HEALTH AND SAFETY CODE
SECTION 1366.20-1366.29

1366.20. (a) This article shall be known as the California Continuation Benefits Replacement Act, or "Cal-COBRA."

(b) It is the intent of the Legislature that continued access to health insurance coverage is provided to employees, and their dependents, of employers with 2 to 19 eligible employees who are not currently offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985.

(c) It is the intent of the Legislature that any federal assistance that is or may become available to qualified beneficiaries under this article be effectively and promptly implemented by the department.

(d) The director, in consultation with the Insurance Commissioner, may adopt emergency regulations to implement this article in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code by making a finding of emergency and demonstrating the need for immediate action in the event that any federal assistance is or becomes available to qualified beneficiaries under this article. The adoption of these regulations shall be considered by the Office of Administrative Law to be necessary to avoid serious harm to the public peace, health, safety, or general welfare. Any regulations adopted pursuant to this subdivision shall be substantially similar to those adopted by the Insurance Commissioner under subdivision (d) of Section 10128.50 of the Insurance Code.

1366.21. The definitions contained in this section govern the construction of this article.

(a) "Continuation coverage" means extended coverage under the group benefit plan in which an eligible employee or eligible dependent is currently enrolled, or, in the case of a termination of the group benefit plan or an employer open enrollment period, extended coverage under the group benefit plan currently offered by the employer.

(b) "Group benefit plan" means any health care service plan contract provided pursuant to Article 3.1 (commencing with Section 1357) to an employer with 2 to 19 eligible employees, as defined in Section 1357, as well as a specialized health care service plan contract provided to an employer with 2 to 19 eligible employees, as defined in Section 1357.

(c) (1) "Qualified beneficiary" means any individual who, on the day before the qualifying event, is an enrollee in a group benefit plan offered by a health care service plan pursuant to Article 3.1 (commencing with Section 1357) and has a qualifying event, as defined in subdivision (d).

(2) "Qualified beneficiary eligible for premium assistance under ARRA" means a qualified beneficiary, as defined in paragraph (1), who (A) was or is eligible for continuation coverage as a result of the involuntary termination of the covered employee's employment during the period specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, (B) elects continuation coverage, and (C) meets the definition of "qualified beneficiary" set

forth in paragraph (3) of Section 1167 of Title 29 of the United States Code, as used in subparagraph (E) of paragraph (10) of subdivision (a) of Section 3001 of ARRA or any subsequent rules or regulations issued pursuant to that law.

(3) "ARRA" means Title III of Division B of the federal American Recovery and Reinvestment Act of 2009 or any amendment to that federal law extending federal premium assistance to qualified beneficiaries.

(d) "Qualifying event" means any of the following events that, but for the election of continuation coverage under this article, would result in a loss of coverage under the group benefit plan to a qualified beneficiary:

(1) The death of the covered employee.

(2) The termination of employment or reduction in hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying event.

(3) The divorce or legal separation of the covered employee from the covered employee's spouse.

(4) The loss of dependent status by a dependent enrolled in the group benefit plan.

(5) With respect to a covered dependent only, the covered employee's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

(e) "Employer" means any employer that meets the definition of "small employer" as set forth in Section 1357 and (1) employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar year, or, if the employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar quarter, (2) has contracted for health care coverage through a group benefit plan offered by a health care service plan, and (3) is not subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

(f) "Core coverage" means coverage of basic health care services, as defined in subdivision (b) of Section 1345, and other hospital, medical, or surgical benefits provided by the group benefit plan that a qualified beneficiary was receiving immediately prior to the qualifying event, other than noncore coverage.

(g) "Noncore coverage" means coverage for vision and dental care.

1366.22. The continuation coverage requirements of this article do not apply to the following individuals:

(a) Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as amended or superseded. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.

(b) Individuals who have other hospital, medical, or surgical coverage or who are covered or become covered under another group benefit plan, including a self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any preexisting condition of the individual, other than a preexisting condition limitation or exclusion that does not apply to or is satisfied by the qualified beneficiary pursuant to Sections 1357 and 1357.06. A group conversion option under any group benefit plan shall not be considered as an arrangement under which an individual is or becomes covered.

(c) Individuals who are covered, become covered, or are eligible for federal COBRA coverage pursuant to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

(d) Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq.

(e) Qualified beneficiaries who fail to meet the requirements of subdivision (b) of Section 1366.24 or subdivision (h) of Section 1366.25 regarding notification of a qualifying event or election of continuation coverage within the specified time limits.

(f) Except as provided in Section 3001 of ARRA, qualified beneficiaries who fail to submit the correct premium amount required by subdivision (b) of Section 1366.24 and Section 1366.26, in accordance with the terms and conditions of the plan contract, or fail to satisfy other terms and conditions of the plan contract.

1366.23. (a) Every health care service plan, including a specialized health care service plan contract, that provides coverage under a group benefit plan to an employer, as defined in Section 1366.21, shall offer continuation coverage, pursuant to this section, to a qualified beneficiary under the contract upon a qualifying event without evidence of insurability. The qualified beneficiary shall, upon election, be able to continue his or her coverage under the group benefit plan, subject to the contract's terms and conditions, and subject to the requirements of this article. Except as otherwise provided in this article, continuation coverage shall be provided under the same terms and conditions that apply to similarly situated individuals under the group benefit plan.

(b) Every health care service plan shall also offer the continuation coverage to a qualified beneficiary who (1) elects continuation coverage under a group benefit plan, as defined in this article or in Section 10128.51 of the Insurance Code, but whose continuation coverage is terminated pursuant to subdivision (b) of Section 1366.27, prior to any other termination date specified in Section 1366.27, or (2) who elects coverage through the health care service plan during any employer open enrollment, and the employer has contracted with the health care service plan to provide coverage to the employer's active employees. This continuation coverage shall be provided only for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan had the employer not terminated the group contract with the previous health care service plan or insurer.

(c) Every health care service plan or specialized health care service plan shall offer a qualified beneficiary the ability to elect the same core, noncore, or core and noncore coverage that the qualified beneficiary had immediately prior to the qualifying event.

(d) Any child who is born to a former employee who is a qualified beneficiary who has elected continuation coverage pursuant to this article or a child who is placed for adoption with a former employee who is a qualified beneficiary who has elected continuation coverage pursuant to this article during the period of continuation coverage provided by this article shall be considered a qualified beneficiary entitled to receive benefits pursuant to this article for the remainder of the period that the former employee is covered pursuant to this article, if the child is enrolled under a group benefit plan as a dependent of that former employee who is a qualified beneficiary within 30 days of the child's birth or placement for adoption.

(e) An individual who becomes a qualified beneficiary pursuant to this article shall continue to receive coverage pursuant to this article until continuation coverage is terminated at the qualified beneficiary's election or pursuant to Section 1366.27, whichever comes first, even if the employer that sponsored the group benefit plan that is continued subsequently becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq.

(f) A qualified beneficiary electing coverage pursuant to this section shall be considered part of the group contract and treated as similarly situated employees for contract purposes, unless otherwise specified in this article.

1366.24. (a) Every health care service plan evidence of coverage, provided for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.

(b) This disclosure shall state that all enrollees who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 1366.21, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the health care service plan, or the employer if the employer contracts to perform the administrative services as provided for in Section 1366.25, of all qualifying events as specified in paragraphs (1), (3), (4), and (5) of subdivision (d) of Section 1366.21 within 60 days of the date of the qualifying event. This disclosure shall inform enrollees that failure to make the notification to the health care service plan, or to the employer when under contract to provide the administrative services, within the required 60 days will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 1366.25, within the 60-day period following the later of (1) the date that the enrollee's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the enrollee was sent notice pursuant to subdivision (e) of Section 1366.25 of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the health care service plan, in accordance with the terms and conditions of the plan contract, which shall be set forth in the notice to the qualified beneficiary pursuant to subdivision (d) of Section 1366.25, the amount of the required premium payment, as set forth in Section 1366.26. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the employer has contracted with the plan to

perform the administrative services pursuant to subdivision (d) of Section 1366.25, within 45 days of the date the qualified beneficiary provided written notice to the health care service plan or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This disclosure shall also state that the first premium payment must equal an amount sufficient to pay any required premiums and all premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under a prior group benefit plan pursuant to subdivision (b) of Section 1366.27 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.

(d) Prior to August 1, 1998, every health care service plan shall provide to all covered employees of employers subject to this article a written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this section a new or amended evidence of coverage that includes the disclosures required by this section. Any specialized health care service plan that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits and does not maintain addresses of covered employees, may comply with the notice requirements of this section through the provision of the notices to its employer group purchasers of benefits.

(e) Every plan disclosure form issued, amended, or renewed on and after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an enrollee may be entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the plan's evidence of coverage.

(f) Every disclosure issued, amended, or renewed on and after July 1, 2006, for a group benefit plan subject to this article shall include the following notice:

"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

1366.25. (a) Every group contract between a health care service plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify the plan, in writing, of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 1366.21, within 30 days of the qualifying event. The group contract shall also require the employer to notify the plan, in writing, within 30 days of the date, when the employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec.

1161 et seq.

(b) Every group contract between a plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, as specified in Section 1366.27, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.

Every health care service plan and specialized health care service plan shall provide to the employer replacing a health care service plan contract issued by the plan, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the plan reasonably required to administer the notification requirements of this subdivision and subdivision (c).

(c) Notwithstanding subdivision (a), the group contract between the health care service plan and the employer shall require the employer to notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by subdivision (c) of Section 1366.24 and subdivision (e) of this section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified beneficiaries who are enrolled in the plan and those qualified beneficiaries who have been notified, pursuant to Section 1366.24, of their ability to continue their coverage and may still elect coverage within the specified 60-day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the employer by the health care service plan or disability insurer currently providing continuation coverage to the qualified beneficiary. The successor plan shall not be obligated to provide this information to qualified beneficiaries if the employer or prior plan or insurer fails to comply with this section.

(d) A health care service plan may contract with an employer, or an administrator, to perform the administrative obligations of the plan as required by this article, including required notifications and collecting and forwarding premiums to the health care service plan. Except for the requirements of subdivisions (a), (b), and (c), this subdivision shall not be construed to permit a plan to require an employer to perform the administrative obligations of the plan as required by this article as a condition of the issuance or renewal of coverage.

(e) Every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, within 14 days of receiving a notice of a qualifying event, provide to the qualified beneficiary the necessary benefits information, premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 1366.24 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.

(f) Every health care service plan, or employer or administrator

that contracts to perform the notice and administrative services pursuant to this section, shall, during the 180-day period ending on the date that continuation coverage is terminated pursuant to paragraphs (1), (3), and (5) of subdivision (a) of Section 1366.27, notify a qualified beneficiary who has elected continuation coverage pursuant to this article of the date that his or her coverage will terminate, and shall notify the qualified beneficiary of any conversion coverage available to that qualified beneficiary. This requirement shall not apply when the continuation coverage is terminated because the group contract between the plan and the employer is being terminated.

(g) (1) A health care service plan shall provide to a qualified beneficiary who has a qualifying event during the period specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, a written notice containing information on the availability of premium assistance under ARRA. This notice shall be sent to the qualified beneficiary's last known address. The notice shall include clear and easily understandable language to inform the qualified beneficiary that changes in federal law provide a new opportunity to elect continuation coverage with a 65-percent premium subsidy and shall include all of the following:

(A) The amount of the premium the person will pay. For qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, if a health care service plan is unable to provide the correct premium amount in the notice, the notice may contain the last known premium amount and an opportunity for the qualified beneficiary to request, through a toll-free telephone number, the correct premium that would apply to the beneficiary.

(B) Enrollment forms and any other information required to be included pursuant to subdivision (e) to allow the qualified beneficiary to elect continuation coverage. This information shall not be included in notices sent to qualified beneficiaries currently enrolled in continuation coverage.

(C) A description of the option to enroll in different coverage as provided in subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA. This description shall advise the qualified beneficiary to contact the covered employee's former employer for prior approval to choose this option.

(D) The eligibility requirements for premium assistance in the amount of 65 percent of the premium under Section 3001 of ARRA.

(E) The duration of premium assistance available under ARRA.

(F) A statement that a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days of the date of the notice.

(G) A statement that a qualified beneficiary eligible for premium assistance under ARRA who rejected or discontinued continuation coverage prior to receiving the notice required by this subdivision has the right to withdraw that rejection and elect continuation coverage with the premium assistance.

(H) A statement that reads as follows:

"IF YOU ARE HAVING ANY DIFFICULTIES READING OR UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name of health plan] at [insert appropriate telephone number]."

(2) With respect to qualified beneficiaries who had a qualifying event between September 1, 2008, and May 12, 2009, inclusive, the notice described in this subdivision shall be provided by the later of May 26, 2009, or seven business days after the date the plan receives notice of the qualifying event.

(3) With respect to qualified beneficiaries who had or have a qualifying event between May 13, 2009, and the later date specified in subparagraph (A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA, inclusive, the notice described in this subdivision shall be provided within the period of time specified in subdivision (e).

(4) Nothing in this section shall be construed to require a health care service plan to provide the plan's evidence of coverage as a part of the notice required by this subdivision, and nothing in this section shall be construed to require a health care service plan to amend its existing evidence of coverage to comply with the changes made to this section by the enactment of Assembly Bill 23 of the 2009-10 Regular Session or by the act amending this section during the second year of the 2009-10 Regular Session.

(5) The requirement under this subdivision to provide a written notice to a qualified beneficiary and the requirement under paragraph (1) of subdivision (h) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed satisfied if a health care service plan previously provided a written notice and additional election opportunity under Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.

(h) (1) Notwithstanding any other provision of law, a qualified beneficiary eligible for premium assistance under ARRA may elect continuation coverage no later than 60 days after the date of the notice required by subdivision (g).

(2) For a qualified beneficiary who elects to continue coverage pursuant to this subdivision, the period beginning on the date of the qualifying event and ending on the effective date of the continuation coverage shall be disregarded for purposes of calculating a break in coverage in determining whether a preexisting condition provision applies under subdivision (c) of Section 1357.06 or subdivision (e) of Section 1357.51.

(3) For a qualified beneficiary who had a qualifying event between September 1, 2008, and February 16, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the continuation coverage shall commence on the first day of the month following the election.

(4) For a qualified beneficiary who had a qualifying event between February 17, 2009, and May 12, 2009, inclusive, and who elects continuation coverage pursuant to paragraph (1), the effective date of the continuation coverage shall be either of the following, at the option of the beneficiary, provided that the beneficiary pays the applicable premiums:

(A) The date of the qualifying event.

(B) The first day of the month following the election.

(5) Notwithstanding any other provision of law, a qualified beneficiary who is eligible for the special election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA may elect continuation coverage no later than 60 days after the date of the notice required under subdivision (j). For a qualified beneficiary who elects coverage pursuant to this paragraph, the continuation coverage shall be effective as of the first day of the first period of coverage after the date of termination of employment, except, if federal law permits, coverage shall take effect on the first day of the month following the election. However, for purposes of calculating the duration of continuation coverage pursuant to Section 1366.27, the period of that coverage shall be determined as though the qualifying event was a reduction of hours of the employee.

(6) Notwithstanding any other provision of law, a qualified

beneficiary who is eligible for any other special election opportunity under ARRA may elect continuation coverage no later than 60 days after the date of the special election notice required under ARRA.

(i) A health care service plan shall provide a qualified beneficiary eligible for premium assistance under ARRA written notice of the extension of that premium assistance as required under Section 3001 of ARRA.

(j) A health care service plan, or an administrator or employer if administrative obligations have been assumed by those entities pursuant to subdivision (d), shall give the qualified beneficiaries described in subparagraph (C) of paragraph (17) of subdivision (a) of Section 3001 of ARRA the written notice required by that paragraph by implementing the following procedures:

(1) The health care service plan shall, within 14 days of the effective date of the act adding this subdivision, send a notice to employers currently contracting with the health care service plan for a group benefit plan subject to this article. The notice shall do all of the following:

(A) Advise the employer that employees whose employment is terminated on or after March 2, 2010, who were previously enrolled in any group health care service plan or health insurance policy offered by the employer may be entitled to special health coverage rights, including a subsidy paid by the federal government for a portion of the premium.

(B) Ask the employer to provide the health care service plan with the name, address, and date of termination of employment for any employee whose employment is terminated on or after March 2, 2010, and who was at any time covered by any health care service plan or health insurance policy offered to their employees on or after September 1, 2008.

(C) Provide employers with a format and instructions for submitting the information to the health care service plan, or their administrator or employer who has assumed administrative obligations pursuant to subdivision (d), by telephone, fax, electronic mail, or mail.

(2) Within 14 days of receipt of the information specified in paragraph (1) from the employer, the health care service plan shall send the written notice specified in paragraph (17) of subdivision (a) of Section 3001 of ARRA to those individuals.

(3) If an individual contacts his or her health care service plan and indicates that he or she experienced a qualifying event that entitles him or her to the special election period described in paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other special election provision of ARRA, the plan shall provide the individual with the written notice required under paragraph (17) of subdivision (a) of Section 3001 of ARRA or any other applicable provision of ARRA, regardless of whether the plan receives information from the individual's previous employer regarding that individual pursuant to Section 24100. The plan shall review the individual's application for coverage under this special election notice to determine if the individual qualifies for the special election period and the premium assistance under ARRA. The plan shall comply with paragraph (5) if the individual does not qualify for either the special election period or premium assistance under ARRA.

(4) The requirement under this subdivision to provide the written notice described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to a qualified beneficiary and the requirement under paragraph (5) of subdivision (h) to provide a new opportunity to a qualified beneficiary to elect continuation coverage shall be deemed

satisfied if a health care service plan previously provided the written notice and additional election opportunity described in paragraph (17) of subdivision (a) of Section 3001 of ARRA to that qualified beneficiary prior to the effective date of the act adding this paragraph.

(5) If an individual does not qualify for either a special election period or the premium assistance under ARRA, the health care service plan shall provide a written notice to that individual that shall include information on the right to appeal as set forth in Section 3001 of ARRA.

(6) A health care service plan shall provide information on its publicly accessible Internet Web site regarding the premium assistance made available under ARRA and any special election period provided under that law. A plan may fulfill this requirement by linking or otherwise directing consumers to the information regarding COBRA continuation coverage premium assistance located on the Internet Web site of the United States Department of Labor. The information required by this paragraph shall be located in a section of the plan's Internet Web site that is readily accessible to consumers, such as the Web site's Frequently Asked Questions section.

(k) For purposes of implementing federal premium assistance for continuation coverage, the department may designate a model notice or notices that may be used by health care service plans. Use of the model notice or notices shall not require prior approval of the department. Any model notice or notices designated by the department for purposes of this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(l) Notwithstanding any other provision of law, a qualified beneficiary eligible for premium assistance under ARRA may elect to enroll in different coverage subject to the criteria provided under subparagraph (B) of paragraph (1) of subdivision (a) of Section 3001 of ARRA.

(m) A qualified beneficiary enrolled in continuation coverage as of February 17, 2009, who is eligible for premium assistance under ARRA may request application of the premium assistance as of March 1, 2009, or later, consistent with ARRA.

(n) A health care service plan that receives an election notice from a qualified beneficiary eligible for premium assistance under ARRA, pursuant to subdivision (h), shall be considered a person entitled to reimbursement, as defined in Section 6432(b)(3) of the Internal Revenue Code, as amended by paragraph (12) of subdivision (a) of Section 3001 of ARRA.

(o) (1) For purposes of compliance with ARRA, in the absence of guidance from, or if specifically required for state-only continuation coverage by, the United States Department of Labor, the Internal Revenue Service, or the Centers for Medicare and Medicaid Services, a health care service plan may request verification of the involuntary termination of a covered employee's employment from the covered employee's former employer or the qualified beneficiary seeking premium assistance under ARRA.

(2) A health care service plan that requests verification pursuant to paragraph (1) directly from a covered employee's former employer shall do so by providing a written notice to the employer. This written notice shall be sent by mail or facsimile to the covered employee's former employer within seven business days from the date the plan receives the qualified beneficiary's election notice pursuant to subdivision (h). Within 10 calendar days of receipt of written notice required by this paragraph, the former employer shall furnish to the health care service plan written verification as to

whether the covered employee's employment was involuntarily terminated.

(3) A qualified beneficiary requesting premium assistance under ARRA may furnish to the health care service plan a written document or other information from the covered employee's former employer indicating that the covered employee's employment was involuntarily terminated. This document or information shall be deemed sufficient by the health care service plan to establish that the covered employee's employment was involuntarily terminated for purposes of ARRA, unless the plan makes a reasonable and timely determination that the documents or information provided by the qualified beneficiary are legally insufficient to establish involuntary termination of employment.

(4) If a health care service plan requests verification pursuant to this subdivision and cannot verify involuntary termination of employment within 14 business days from the date the employer receives the verification request or from the date the plan receives documentation or other information from the qualified beneficiary pursuant to paragraph (3), the health care service plan shall either provide continuation coverage with the federal premium assistance to the qualified beneficiary or send the qualified beneficiary a denial letter which shall include notice of his or her right to appeal that determination pursuant to ARRA.

(5) No person shall intentionally delay verification of involuntary termination of employment under this subdivision.

(p) The provision of information and forms related to the premium assistance available pursuant to ARRA to individuals by a health care service plan shall not be considered a violation of this chapter provided that the plan complies with all of the requirements of this article.

1366.26. A qualified beneficiary electing continuation coverage shall pay to the health care service plan, on or before the due date of each payment but not more frequently than on a monthly basis, not more than 110 percent of the applicable rate charged for a covered employee or, in the case of dependent coverage, not more than 110 percent of the applicable rate charged to a similarly situated individual under the group benefit plan being continued under the group contract. In the case of a qualified beneficiary who is determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, the qualified beneficiary shall be required to pay to the health care service plan an amount no greater than 150 percent of the group rate after the first 18 months of continuation coverage provided pursuant to this section. In no case shall a health care service plan charge an employer an additional fee for administering Cal-COBRA other than those incorporated in the risk adjusted employee risk rate as provided for in subdivision (i) of Section 1357.

1366.27. (a) The continuation coverage provided pursuant to this article shall terminate at the first to occur of the following:

(1) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 1366.21, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event.

(2) Except as provided in Section 3001 of ARRA, the end of the

period for which premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required premium, in accordance with the terms and conditions of the plan contract. In the case of nonpayment of premiums, reinstatement shall be governed by the terms and conditions of the plan contract and by Section 3001 of ARRA, if applicable.

(3) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (1), (3), (4), or (5) of subdivision (d) of Section 1366.21, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event.

(4) The requirements of this article no longer apply to the qualified beneficiary pursuant to the provisions of Section 1366.22.

(5) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 1366.21, and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first 60 days of continuation coverage, and the spouse or dependent who has elected coverage pursuant to this article, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event. The qualified beneficiary shall notify the plan, or the employer or administrator that contracts to perform administrative services, of the social security determination within 60 days of the date of the determination letter and prior to the end of the original 36-month continuation coverage period in order to be eligible for coverage pursuant to this subdivision. If the qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act, the benefits provided in this paragraph shall terminate on the later of the date provided by paragraph (1), or the month that begins more than 31 days after the date of the final determination under Title II or Title XVI of the United States Social Security Act that the qualified beneficiary is no longer disabled. A qualified beneficiary eligible for 36 months of continuation coverage as a result of a disability shall notify the plan, or the employer or administrator that contracts to perform the notice and administrative services, within 30 days of a determination that the qualified beneficiary is no longer disabled.

(6) In the case of a qualified beneficiary who is initially eligible for and elects continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 1366.21, but who has another qualifying event, as described in paragraph (1), (3), (4), or (5) of subdivision (d) of Section 1366.21, within 36 months of the date of the first qualifying event, and the qualified beneficiary has notified the plan, or the employer or administrator under contract to provide administrative services, of the second qualifying event within 60 days of the date of the second qualifying event, the date 36 months after the date of the first qualifying event.

(7) The employer, or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees.

(8) The qualified beneficiary moves out of the plan's service area or the qualified beneficiary commits fraud or deception in the use of plan services.

(b) If the group contract between the plan and the employer is terminated prior to the date the qualified beneficiary's continuation coverage would terminate pursuant to this section, coverage under the prior plan shall terminate and the qualified beneficiary may elect continuation coverage under the subsequent group benefit plan, if any, pursuant to the requirements of subdivision (b) of Section

1366.23 and subdivision (c) of Section 1366.24.

(c) The amendments made to this section by Assembly Bill 1401 of the 2001-02 Regular Session shall apply to individuals who begin receiving continuation coverage under this article on or after January 1, 2003.

1366.28. A health care service plan subject to this article shall not be obligated to provide continuation coverage to a qualified beneficiary pursuant to this article if an enrollee fails to make the notification required by Section 1366.24, or if the employer of the enrollee fails to comply with Section 1366.25.

1366.29. (a) A health care service plan shall offer an enrollee who has exhausted continuation coverage under COBRA the opportunity to continue coverage for up to 36 months from the date the enrollee's continuation coverage began, if the enrollee is entitled to less than 36 months of continuation coverage under COBRA. The health care service plan shall offer coverage pursuant to the terms of this article, including the rate limitations contained in Section 1366.26.

(b) Notification of the coverage available under this section shall be included in the notice of the pending termination of COBRA coverage that is required to be provided to COBRA beneficiaries and that is required to be provided under Section 1366.24.

(c) For purposes of this section, "COBRA" means Section 4980B of Title 26 of the United States Code, Sections 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code.

(d) This section shall not apply to specialized health care service plans providing noncore coverage, as defined in subdivision (g) of Section 1366.21.

(e) This section shall become operative on September 1, 2003, and shall apply to individuals who begin receiving COBRA coverage on or after January 1, 2003.