as to when benefits shall cease in the event of~~  
37    ~~nonpayment of premium and the effect of nonpayment upon an~~  
38    ~~insured who is hospitalized or undergoing treatment for an ongoing~~  
39    ~~condition.~~

1     ~~(3) To the extent that the policy or insurer permits a free choice~~  
2     ~~of provider to its insureds, the statement shall disclose, consistent~~  
3     ~~with Section 10123.12, the nature and extent of choice permitted~~  
4     ~~and the financial liability that is, or may be, incurred by the insured,~~  
5     ~~covered dependents, or a third party by reason of the exercise of~~  
6     ~~that choice.~~

7     ~~(4) For group health insurance policies, including small group~~  
8     ~~health insurance policies, a summary of the terms and conditions~~  
9     ~~under which insureds may remain in the policy in the event the~~  
10    ~~group ceases to exist, the group policy is terminated, or an~~  
11    ~~individual insured leaves the group, or the insureds' eligibility~~  
12    ~~status changes.~~

13    ~~(5) If the policy utilizes arbitration to settle disputes, a statement~~  
14    ~~of that fact. If the policy requires binding arbitration, a disclosure~~  
15    ~~pursuant to Section 10123.19.~~

16    ~~(6) A description of any limitations on the insured's choice of~~  
17    ~~primary care physician, specialty care physician, or nonphysician~~  
18    ~~health care practitioner, based on service area and limitations on~~  
19    ~~the insured's choice of acute care hospital care, subacute or~~  
20    ~~transitional inpatient care, or skilled nursing facility.~~

21    ~~(7) Conditions and procedures for cancellation, rescission, or~~  
22    ~~nonrenewal.~~

23    ~~(8) A description as to how an insured may request continuity~~  
24    ~~of care as required by Sections 10133.55 and 10133.56, and request~~  
25    ~~a second opinion pursuant to Section 10123.68.~~

26    ~~(9) Information concerning the right of an insured to request an~~  
27    ~~independent medical review in accordance with Article 3.5~~  
28    ~~(commencing with Section 10169) of Chapter 1.~~

29    ~~(10) A notice as required by Section 791.04.~~

30     ~~SEC. 12. No reimbursement is required by this act pursuant~~  
31     ~~to Section 6 of Article XIII B of the California Constitution because~~  
32     ~~the only costs that may be incurred by a local agency or school~~  
33     ~~district will be incurred because this act creates a new crime or~~  
34     ~~infraction, eliminates a crime or infraction, or changes the penalty~~  
35     ~~for a crime or infraction, within the meaning of Section 17556 of~~  
36     ~~the Government Code, or changes the definition of a crime within~~  
37     ~~the meaning of Section 6 of Article XIII B of the California~~  
38     ~~Constitution.~~