From: DMHC Licensing eFiling
Subject: APL 19-020 (OPL) – Guidance for Sec. 1365 Cancellation Regulations
Date: Monday, October 21, 2019 2:01:12 PM
Attachments: APL 19-020 (OPL) - Guidance for Sec. 1365 Cancellation Regulations (10.21.19)
Checklist for Sec. 1365 Cancellation Regulations (10.21.19)

Dear Health Plan Representative,

Please see the attached All Plan Letter with Checklist, regarding guidance for Section 1365 Cancellation Regulations.

Thank you.

DEPARTMENT OF Managed Health Care

Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
www.HealthHelp.ca.gov

ALL PLAN LETTER

DATE: October 21, 2019

TO: All Health Care Service Plans

FROM: Phuc Nguyen
Acting Deputy Director, Office of Plan Licensing

SUBJECT: APL 19-020 (OPL) Guidance for Regulations Regarding Cancellations, Rescissions and Nonrenewals

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The Department of Managed Health Care (the DMHC or Department) issues this All Plan Letter (APL) to provide guidance to health care service plan (plans) regarding the recently adopted revised regulations regarding cancellations, rescissions and nonrenewals. The regulations are codified in the California Code of Regulations, title 28, sections 1300.65 through 1300.65.5 (Cancellation Regulations) and became effective October 1, 2019. Attached to this APL is the Checklist for Health Care Service Plan Cancellations, Rescissions, and Nonrenewals of an Enrollment or Subscription (Checklist).

I. Background

The Knox Keene Health Care Service Plan Act of 1975, as amended, (Health and Safety Code Section 1340, *et seq.*) (Act) imposes limitations on the cancellation, rescission and nonrenewal of health care service plan contracts (health plan contracts) and provides enrollees, subscribers, and group contract holders with a right to file a grievance with the DMHC in certain circumstances, consistent with federal law under the Patient Protection and Affordable Care Act (ACA).[1]

The law specifies that unless one of the seven reasons set out Health and Safety Code sections 1365 and 1389.21[2] is present, and specific requirements are met, an enrollment, subscription, or contract cannot be canceled, rescinded, or not renewed.

[1] Codified at Title 42, United States Code (USC) sections 300gg-2, 300gg-12, and 300gg-42.

[2] References to California Code of Regulations sections will be designated as "Rule," e.g., Rule 1300.65.1, and references to California Health and Safety Code sections will be designated as "Section," e.g., Section 1365.

The rulemaking amended Rules 1300.65, 1300.65.1, 1300.65.2, and added Rules 1300.65.3, 1300.65.4, and 1300.65.5 to implement, interpret and make specific the rights and requirements under Sections 1365 and 1389.21, and parts 156.270 and 155.430 of title 45, Code of Federal Regulations (CFR).

II. Key Clarifications

The following is a non-exhaustive list of highlights of the revised Cancellation Regulations.[3]

A. Grace Periods

The Cancellation Regulations define "grace period" to mean the period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated. Rule 1300.65(a)(9). The grace period may not begin sooner than the day after the last date of paid coverage. Rule 1300.65.2(a)(2)(A).

The Cancellation Regulations define "federal grace period" to mean the period of three consecutive months a QHP Issuer must provide to an APTC enrollee, before terminating the APTC enrollee's health care coverage for nonpayment of premiums. Rule 1300.65(a)(8). The effective date of cancellation for an APTC enrollee canceled or not renewed shall be the day after the last day of the first month of the 3-month federal grace period pursuant to 45 Code of Federal Regulations part 155.430(d)(4). Rule 1300.65.3(a)(5)(A).

Section 1365, subdivision (a)(1)(C)(iv) states "for a health care service plan contract issued, amended, or renewed on or after January 1, 2020, all requirements applicable to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advance payments of premium tax credit authorized by Section 36B of the Internal Revenue Code shall apply to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advanced premium assistance subsidy authorized by Section 100800 of the Government Code." The DMHC interprets the law to require plans to provide an individual who receives the State advance premium assistance subsidy (State premium assistance subsidy enrollee) with a "federal grace period," which includes complying with all notice and timing requirements.

B. Suspension of Coverage

Suspension of coverage during months two and three of the federal grace period is optional for the Plan. Rule 1300.65.3(a)(3)(A). However, a Suspension QHP Issuer that fails to send the Notice of Start of Federal Grace Period by the applicable deadline(s) shall not suspend the APTC enrollee's coverage during the second and third months of the federal grace period. Rule 1300.65.3(a)(2)(E).

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[3] This document does not purport to describe the Cancellation Regulations in their entirety, and should not be a substitute for review of the entire Cancellation Regulations.

C. Grievance

The Cancellation Regulations define "grievance" to mean a written or oral expression of dissatisfaction to the plan or the Director regarding the plan and/or provider, including a written or oral expression of dissatisfaction by an enrollee, subscriber, or group contract holder who believes their plan contract, enrollment or subscription has been or will be improperly cancelled, rescinded or not renewed. The right to request a review by filing a complaint authorized under Section 1365(b) shall be handled as an expedited grievance pursuant to the requirements of Sections 1368 and 1368.01, and Rules 1300.68 and 1300.68.01. Rule 1300.65(a)(10).

Grievances to the Director may be made electronically, verbally, or in writing signed by the enrollee, subscriber, or group contract holder (or their legal representative). Rule 1300.65.4(a). An enrollee, subscriber, or group contract holder is not required to use a specific form to submit a written grievance to the Director pursuant to Section 1365(b)(1). Rule 1300.65.4(b). If an enrollee, subscriber, or group contract holder submits a grievance before the effective date of a cancellation, rescission, or nonrenewal for reasons other than nonpayment of premiums the plan shall continue to provide coverage as specified in Rule 1300.65(c). Rule 1300.65(b)(5).

D. Strict Compliance

The Cancellation Regulations provide that if the Director determines the cancellation, rescission, or nonrenewal fails to comply with all legal requirements, including, but not limited to, all notice and timing requirements in this Article, the Director shall order reinstatement, in accordance with Section 1300.65(d), or direct the plan not to cancel coverage. Rule 1300.65(b)(7).

E. Payment of Accrued Premiums

The Cancellation Regulations provide that an enrollee, subscriber, or group contract holder shall be responsible for any and all premium payments accrued from the effective date of cancellation, rescission, or nonrenewal. An enrollee, subscriber, or group contract holder must pay all outstanding premiums before reinstatement. Rule 1300.65(d)(4).

III. Miscellaneous Provisions

A. Premium Payment Threshold Policy

Rules 1300.65.2(a)(4) and 1300.65.3(a)(2)(C) provides authority for a Plan to implement a premium payment threshold policy. Plans may exercise the discretion to implement such a policy so long as the policy meets the requirements set out in Rule 1300.65(a)(21), i.e., the policy is reasonable and is applied in a uniform manner to all enrollees, subscribers, and group contract holders.

Plans exercising the discretion to implement such a policy should indicate so, and affirm in its 2019 Cancellation Regulations Compliance Filing that the Plan's premium payment threshold policy complies with the requirements of Rule 1300.65(a)(21).

B. State Advanced Premium Assistance Subsidy

Senate Bill 78[4] created Individual Market Assistance, including advanced premium assistance subsidies. The bill authorizes plans to cancel, nonrenew or rescind an enrollment or subscription of an enrollee who receives advanced premium assistance subsidy or advance payments of the federal premium tax credit for nonpayment of premiums after a three-month grace period is exhausted and all other requirements are met. *See* Section 1365(a)(1)(C)(iv). Section 1365, subdivision (a)(1)(C)(i) provides:

> For nonpayment of the required premiums by an individual who receives advance payments of the premium tax credit authorized by Section 36B of the Internal Revenue Code or advanced premium assistance subsidy authorized by Section 100800 of the Government Code, or both, if the individual has been duly notified and billed for the charge and a grace period of three consecutive months has elapsed since the last day of paid coverage.

Plans may comply with the notice requirements either by issuing (1) any notice(s) developed by Covered California for this purpose, or (2) Federal grace period notices edited to reflect the enrollee is a recipient of only the State subsidy, and/or the enrollee is a recipient of both the State and Federal subsidies. *See* Rules 1300.65(a)(2) and 1300.65.3. For enrollees who are recipients of only the State- subsidy, plans may edit the language of the federal grace period notices as appropriate, e.g., the plan may substitute the name of enrollee's health care service plan wherever "QHP Issuer" is referenced, etc. For enrollees who are recipients of both state- and federal-based subsidies, plans may combine language to make one set of notices.[5]

The Plan should submit template notices for cancellations, rescissions, or nonrenewals based on nonpayment of premiums for enrollees who receive State APTC as an Exhibit I-9. (*See* Attached Checklist at pp. 7-8).

IV. 2019 Cancellation Regulations Compliance Filing[6]

The Cancellation Regulations became effective on October 1, 2019. By December 2, 2019, plans are required to submit an <u>Amendment</u> filing that demonstrates, at a minimum, certain plan documents meet requirements set forth in the Cancellation

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[4] Health Trailer Bill, approved by Governor, June 27, 2019.
[5] Notices with combined language should be clear and not mislead enrollees, e.g., notices should not mislead an APTC enrollee to believe s/he is also eligible for the State advanced premium assistance subsidy (and vice-versa) if s/he is not.
[6] Plans with only Medi-Cal, Medicare Advantage or Employee Assistance Program lines of business are not required to submit a compliance filing.

Regulations. The Amendment filing should be captioned "2019 Cancellation Regulations Compliance Filing."
Specifically, Plans must submit for Department review the following new and/or revised plan documents:

- Enrollee, Subscriber, and Group Contract Holder Notices -- Exhibit I-9.
- Grievance Policies, and Grievance Policies and Procedures -- Exhibit W-1.[7]
- Forms and Templates -- Exhibit W-2.

(*See* Attached Checklist). Plan documents instructed to be filed as I-9, W-1, and W-2 Exhibits must be filed no later than December 2, 2019, for Department review and approval. Plans should not submit previously approved, and unchanged exhibits; instead, Plans should indicate in the Exhibit E-1 which Exhibits, if any, that are not revised and identify the eFiling No. where the Exhibit was previously approved.

Other plan documents will also need to be submitted to demonstrate compliance with the Cancellation Regulations; however, Plans may defer submitting other plan documents in the 2019 Cancellation Regulations Compliance Filing by including in the filing (1) an affirmation that the plan will comply with the Cancellation Regulations, (2) an affirmation that the Plan will, at a later date, issue new and/or revised Plan documents that demonstrate compliance with the Cancellation Regulations, and (3) description of how the Plan will provide information regarding revised cancellation, renewal and rescission procedures to enrollees and subscribers in the meantime. Plan documents that may be deferred include:

- Subscriber and Group Contracts -- Exhibit P-1.
- Evidences of Coverage (EOCs) and Disclosure Documents -- Exhibit S-1, T-1 and/or U-1.
- Any other Plan documents impacted by the Cancellation Regulations.

(See Attached Checklist). Plan documents instructed to be filed as P-1, S-1, T-1, and U-1 Exhibits may be filed after December 2, 2019, for Department review and approval.

V. Effective Date and Deadline

The Cancellation Regulations became effective on October 1, 2019. To demonstrate compliance with the Cancellation Regulations, Plan are required to submit an Amendment filing that includes submission of new and/or revised I-9, W-1, and W-2 Exhibits. Plans may defer submission of new and/or revised P-1, S-1, T-1, and U-1 Exhibits by making the affirmation described above. The 2019 Cancellation Regulations Compliance Filing must be submitted **no later than December 2, 2019**.

[7] The Department will focus its review of a plan's grievance policies in its *2019 Cancellation Regulations Compliance Filing* to issues relating to the Cancellation Regulations; however, the Department reserves the right to require plans to address any other compliance issues within the same filing or in a separate filing, as appropriate on a case-by-case basis.

Plans must fully implement newly-approved notices no later than April 1, 2020, for any enrollee entitled to a grace period starting on or after April 1, 2020. Plans that fully implement newly approved notices by April 1, 2020, will not be considered non-complaint with the Cancellation Regulations' notice requirements. The Cancellation Regulations' requirements unrelated to notice provisions are effective as of October 1, 2019.

Please direct questions regarding this APL or the Checklist to your Plan's assigned Licensing reviewer.

CHECKLIST FOR HEALTH CARE SERVICE PLAN CANCELLATIONS, RESCISSIONS, AND NONRENEWALS OF AN ENROLLMENT OR SUBSCRIPTION

This checklist is not intended to be all-inclusive; it only represents what issues, at a minimum, the Health Care Service Plan (Plan) must address when proposing new or revised Plan document(s) subject to the regulations related to Cancellations, Rescissions, and Nonrenewals of Health Care Service Plan Enrollment, Subscriptions, or Contracts (California Code of Regulations, title 28, sections 1300.65, 1300.65.1, 1300.65.2, 1300.65.3, 1300.65.4 and 1300.65.5 ("Cancellation Regulations")). The Department of Managed Health Care (Department or DMHC) may request additional information as necessary during its review to make a finding under the Knox-Keene Health Care Service Plan Act of 1975, (Act) as amended.[1]

Background:

Pursuant to Sections 1351(d), 1352, 1363(a), and 1365 and Rules 1300.51(d), 1300.65, 1300.65.1,1300.65.2, 1300.65.3, 1300.65.4 and 1300.65.5, the Plan must file for review its Subscriber Notices; Group and Individual Contract Holder Billing Statements; Group and Individual Subscriber Contracts; Provider Contracts; Evidences of Coverage (EOCs) and Disclosure Documents; Grievance Policies and Procedures; and Cancellation, Rescission and Nonrenewals Policies and Procedures; and, any other Plan document(s) to comply with the Act. Whether a particular change should be filed with the Department is an issue that should be addressed with the Plan's assigned counsel in the Office of Plan Licensing prior to submission of the Plan's Filing.

Applicability:

The provisions of the Cancellation Regulations do not apply to a plan contract offered in the Medi-Cal, Medicare Advantage, or Employee Assistance Program lines of business.

General Filing Information:

- ❑ File Plan documents as either a Notice of Material Modification or Amendment Filing.

  - Notice of Material Modification: Submit a Notice of Material Modification (Notice) when the Plan's proposed change or addition to the Plan documents have a material effect on the Plan's operations in accordance with Rule 1300.52.4(d).

    TIMING**:** The Plan should submit a Notice as early as possible, and prior to the document going into effect. Changes filed in a Notice may not go into effect until granted approval by the Department. Rule 1300.52.4(d).

  - Amendment Filing: Submit an Amendment Filing in accordance with Section 1352, Rule 1300.52 and Rule 1300.52.4(a) or (b). The Plan must file redlined changes to all information previously provided to and reviewed by the Department, including amendments to existing notices, EOCs, provider and

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[1] California Health and Safety Code Sections 1340 *et seq.* (Act). References herein to "Section" are to Sections of the Act. References to "Rule" refer to the regulations promulgated by the Department, the California Code of Regulations, title 28.

subscriber contracts and policies and procedures governing oversite of grievances and cancellations, rescissions, and nonrenewals.

TIMING: If possible, submit Amendment Filing prior to the document(s) going into effect. Amendment Filings must be submitted within 30 days of going into effect. Rule 1300.52.4(b)(i)(A).

- ❑ Revised Exhibits: If the Plan has revised documents previously approved by the Department, file the revised document as the proper Exhibit type, and identify in the Exhibit E-1 the eFiling number affiliated with the previously-approved document. Changes to the approved document must be identified via highlight or strikeout, in accordance with Rule 1300.52(d). Also submit a clean copy of the revised Exhibit in the filing.

- ❑ Improperly Filed Documents: The Department will not review improperly filed Notices, Amendments, and Exhibits. The Plan will be required to re-file and/or withdraw improperly filed Notices, Amendments, and Exhibits prior to review by the Department.

- ❑ Duration of Department Review: The duration of the Department's review will vary on a case-by-case basis. Duration of review depends on the quality of the documents and information provided by the Plan, responses to Department comments, and the complexity of the filing.

MINIMUM REQUIRED INFORMATION: CANCELLATION REGULATIONS FILING

Exhibit E-1: eFiling Narrative

To allow the Department to conduct an effective review, the Plan must provide a summary description of the filing, covering the highlights and essential features of the information and documents provided by the Plan in the filing. *See* Rule 1300.51(d)(E)(1). The Plan must also provide all information necessary for the Department to make a finding under the Act that the proposed Amendment or Notice is in the public interest and consistent with the intent and purposes of the Act. *See* Rule 1300.52.4(a)(ii). Therefore, in the Exhibit E-1 provide a detailed narrative description of the filing including a response to each item below:

1. **Purpose of Filing:** Describe the purpose of the filing.
   Examples:
   - *The purpose of this filing is to respond to the DMHC APL 19-0xx.*
   - *The purpose of this filing is to respond to Survey/Exam No. 2019xxxx.*
   - *The purpose of this filing is to respond to a Corrective Action Plan (CAP), dated xx/xx/xx, eFiling no. 2019xxxx.*

2. **Exhibits Included in Filing:** Describe and identify by name and Exhibit type all documents submitted for Department review.

   Examples:
   - *The Plan's 2019 Cancellation Regulations Compliance filing contains revised Exhibits I-9, W-1, and W-2 that comply with the Cancellation Regulations.*
   - *This Amendment filing contains revised Exhibits S-1. T-1, U-1, P-1 that comply with Rules 1300.65.2 and 1300.65.3.*

   Do not submit previously approved, and unchanged exhibits. For example, if the Plan is revising *only* a Billing Statement template, the Plan should only file the clean and redlined Billing Statement templates as an Exhibit I-9, and should not submit unchanged Exhibits W-1 or W-2.

3. **Previously Approved Documents:** If the Plan's filing includes amendments to consumer Notices, EOCs, Provider and/or Subscriber and Group Contracts, Grievance and Appeals policies and procedures and/or other policies and procedures documents previously approved by the Department, provide the eFiling number(s) associated with the original document(s) and any subsequent amendments.

4. **Scope of Policy, Procedure, or Document:** If the Plan is providing a policy, procedure or document for review, identify the scope of the policy, procedure or document, including whether the policy is comprehensive, i.e., demonstrates the Plan's compliance with all Cancellation Regulations for all of the Plan's products, or if the policy is one of a series of Plan policies or documents developed to comply with the Cancellation Regulations for a specific Plan product.

   One all-inclusive policy, procedure or document is not required. The Plan may use a group of separate policies to satisfy the requirements of the Cancellation Regulations. The Plan may file one policy to satisfy specific provisions of the Cancellation Regulations if the Plan has additional, separate policies for ensuring compliance with other cancellation, rescission, and nonrenewal provisions of the Act.

   Example:
   - *The Plan has a series of policies, procedures, and forms to ensure compliance with the Cancellation Regulations' provisions relating to nonpayment of premiums by enrollees who (1) do not receive any APTC, (2) receive Federal APTC, and (3) receive State advance premium assistance subsidy. This filing includes the Plan's policy and template enrollee correspondence for each series. In instances where a policy, procedure or form is the same between series, the Plan has indicated so.*

5. **Impact on other Plan Documents:** Explain the effect of the proposed change on any other enrollee or provider-facing documents, including, but not limited to, the description of the Plan's cancellation, rescission, and nonrenewal procedure and/or forms available to enrollees, and the evidence of coverage and/or disclosure form, or provider manual. Describe how:
   - The change will be communicated to the affected audience;
   - The timing for communication of the change; and,
   - Whether the change will necessitate revisions to other Plan documents.

6. **Implementation of Change:** If the Plan files a new or revised form, notice, or template correspondence, describe how and when the Plan will implement the change.

7. **Oversight Policies and Procedures:** If the Plan files a new or revised policy and procedure document, describe how and when the Plan will inform appropriate Plan personnel, vendors, and/or providers of the change(s).

8. **Use by Contracted or Subcontracted (Downstream) Entities:** Describe how the Plan will ensure downstream individuals or entities do not use or circulate the outdated policy, procedure, notice, form, or template correspondence, replaced by the new or revised policy, procedure, notice, form or template correspondence.

9. **Application of Changes to Delegates:** If the plan is required to amend contracts with vendors or other delegates to be consistent with the Cancellation Regulations, the Plan should describe in the Exhibit E-1 what contracts will be amended and the Plan's proposed timeframe for doing so. Pursuant to Section 1352(a) and (b) all contract amendments must be filed with the Department as either an Amendment or a Material Modification.

   If there is no change to the underlying Plan – to – Plan contract or Plan/ASA contract with a delegated entity and the delegated entity/Plan is required to use a template notice approved by the full-service Plan, indicate this in the each Plan's Exhibit E-1.

   If the Plan is a QHP issuer, indicate whether the Plan delegates any of the requirements contained in Rules 1300.65, 1300.65.1, 1300.65.2, and 1300.65.3 to a delegated group. Rule 1300.65(a)(22).

10. **State Advanced Premium Assistance Subsidy:** For cancellations or nonrenewals based on nonpayment of premiums for individuals receiving the Advanced Premium Assistance Subsidy authorized by Section 100800 of the Government Code (State premium assistance subsidy enrollee), the Plan may submit any of the following to demonstrate compliance with Section 1365(a)(1)(C):
    - Any notice developed by Covered California for this purpose.

- The notices required pursuant to the Cancellation Regulations for enrollees receiving the Federal APTC amended to incorporate requirements based on the state advanced premium assistance subsidy, as appropriate. *See* Rules 1300.65(a)(2) and 1300.65.3.

11. **End of Coverage Notification to Enrollee:** Rules 1300.65.1(a)(4) requires a Notice of End of Coverage for cancellations, rescissions or nonrenewals for reasons other than for nonpayment of premiums. Rules 1300.65.2(a)(3)(E) and 1300.65.3(a)(5)(B) permit health plans to choose between sending the notice adopted by Covered California pursuant to California Code of Regulations, title 10 section 6506(e)(1), or the End of Coverage notice under Rules 1300.65.1(b)(2), 1300.65.2(b)(2) or 1300.65.3(B)(4), for cancellations, rescissions or nonrenewals for nonpayment of premiums.

    For cancellations, rescissions or nonrenewals for nonpayment of premiums, indicate whether the Plan will be issuing Covered California's notice of termination or the Cancellation Regulations' Notices of End of Coverage. All Notices of End of Coverage must contain the required notice of grievance rights pursuant to Rules 1300.65.1(b)(2)(G)-(H), Rule 1300.65.2(b)(2)(G)-(H), and 1300.65.3(b)(4)(G)-(H), and may contain the notice required pursuant to Section 1366.50.

12. **Premium Payment Threshold Policy:** Rules 1300.65.2(a)(4) and 1300.65.3(a)(2)(C) permits a plan to have a "premium payment threshold policy" provided that the policy is reasonable and that level and policy are applied in a uniform manner to all enrollees, subscribers, and group contract holders. Indicate if the plan has a premium payment threshold policy; and if the Plan does, affirm that the Plan's premium payment threshold policy complies with the requirements of Rule 1300.65(a)(21).

13. **Timelines for Cancellation, Rescissions, and Nonrenewals:** The Cancellation Regulations require the Plan to meet various timelines and requirements with respect to notifying enrollees, subscribers, and contract holders regarding cancellations, rescissions and nonrenewals. In the Exhibit E-1, the Plan must describe how timelines and other requirements will be implemented and communicated by the Plan and any delegates/vendors the plan uses to process cancellations, rescissions and nonrenewals, and notices.

    Policies and procedures, handbooks, or other matrices/documents demonstrating how the Plan will comply with the requirements of the Cancellation Regulations, must be revised to be consistent with the Cancellation Regulations and submitted for review, using highlight and/or redline to display revisions and filed as an Exhibit E-1 Attachment.

14. **Evidences of Coverage and Disclosure Documents:** Indicate what revisions were needed to the Plan's EOCs and Disclosure Documents. If the Plan will

make changes to its EOCs and disclosure documents at a later date, indicate the sections of the EOC and/or disclosure forms that will be amended, how and when the plan will inform enrollees, subscribers and contract holders of the changes.

Examples:

- *The Plan reviewed its current EOCs and disclosure documents and determined those documents are consistent with requirements in the Cancellation Regulations. The Plan did not revise its EOCs and/or disclosure forms, and those documents are not included in this filing.*
- *The Plan reviewed its current EOCs and disclosure documents and determined those documents are inconsistent with requirements in the Cancellation Regulations. The plan revised its EOCs and/or disclosure forms to amend the grace period provisions to comply with the Act and Rules, and those documents are included in this filing. The Plan will provide timely electronic notice to enrollees and subscribers.*
- *The Plan reviewed its current EOCs and disclosure documents and determined those documents are inconsistent with requirements in the Cancellation Regulations. The plan is in the process of revising its EOCs and/or disclosure forms to amend the grace period provisions to comply with the Act and Rules, and those documents will be filed as soon as possible. The Plan will provide timely electronic notice to enrollees and subscribers.*

15. **Subscriber Contracts:** Indicate whether the Plan needs to make changes to its Subscriber Contracts. If the Plan will make changes to its Subscriber Contracts at a later date, indicate the sections of the Subscriber Contracts that will be amended, how and when the plan will inform enrollees, subscribers and contract holders of the changes.

Examples:

- *The Plan reviewed its current Subscriber Contracts and determined those documents are consistent with requirements in the Cancellation Regulations. The Plan did not revise its Subscriber Contracts, and those documents are not included in this filing.*
- *The Plan reviewed its current Subscriber Contracts and determined those documents are inconsistent with requirements in the Cancellation Regulations. The plan revised its Subscriber Contracts to amend the billing provisions to comply with the Act and Rules, and those documents are included in this filing. The Plan will provide timely electronic notice to enrollees and subscribers.*
- *The Plan reviewed its current Subscriber Contracts and determined those documents are inconsistent with requirements in the Cancellation Regulations. The plan is in the process of revising its Subscriber Contracts to amend the billing provisions to comply with the Act and Rules, and those documents will be filed as soon as possible. The Plan will provide timely electronic notice to enrollees and subscribers.*

16. **Language Assistance:** Provide an affirmation the Plan will comply with all language assistance requirements for the Notices and grievance forms as required pursuant to Section 1367.04 and Rules 1300.67.04(c)(1)(D) and (F), and 1300.68(b)(3).

17. **Other Information:** Include any other information the Plan thinks would help the Department in its review of this filing.

Exhibit I-9: Enrollee, Subscriber, and Group Contract Holder Notices

The Plan must file template Notices and a template billing statement for review and approval. To the extent existing notices have been revised to comply with the Cancellation Regulations, submit the redlined copy of such notices pursuant to Rule 1300.52(d). If the same template notice will be used for compliance with more than one section of the Cancellation Regulations, ensure any differences that reflect the different notice elements are highlighted, bracketed or otherwise clearly indicated.

- ❑ Exhibit I-9: Submit the following template notices as an Exhibit I-9:
  - ❑ **Bill**. Rule 1300.65(a)(2).
  - ❑ **Notice of Cancellation, Rescission, or Nonrenewal**. Rule 1300.65.1(b)(1).
  - ❑ **Notice of Start of Grace Period**. Rule 1300.65.2(b)(1).
  - ❑ **Notice of End of Coverage**. Rule 1300.65.1(b)(2); *See* Rules 1300.65.2(b)(2) and 1300.65.3(b)(4).
  - ❑ **Notice of Termination** and/or **Notice of End of Coverage**. 10 C.C.R. § 6506(e)(1), Rules 1300.65.1(a)(4), 1300.65.2(a)(3)(E), 1300.65.1(b)(2), and 1300.65.2(b)(2).

- ❑ Exhibit I-9 for Federal APTC enrollees: Submit the following template notices, for cancellations, rescissions, or nonrenewals based on nonpayment of premiums for enrollees who receive Federal APTC, as an Exhibit I-9:
  - ❑ **Bill**. Rule 1300.65(a)(2).
  - ❑ **Notice of Start of Federal Grace Period to APTC Enrollee**. Rule 1300.65.3(b)(1).
  - ❑ **Notice of Suspension to APTC Enrollee**. Rule 1300.65.3(b)(2).
  - ❑ **Notice of Suspension to APTC Enrollee's Provider(s)**. Rule 1300.65.3(b)(3).
  - ❑ **Notice of Termination** and/or **Notice of End of Coverage**. 10 C.C.R. § 6506(e)(1), Rules 1300.65.3(a)(5)(B), and 1300.65.3(b)(4).

- ❑ Exhibit I-9 for State premium assistance subsidy enrollees: Submit the following template notices, for cancellations, rescissions, or nonrenewals based on nonpayment of premiums for enrollees who receive State premium assistance subsidies, as an Exhibit I-9:
  - ❑ **Bill**. Rule 1300.65(a)(2).
  - ❑ ***Notice of Start of Grace Period to State Premium Assistance Subsidy Enrollee***. *Cf.* Rule 1300.65.3(b)(1).

- ❑ ***Notice of Suspension to State Premium Assistance Subsidy Enrollee***. *Cf.* Rule 1300.65.3(b)(2).
- ❑ ***Notice of Suspension to State Premium Assistance Subsidy Enrollee's Provider(s)***. *Cf.* Rule 1300.65.3(b)(3).
- ❑ **Notice of Termination** and/or **Notice of End of Coverage**. *Cf.* 10 C.C.R. § 6506(e)(1), Rules 1300.65.3(a)(5)(B), and 1300.65.3(b)(4).

Exhibit W-1: Grievance Policies, and Grievance Policies and Procedures

The Plan must file its grievance policies, policies and procedures for review and approval. Pursuant to Section 1351(l), the Plan must provide a description of its grievance policies, and provide policies and procedures demonstrating compliance with Section 1368 and Rule 1300.68. *See* Section 1368, Rules 1300.51(d)(W)(1) and 1300.68.

- ❑ Exhibit W-1: Submit new or revised grievance policies, policies and procedures as an Exhibit W-1.

Exhibit W-2: Forms and Template Letters

The Plan must file copies of its grievance and independent medical review (IMR) forms. *See* Sections 1351 and 1352, and Rules 1300.51(d)(W)(2), 1300.65.4(c) and (d). The Plan must also file templates of its enrollee correspondence related to grievances and IMR requirements. *See* Rules 1300.52.4(a)(ii) and 1300.65.4(c).

- ❑ Exhibit W-2: Submit the following template forms and documents, if applicable, as an Exhibit W-2:
  - ❑ **Grievance form**. *See* Rules 1300.65.4(c) and (d).
  - ❑ **Grievance receipt acknowledgement letter**. *See* Section 1300.68 (d)(1).
  - ❑ **Grievance resolution letter**. *See* Section 1300.68 (d)(3).
  - ❑ **Enrollee rights to submit an urgent grievance letter**. *See* Section 1368.01(b).
  - ❑ **Disposition or pending status of urgent grievance letter**. *See* Section 1300.68.01(a)(2).

Exhibit P-1: Subscriber and Group Contracts

The Plan must file subscriber and group contracts for review and approval in accordance with Section 1352, and Rules 1300.52 and 1300.52.4(a) or (b). Subscriber contracts must include provisions relating to cancellation. *See* Rule 1300.67.4(a)(5).

- ❑ Exhibit P-1: Submit revised subscriber and group contracts as an Exhibit P-1.

Exhibit(s): S-1, T-1 and/or or U-1, EOCs and Disclosure Documents

The Plan must file EOCs and/or disclosure forms for review and approval. The Plan's EOCs and/or disclosure forms must include the conditions and procedures under which coverage may cease. *See* Section 1363(a)(5), (7) and (14), and Rules 1300.63 and 1300.63.1.

- ❑ Exhibit S-1: Submit revised disclosure forms as an Exhibit S-1.
- ❑ Exhibit T-1: Submit revised EOCs as an Exhibit T-1.
- ❑ Exhibit U-1: Submit revised combined EOCs/disclosure forms as an Exhibit U-1.