

**Title 10: California Code of Regulations  
Chapter 5.8 Managed Risk Medical Insurance Board  
Healthy Families Program**

**Article 3. Health, Dental and Vision Benefits  
Amend Sections 2699.6700, 2699.6709, 2699.6721, and 2699.6725**

Text proposed to be added is displayed in underline type.  
Text proposed to be deleted is displayed in ~~strikeout~~ type.

**Section 2699.6700 is amended to read:**

**§ 2699.6700. Scope of Health Benefits.**

- (a) The basic scope of benefits offered by participating health plans must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in this section and Section 2699.6703. No other benefits shall be permitted to be offered by a participating health plan as part of the program. The basic scope of benefits shall include:

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(23)

(A) Participating health plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. ~~If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating health plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.~~

(B) The plan is excused from responsibility from providing a covered service to treat the subscriber's CCS condition only to the extent that the treatment is

authorized by the CCS program and provided by a CCS provider as described in the California Code of Regulations, Title 22, Division 2, Part 2, Subdivision 7, Section 41412.

- (C) If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating dental plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.
- (24) Participating health plans shall be responsible for identifying subscriber children who are severely emotionally disturbed and shall refer these individuals to their county mental health department for continued treatment of the condition.
- (b) This part shall not be construed to prohibit a plan's ability to impose cost-control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.
- (c) (1) The scope of benefits shall include all benefits which are covered under the California Children's Services (CCS) Program (Health and Safety Code Section 123800, et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.
- (2) When a subscriber under the age of 21 is determined by the CCS Program to be eligible for benefits under that program, a participating health plan shall not be responsible for the provision of, or payment for, the particular services authorized by the CCS Program for the particular subscriber for the treatment of CCS eligible medical condition. All other services provided under the participating health plan shall be available to the subscriber.
- (d) (1) The scope of benefits shall include benefits provided by a county mental health department to a subscriber child the department has determined is seriously emotionally disturbed or has a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code.

- (2) The plan is excused from responsibility for providing a covered service to treat a subscriber child's serious emotional disturbance or serious mental disorder only to the extent that the treatment is authorized and provided by a County Mental Health Department as defined in Welfare and Institutions Code Section 5600.3.
- (e) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, benefits are provided or payable or payable to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such services.
- (f) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Medi-Cal. Benefits paid under this Program are determined after benefits have been paid as a result of a subscriber's enrollment in any other health care program. If medical services are eligible for reimbursement by insurance or covered under any other insurance or health care service plan, the participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such services.

Note: Authority cited: Sections 12693.21, 12693.22, 12693.62 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.22, 12693.60, 12693.61, 12693.62 and 12693.755, Insurance Code.

**Section 2699.6709 is amended to read:**

**2699.6709. Scope of Dental Benefits for Subscriber Children.**

- (a) The basic scope of benefits for subscriber children offered by a participating dental plan must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6713. The covered dental benefit is limited to the benefit level for the least costly dentally appropriate alternative. If a more costly, optional alternative is chosen by the applicant, the applicant will be responsible for all charges in excess of the covered dental benefit. No other dental benefits

shall be permitted to be offered by a participating dental plan as part of the program. The basic scope of dental benefits shall be as follows:

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- (11) (A) Participating dental plans shall be responsible for identifying subscribers who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program, and shall refer these individuals to the local CCS Program for determination of eligibility. ~~If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating dental plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.~~
- (B) The plan is excused from responsibility from providing a covered service to treat the subscriber's CCS condition only to the extent that the treatment is authorized by the CCS program and provided by a CCS provider as described in the California Code of Regulations, Title 22, Division 2, Part 2, Subdivision 7, Section 41412.
- (C) If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating dental plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.
- (b) (1) The scope of dental benefits shall also include all dental benefits which are covered under the California Children's Services program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.
- (2) When a subscriber is determined by the California Children's Services Program (Health and Safety Code Section 123800 et seq.) to be eligible for benefits under that program, a participating dental plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's

Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating dental plan shall be available to the subscriber.

- (c) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of dental services to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such services.(d) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Denti-Cal. Benefits paid under this Program are determined after benefits have been paid as a result of a subscriber's enrollment in any other dental care program. If dental services are eligible for reimbursement by insurance or covered under any other insurance or dental care service plan, the participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such services.

Note: Authority cited: Sections 12693.21, 12693.22, 12693.62 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.62, 12693.63 and 12693.64, Insurance Code.

**Section 2699.6721 is amended to read:**

**§ 2699.6721. Scope of Vision Benefits.**

- a) The basic scope of benefits offered by a participating vision plan must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6723. No other vision benefits shall be permitted to be offered by a participating vision plan as part of the program. The basic scope of vision benefits shall be as follows:
- 1) Examinations: Each subscriber shall be entitled to a comprehensive vision examination, including a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities as follows:

- (A) Case history: Review of subscriber's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.
  - (B) Evaluation of the health status of the visual system; including:
    - 1. External and internal examination, including direct and/or indirect ophthalmoscopy;
    - 2. Assessment of neurological integrity, including that of pupillary reflexes and extraocular muscles;
    - 3. Biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes;
    - 4. Screening of gross visual fields; and
    - 5. Pressure testing through tonometry.
  - (C) Evaluation of refractive status, including:
    - 1. Evaluation for visual acuity;
    - 2. Evaluation of subjective, refractive, and accommodative function; and
    - 3. Objective testing of a patient's prescription through retinoscopy.
  - (D) Binocular function test.
  - (E) Diagnosis and treatment plan, if needed.
  - (F) Examinations are limited to once each twelve consecutive month period.
- (2) When the vision examination indicates that corrective lenses are necessary, each subscriber is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, lenticular, and polycarbonate lenses as appropriate.

Frames and lenses are limited to once each twelve consecutive month period.

- (3) Contact lenses shall be covered as follows:
- (A) Necessary contact lenses shall be covered in full upon prior authorization from the vision plan, for certain conditions. These conditions may include the following:
    - 1. Following cataract surgery;
    - 2. To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
    - 3. Certain conditions of Anisometropia; and
    - 4. Keratoconus.
  - (B) Elective contact lenses may be chosen instead of corrective lenses and a frame a maximum benefit allowance of ~~\$140~~ \$100, which includes examinations, fittings and lenses.
  - (C) Contact lenses are limited to once each twelve consecutive month period.
- (4) A low vision benefit shall be provided to subscribers who have severe visual problems that are not correctable with regular lenses. This benefit requires prior approval from the participating vision plan. With this prior approval, supplementary testing and supplemental care, including low vision therapy as visually necessary or appropriate, shall be provided.

For subscriber parents, the covered person is required to pay a \$5 copayment for any approved Low Vision services.

- (5) (A) Participating vision plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program, and shall refer these individuals to the local CCS program for determination of eligibility. ~~If a subscriber is determined by the CCS Program to be~~

~~eligible for CCS benefits, participating vision plans shall provide services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.~~

(B) The plan is excused from responsibility from providing a covered service to treat the subscriber's CCS condition only to the extent that the treatment is authorized by the CCS program and provided by a CCS provider as described in the California Code of Regulations, Title 22, Division 2, Part 2, Subdivision 7, Section 41412.

(C) If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating vision plans shall provide services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

- (b) (1) The scope of vision benefits shall also include all vision benefits which are covered under the California Children's Services Program (Health and Safety Code Section 123800 et seq.) provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.
- (2) When a subscriber under the age of 21 is determined by the California Children's Services Program to be eligible for vision benefits under that program, a participating vision plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating vision plan shall be available to the subscriber.
- (c) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of vision services to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating vision plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating vision plan is reimbursed for such services.

- (d) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Medi-Cal. Benefits paid under this Program are determined after benefits have been paid as a result of a subscriber's enrollment in any other vision care program. If vision services are eligible for reimbursement by insurance or covered under any other insurance or vision care service plan, the participating vision plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating vision plan is reimbursed for such services.

Note: Authority cited: Sections 12693.21, 12693.22, 12693.62 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.22, 12693.62, 12693.65, 12693.66 and 12693.755, Insurance Code.

**Section 2699.6725 is amended to read:**

**2699.6725. Share of Cost for Vision Benefits.**

- (a) A participating vision plan shall require copayments for benefits provided to subscribers utilizing the services of the vision plan's panel of approved providers subject to the following except that subscribers with household income at or below 150% of the Federal Poverty Level shall pay a \$5 copayment when a copayment is required:
- (1) Examinations: \$10 copayment per examination.
  - (2) Frames and lenses: \$10 copayment, for frames with lenses, or for frames or lenses when purchased separately. No additional copayment for tinted or photochromic lenses when otherwise deemed medically necessary, or polycarbonate lenses.

A frame allowance of ~~\$75~~ \$35 is provided by the vision plan. The subscriber is responsible for any costs exceeding this allowance. The participating vision plan shall ensure that a selection of frames that do not cost more than the frame allowance is available to all subscribers.

The following options are considered cosmetic and any costs associated with the selection of these options will be the financial responsibility of the applicant.

- (A) Blended lenses (bifocals which do not have a visible dividing line).
- (B) Contact lenses except as specified in Section 2699.6721(a)(3).

- (C) Oversized lenses (larger than standard lens blank to accommodate prescriptions).
  - (D) Progressive multifocal lenses.
  - (E) Coated or laminated lenses.
  - (F) UV protected lenses.
  - (G) Other optional cosmetic processes.
  - (H) A frame that costs more than the plan's allowance.
- (3) Necessary contact lenses, as defined in Subsection 2699.6721(a)(3):  
No copayment.
- (4) Elective contact lenses: an allowance of ~~\$110~~ \$100 will be provided by the vision plan toward the cost of an examination, contact lens evaluation, fitting costs and materials. This allowance will be in lieu of all benefits including examination and material costs. The subscriber is responsible for any costs exceeding this allowance.
- (5) Low vision benefits:
- (A) Supplementary testing: No copayment; and
  - (B) Supplemental care: \$10 copayment.

- (b) Services from providers not included in the vision plan's panel of approved providers:

When a subscriber obtains services from a provider not included in the vision plan's panel of approved providers, the applicant will be responsible for paying the provider for all services and materials received at the time of their appointment. The participating vision plan will reimburse the applicant within fourteen (14) calendar days after receipt of the paid itemized bill or statement, according to the schedule of allowances as follows:

- (1) Professional fees:
  - (A) Vision exams, up to \$35.00

(2) Materials:

- (A) Each single vision lens - up to ~~\$12.50~~ \$7.50 or a pair of single vision lenses up to ~~\$25.00~~ \$15.00.
  - (B) Each bifocal lens - up to ~~\$20.00~~ \$15.00 or a pair of bifocal lenses up to ~~\$40.00~~ \$30.00.
  - (C) Each trifocal lens - up to ~~\$25.00~~ \$20.00 or a pair of trifocal lenses up to ~~\$50.00~~ \$40.00.
  - (D) Each lenticular lens - up to ~~\$50.00~~ \$45.00 or a pair of lenticular lenses up to ~~\$100.00~~ \$90.00.
  - (E) Frame up to ~~\$40.00~~ \$25.00.
  - (F) Tinted or photochromic lenses when otherwise deemed medically necessary - up to \$5.00.
  - (G) Polycarbonate lenses - up to \$10.00.
  - (H) Each pair of necessary contact lenses - up to \$250.00.
  - (I) Each pair of elective contact lenses - up to ~~\$110.00~~ \$100.  
Determination of whether contact lenses are necessary or elective when obtained from providers not included in the vision plan's panel of approved providers will be the responsibility of the vision plan. Reimbursement for elective contact lenses is in lieu of all benefits, including examination and materials.
- (3) Low vision benefits: Low vision benefits obtained from a provider not included in the vision plan's panel of approved providers will be reimbursed in accordance with what the participating vision plan would pay a provider included in the vision plan's panel of approved providers for this benefit.
- (c) No deductibles shall be charged to subscribers for vision benefits.
  - (d) For subscriber parents who receive vision services from one of the participating member doctors, covered services as described are provided with no additional out-of-pocket costs after an applicable copayment.

Additional services selected for cosmetic purposes are the financial responsibility of the patient.

- (e) No copayments shall apply if the applicant has submitted acceptable documentation as described in Section 2699.6600(c)(1)(GG) that the applicant or the subscriber is American Indian or Alaska Native. However, there is no limitation on the payments required under Subsection (b) above.

Note: Authority cited: Sections 12693.21, 12693.22, 12693.62 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.22, 12693.62, 12693.65 and 12693.755, Insurance Code.

## ADOPTION OF EMERGENCY REGULATIONS

Insurance Code Section 12693.22 provides, in part:

During the 2009-10 and 2010-11 fiscal years, the adoption and readoption of regulations to modify health, dental and vision benefits or otherwise modify program requirements and operations consistent with the provisions of this part shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health and safety, or general welfare for purposes of Section 11346.1 and 11349.6 of the Government Code. . .

The Board confirms that these regulations modify the Healthy Families Program program requirements and operations consistent with the provisions of Part 6.2 of Division 2 of the Insurance Code.

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## CERTIFICATION

I, Janette Casillas, Executive Director of the Managed Risk Medical Insurance Board, do hereby certify that the foregoing action was duly passed and adopted by the Managed Risk Medical Insurance Board at an official meeting thereof on May 12, 2011.

Dated this 12th day of May, 2011.

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Janette Casillas, Executive Director  
Managed Risk Medical Insurance Board