TITLE 10: CALIFORNIA CODE OF REGULATIONS

CHAPTER 5.8 MANAGED RISK MEDICAL INSURANCE BOARD

HEALTHY FAMILIES PROGRAM

ARTICLE 1. DEFINITIONS

2699.6500. Definitions.

(a) "Access for Infants and Mothers (AIM) Program" means the State funded program operated pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the California Insurance Code, and that provides low-cost health care coverage for pregnant women and the newborns of subscribers who are enrolled in the AIM program prior to July 1, 2004.

(~~a~~b) "Agriculture" means farming in all its branches and includes: the cultivation and tillage of the soil, the production of dairy products, the production, cultivation growing and harvesting of any agricultural or horticultural commodities, the raising of livestock, bees, forbearing animals, or poultry, any practice performed by a farmer or on a farm as an incident to or in conjunction with such farming operations, including preparation for market, delivery to storage or to market or to carriers for transportation to market.

(c) "AIM infant" means a child born to an AIM subscriber who is enrolled in the AIM program on or after July 1, 2004.

(~~b~~d) "Alaska Native" means any person who is an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601.

(~~c~~e) "American Indian" means any person who is eligible under federal law (25 U.S.C. Section 1603) to receive health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.

(~~d~~f) "Anniversary date" means the day each year that corresponds to the day and month a person's coverage began in the program.

(~~e~~g) ''Applicant'' means:

(1) A person age 18 or over who is a parent; a legal guardian; or a caretaker relative, foster parent, or stepparent with whom the child

resides, who applies for coverage under the program on behalf of a child.

(2) A person who is applying for coverage on his or her own behalf and who is 18 years of age; or an emancipated minor; or a minor not living in the home of a parent, a legal guardian, caretaker relative, foster parent, or stepparent.

(3) A minor who is applying for coverage on behalf of his or her child.

(4) A person who is age 19 or over and who is applying for coverage on his or her own behalf and/or that of another child-linked adult.

(~~f~~h) “Benefit year” means the twelve (12) month period commencing July 1 of each year at 12:01 a.m.

(~~g~~i) ‘‘Board’’ means the Managed Risk Medical Insurance Board.

(~~h~~j) "Caretaker relative" means a relative who provides care and supervision to a child if there is no parent living in the home. The caretaker relative may be any relation by blood, marriage, or adoption.

(~~i~~k) "Child-linked adult" means:

(1) A parent living in the home with his or her child under age 19 who is enrolled in the program, or in no-cost Medi-Cal, or is eligible and applying for no-cost Medi-Cal.

(2) A stepparent living in the home with the parent described in (1).

(3) A caretaker relative living in the home with a child under age 19 who is enrolled in the program, or in no-cost Medi-Cal, or is eligible and applying for no-cost Medi-Cal. For any child or group of siblings, only one (1) caretaker relative may be eligible as a child-linked adult.

(4) A legal guardian living in the home with a child under age 19 who is enrolled in the program, or in no-cost Medi-Cal, or is eligible and applying for no-cost Medi-Cal. For any child or group of siblings, only one (1) legal guardian may be eligible as a child-linked adult.

(~~j~~l) “Community provider plan” means that participating health plan in each county that has been so designated by the Board pursuant to Section 2699.6805.

(~~k~~m) "Family contributions'' means the monthly cost to an applicant for "family child contributions" and "family parent contributions." Family contributions do not include copayments for services.

(~~l~~n) "Family child contributions" means the monthly cost to an applicant to enable a subscriber child or subscriber children to participate in the program. Family child contributions do not include copayments for services.

(~~m~~o) "Family parent contributions" means the monthly cost to an applicant to enable a subscriber parent or subscriber parents to participate in the program. Family parent contributions do not include copayments for services.

(~~n~~p) "Family contribution sponsor" means a person or entity that is registered with the Program and that pays the family child contributions and/or family parent contributions on behalf of an applicant for any twelve (12) consecutive months of the subscriber child or subscriber parent's participation in the program. A family contribution sponsor may sponsor a subscriber parent linked to a subscriber child enrolled in the program if the subscriber child is sponsored, or may sponsor only the subscriber parent if the subscriber parent is not linked to any subscriber children enrolled in the program and instead is linked to a child enrolled in no-cost Medi-Cal.

(~~o~~q) "Family member" means the following persons living in the home, unless the individual receives public assistance benefits such as SSI/SSP:

(1) Children under age 21 of married or unmarried parents living in the home.

(2) The married or unmarried parents of the child or sibling children.

(3) The stepparents of the child or sibling children.

(4) An unborn child of any family member.

(5) Children under age 21 who are away at school and who are claimed as tax dependents.

(~~p~~r) "Family value package" means the combination of participating health, dental, and vision plans available to subscribers in each county offering the lowest price and each of the combinations offering a price within seven and one half percent (7.5%) of the average price of the lowest priced combination and the second lowest price combination of health, dental, and vision plans. The second lowest price combination is calculated by

summing the second lowest price health plan, the second lowest price dental plan, and the second lowest price vision plan. If only one health, dental, or vision plan is available to subscribers in a county, the price of the one available plan shall be used in the calculations of the second lowest price combination. A health, dental, or vision plan with a service area which does not include zip codes in which at least eighty-five percent (85%) of the residents of the county reside or that has enrollment limits unrelated to network capacity shall not be considered the lowest or second lowest price plan, unless it is the only health, dental, or vision plan in the county. In addition, any combination of health, dental, and vision plans in which the health, dental, and vision plan are each available in at least one plan combination that is within seven and one half percent (7.5%) of the average price of the lowest and second lowest price combination of health, dental, and vision plans, is a family value package. In all family value package calculations, the health plan rate to be used is the rate for subscriber children from one year old up to the age of nineteen. The dental and vision plan rates to be used are the rates for subscriber children. The family value package determinations shall be made once each year by the Board, no later than the last day of March for the following benefit year, based on calculations using the prices of the plans that at the time of the calculations are expected to be available the following benefit year. Calculations will not be redone if plans are later dropped from or added to a county. However, if the Board at any time determines that the seven and one half percent (7.5%) level is insufficient to assure that adequate network capacity exists in a specified county so that all subscribers may be enrolled in a family value package, the Board may increase the percentage for that county to a percentage at which sufficient capacity is assured. Such increased percentage shall be in effect only for the benefit year in which the increase is made. The Board may determine, if requested as a part of a rural demonstration project for a special population, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for applicants and subscribers that are members of the special population; in addition the Board may determine, if requested as part of a rural demonstration project for rural area residents, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for subscribers that are residents of the rural area. The Board may determine that a combination of health, dental, and vision plans in a county that includes health and vision plans available in at least one family value package plan combination is deemed a family value package even if the dental plan is not in any other family value package plan combination, but only for applicants with subscribers who are enrolled prior to the beginning of the benefit year in that dental plan, and only if the Board determines it necessary in order to avoid requiring fifty percent

(50%) of subscribers or one-thousand (1,000) subscribers in a county to change their dental plan.

(~~q~~s) "Federal Poverty Level" means the level determined by the "Poverty Guidelines for the 48 Contiguous States and the District of Columbia" as contained in the Annual Update of HHS Poverty Guidelines as published in the Federal Register by the U.S. Department of Health and Human Services.

(~~r~~t) "Household income" means the total annual income of all family members in a household. Income includes before tax earnings from a job, including cash, wages, salary, commissions and tips, selfemployment net profits, Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings and interest income. Income excludes public assistance program benefits such as SSI/SSP and CalWORKS payments, foster care payments, general relief, loans, grants or scholarships applied toward college expenses, or earned income of a child aged 13 or under, or a child attending school. Income does not include income exclusions applicable to all federal means tested programs such as, disaster relief payments, per capita payments to Native Americans from proceeds held in trust and/or arising from use of restricted lands, Agent Orange payments, Title IV student assistance, energy assistance payments to low income families, relocation assistance payments, victims of crime assistance program, Spina Bifida payments, earned income tax credit and Japanese reparation payments.

(~~s~~u) "Income deduction" means any of the following:

(1) Work expenses of $90 per month for each family member working or receiving disability worker's compensation or State Disability Insurance. If a family member earns less than $90, the deduction can only be for the amount earned.

(2) Child care expenses while a family member works or trains for a job of up to $200 per month for each family member under age 2, up to $175 per month for each family member over age 2 and dependent care expenses of up to $175 for a disabled dependent.

(3) The amount paid by a family member per month for any court ordered alimony or child support.

(4) A maximum of $50 for child support payments or alimony received. If less than $50 in child support and/or alimony is received, the deduction can only be for the amount received.

(~~t~~v) "Indian Health Service Facility" means a tribal or urban Indian organization operating health care programs or facilities with funds from the United States Department of Health and Human Service's Indian Health Service, pursuant to the Indian Health Care Improvement Act (25 U.S.C. Section 1601) or the Snyder Act (25 U.S.C. Section 13).

(~~u~~w) "Living in the home" means all of the following:

(1) Physically present in the home;

(2) Temporarily absent from the home because of hospitalization, visiting, vacation, work-related trips, or other similar reasons. A temporary absence is normally one where a person leaves and returns to the home in the same or the following month.

(3) Away at school or vocational training if the person will resume living in the home as evidenced by the person's return to the home for vacations, weekends, and other times.

(4) When a child stays alternately with each of his or her parents and the child's parents are separated or divorced, the home in which the child is living shall be determined as follows:

(A) The child is determined to be living in the home of the parent with whom the child stays for the majority of the time.

(B) If the child spends an equal amount of time with each parent, the child is determined to be living in the home of the parent who has the majority of the responsibility for the care of the child. Factors that determine majority responsibility include but are not limited to which parent decides where the child attends school, deals with the school on educational decisions and problems, controls participation in extracurricular and recreational activities, arranges medical and dental care services, claims the child as a tax dependent, and purchases and maintains the child's clothing.

(C) If both parents exercise an equal share of responsibility for the child and the child spends an equal amount of time with each parent, the child is determined to be living in the home

of the parent who meets one of the following conditions in the order specified:

1. Is designated, through mutual agreement of both parents, as the primary parent for purposes of the program or Medi-Cal.

2. Is otherwise eligible for the program.

3. If both parents are eligible for the program then the child is determined to be living in the home of the parent who first applied for the program or Medi-Cal on behalf of the child.

(~~v~~x) "Migratory worker" means an individual whose principal employment is in agriculture, fishing, and/or forestry, on a seasonal basis, as opposed to year-round employment; and who, for purposes of employment, does establish a temporary place of residence. Migrant workers live in a work area temporarily. Such employment must have been within the last twenty-four months.

(~~w~~y) "Parent" means the natural or adoptive parent of a child.

(~~x~~z) "Parental coverage start date" means the effective date for which the State of California enacts appropriation for the coverage of child linked adults pursuant to a budget act and/or any other applicable state statute.

(~~y~~aa) ''Participating dental plan'' means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal dental services under insurance policies or contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the Board to provide coverage to program subscribers:

(1) A dental insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.

(~~z~~bb) ''Participating health plan'' means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in

consideration of premiums or other periodic charges payable to it, and that contracts with the Board to provide coverage to program subscribers:

(1) A private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code. The term health care service plan shall include a plan operating as a geographic managed care plan as defined in Insurance Code Section 12693.16, in the area which it operates pursuant to a contract entered into under Article 2.91 (commencing with Section 14089 of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(3) A county organized health system as defined in Insurance Code Section 12693.05, in the county in which it provides comprehensive health care to eligible Medi-Cal beneficiaries.

(4) A local initiative as defined in Insurance Code Section 12693.08, in the region in which it provides comprehensive health care to eligible Medi-Cal beneficiaries.

(~~aa~~cc) "Participating plan" means a participating health, participating dental or participating vision care plan.

(~~bb~~dd) ''Participating vision care plan'' means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal vision services under insurance policies or contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contract with the Board to provide coverage to program subscribers:

(1) A vision insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.

(~~cc~~ee) ''Program'' means the Healthy Families Program.

(~~dd~~ff) (1) "Qualified alien" means an alien who, at the time he or she applies for, receives, or attempts to receive program benefits, is, under Section 431 of the Personal Responsibility and Work Opportunity

Reconciliation Act of 1996 (PRWORA) (8 U.S.C. Section 1641), any of the following:

(A) An alien lawfully admitted for permanent residence under the Immigration and Naturalization Act (INA) (8 U.S.C. Section 1101 et seq.).

(B) An alien who is granted asylum under Section 208 of the INA (8 U.S.C. Section 1158).

(C) A refugee who is admitted to the United States under Section 207 of the INA (8 U.S.C. Section 1157).

(D) An alien who is paroled into the United States under Section 212(d)(5) of the INA (8 U.S.C. Section 1182 (d)(5)) for a period of at least one year.

(E) An alien whose deportation is being withheld under Section 243(h) of the INA (8 U.S.C. Section 1253(h), as in effect immediately before the effective date (April 1, 1997) of Section 307 of Division C of Public Law 104-208, or Section 241(b)(3) of such Act (8 U.S.C. Section 1251(b)(3)) (as amended by Section 305(a) of Division C of Public Law 104-208).

(F) An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980 (8 U.S.C. Section 1153(a)(7)). (See editorial note under 8 U.S.C. Section 1101, “Effective Date of 1980 Amendment.”)

(G) An alien who is a Cuban and Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980) (8 U.S.C. Section 1522nt.).

(H) An alien who, under Section 431(c)(1) of PRWORA (8 U.S.C. Section 1641 (c)(1)), meets all of the conditions of subparagraphs 1., 2., 3., and 4. below:

1. The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse’s or parent’s family residing in the same household as the alien, and the spouse or parent of the alien consented to, or acquiesced in, such battery or cruelty.

2. There is a substantial connection between such battery or cruelty and the need for the benefits to be provided.

3. The alien has been approved or has a petition pending which sets forth a prima facie case for any of the following:

   a. Status as a spouse or child of a United States citizen pursuant to clause (ii), (iii), or (iv) of Section 204(a)(1)(A) of the INA (8 U.S.C. Section 1154(a)(1)(A)(ii), (iii) or (iv)).

   b. Classification pursuant to clause (ii) or (iii) of Section 204(a)(1)(B) of the INA (8 U.S.C. Section 1154 (a)(1)(B)(ii) or (iii)).

   c. Cancellation of removal under Section 240A of the INA (8 U.S.C. Section 1229b) (as in effect prior to April 1, 1997).

   d. Status as a spouse or child of a United States citizen pursuant to clause (i) of Section 204(a)(1)(A) of the INA (8 U.S.C. Section 1154(a)(1)(A)(i)) or classification pursuant to clause (i) of Section 204(a)(1)(B) of the INA (8 U.S.C. Section 1154(a)(1)(B)(i)).

   e. Cancellation of removal pursuant to Section 240A(b)(2) of the INA (8 U.S.C. Section 1229b(b)(2)).

4. For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(I) An alien who, under Section 431(c)(2) of the PRWORA (8 U.S.C. Section 1641 (c)(2)), meets all of the conditions of subparagraphs 1., 2., 3., 4. and 5. below:

1. The alien has a child who has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or

by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty.

2. The alien did not actively participate in such battery or cruelty.

3. There is a substantial connection between such battery or cruelty and the need for the benefits to be provided.

4. The alien meets the requirements of subparagraph (H)(3) above.

5. For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(J) An alien child who meets all of the conditions of subparagraphs 1., 2., 3., and 4. below:

1. The alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty.

2. There is a substantial connection between such battery or cruelty and the need for the benefits to be provided.

3. The alien child meets the requirements of subparagraph (H)(3) above.

4. For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(2) For purposes of subparagraphs (1)(H), (1)(I), and (1)(J), there is a "substantial connection between such battery or cruelty and the need for benefits to be provided" if the alien declares, and the program verifies, any of the following circumstances:

(A) The alien or the alien's child is receiving cash assistance based on the battery or extreme cruelty.

(B) The benefits are needed due to a loss of financial support resulting from the alien's and/or his or her child's separation from the abuser.

(C) The benefits are needed because the alien or his or her child requires medical attention or mental health counseling, or has become disabled, as a result of the battery or cruelty.

(D) The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien or his or her child, and/or to care for any resulting children.

(E) The medical coverage and/or health care services are needed to replace medical coverage or health care services the applicant or child had when living with the abuser.

(3) An alien who is a qualified alien pursuant to subparagraphs (1)(H), (1)(I), or (1)(J), will remain eligible for the program as long as the need for benefits related to the battery or cruelty is necessary as determined by the program, and the alien continues to meet all other program eligibility requirements. The program shall review the alien's circumstances to evaluate the subscriber's continued need for program benefits at the annual eligibility review.

(~~ee~~gg) "Qualifying event" means one of the following situations in which a child-linked adult may enroll in the program:

(1) A subscriber child through whom the child-linked adult is eligible enrolls in no-cost Medi-Cal or the program and the child-linked adult requests enrollment at the same time as the child. If the child-linked adult is not the applicant on behalf of the subscriber child, the child-linked adult may request enrollment within 2 months of the subscriber child's enrollment in no-cost Medi-Cal or the program.

(2) A subscriber child through whom the child-linked adult is eligible qualifies for an additional year of coverage under no-cost Medi-Cal or the program pursuant to Section 2699.6625 and the child-linked

adult requests enrollment at the time of the child's annual eligibility review. If the child-linked adult is not the applicant on behalf of the subscriber child, the child-linked adult may request enrollment within 2 months of the subscriber child's qualification for an additional year of coverage through no-cost Medi-Cal or the program.

(3) A child-linked adult loses no-cost Medi-Cal coverage and requests enrollment within 2 months after notification of this loss of coverage.

(4) A subscriber child turns 19 and qualifies to participate in the program as a subscriber parent, and requests enrollment within 2 months of his or her 19th birthday.

(5) A child-linked adult has lost or will lose coverage under employer sponsored coverage as a result of one of the following and the child-linked adult requests enrollment within 2 months of the termination of coverage.

(A) The child-linked adult or other individual through whom the child-linked adult was covered lost employment or experienced a change in employment status.

(B) The child-linked adult or other individual through whom the child-linked adult was covered changed address to a zip code that is not covered by the employer-sponsored coverage.

(C) The employer of the child-linked adult or other individual through whom the child-linked adult was covered discontinued health benefits to all employees or dependents, or ceased to provide coverage or contributions for one or more categories of employees or dependents.

(D) Death of the individual, through whom the child-linked adult was covered, or a legal separation or divorce from the individual through whom the child-linked adult was covered.

(E) The child-linked adult was covered under a COBRA policy, and the COBRA coverage period has ended.

(6) A subscriber parent's period of disqualification pursuant to Subsection 2699.6611(d) has expired and enrollment is requested within 2 months of the end of the period of disqualification.

(7) The household income for a child-linked adult falls to a level at or below 200% of the federal poverty level and the child-linked adult requests enrollment within 2 months of this change in income.

(8) A subscriber parent marries and his or her spouse requests enrollment within 2 months of newly obtaining the status of a child-linked adult.

(9) A subscriber child begins living in the home with a parent, caretaker relative, or legal guardian and the parent, caretaker relative, or legal guardian requests enrollment within 2 months of newly obtaining the status of a child-linked adult.

(10) The program informs a child-linked adult who previously applied at a time when the program was closed to new enrollment that he or she may apply and he or she requests enrollment within 2 months of notification of the program's opening to new enrollment for child-linked adults.

(~~ff~~hh) “Rural demonstration projects” means health, dental and vision plan projects approved by the Board to address the unique access needs of special populations and/or residents of rural medical service study areas.

(~~gg~~ii) “Rural Medical Service Study Area” means an area with (1) a population density of less than 250 persons per square mile: and (2) no town with a population in excess of 50,000 within the area, as determined by the Office of Statewide Health Planning and Development.

(~~hh~~jj) “Seasonal worker” means an individual whose principal employment is in agriculture, fishing and/or forestry, on a seasonal basis, as opposed to year-round employment; and who, for purposes of employment, does not establish a temporary place of residence. Seasonal workers commute to work in the area of their permanent address. Such employment must have been within the last twenty-four months.

(~~ii~~kk) “Special population” means seasonal workers, migratory workers or American Indians.

(~~jj~~ll) “State Supported Services” means abortions that are not the result of incest or rape, and are not necessary to save the life of the mother.

(~~kk~~mm) "Stepparent" means a person who is married to the parent of a child and who is not the other parent of the child.

(~~ll~~nn) "Subscriber" means either a “subscriber child” or a “subscriber parent.”

(~~mm~~oo) “Subscriber child” means a person age 18 or a child who is eligible for and participates in the program.

(~~nn~~pp) “Subscriber parent” means a child-linked adult age 19 or over who is eligible for and participates in the program.

(~~oo~~qq) Tenses, and Number. The present tense includes the past and future, and the future the present; the singular includes the plural and the plural the singular.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.02, 12693.03, 12693.045, 12693.06, 12693.065, 12693.08, 12693.09, 12693.10, 12693.70, 12693.105, 12693.11, 12693.12, 12693.13, 12693.14, 12693.16, 12693.17, 12693.755 and 12693.91, Insurance Code.

ARTICLE 2. ELIGIBILITY, APPLICATION, AND ENROLLMENT

2699.6600. Application.

(a) To apply for the program:

(1) An applicant shall submit all information, documentation, and declarations required in subsection (c) of this section and a personal check, cashier's check or money order for the first month's required family contribution for the program, or a personal check, cashier's check or money order for the first three months' required family contribution if the applicant wishes to receive the fourth month of coverage with no required family contribution.

(2) No payment from the applicant pursuant to (1) is required if the applicant has a family contribution sponsor and both the sponsor's family contribution payment for twelve (12) months and the family contribution sponsorship payment form accompany the application.

(3) No payment from the applicant pursuant to (1) is required if the applicant or the person for whom application is being made is American Indian or Alaska Native and submits acceptable documentation as described in Subsection (c)(1)(FF).

(4) Payment in full of the following arrears, incurred within the prior twelve (12) months, by the applicant is required prior to enrollment of a person under age 19:

(A) Family child contributions owed on behalf of any person under age 19 for whom the same applicant previously applied;

(B) Family child contributions owed on behalf of a person under age 19 for whom the applicant did not previously apply but for whom the applicant is currently requesting coverage if the applicant:

1. Is the parent of the person under age 19 for whom premiums are owed; and

~~(~~2.~~)~~ Lived in the same home as the person under age 19 when the premiums were incurred.

(5) Payment in full of the following arrears, incurred within the prior twelve (12) months, by the applicant is required prior to enrollment

of a person age 19 or over:

(A) Family contributions owed on behalf of any person for whom the same applicant previously applied;

(B) Family child contributions owed on behalf of a person under age 19 for whom the applicant did not previously apply but for whom the applicant is currently requesting coverage if the applicant:

1. Is the parent of the person under age 19 for whom premiums are owed; and

2. Lived in the same home as the person under age 19 when the premiums were incurred.

(C) Family parent contributions owed on behalf of a person for whom the applicant is requesting coverage for coverage provided on or after the person's 19th birthday.

(6) The program application, entitled "Family Health Coverage Mail-In Application, for Medi-Cal and Healthy Families" (MC321 HFP, June, 2002 New), is hereby incorporated by reference.

(b) The applicant shall sign and date the following declaration: I declare under penalty of perjury under the laws of the State of California that the answers I have given in this Application and the documents given are correct and true to the best of my knowledge and belief. I declare that I have read and understand the Application Instructions, the declarations, and all information printed on this Application.

(c) (1) The application shall contain the following:

(A) The applicant's full name.

(B) The applicant's date of birth.

(C) The applicant's primary written and oral language.

(D) The home and mailing address for the applicant and for all persons for whom application is being made, the applicant's county of residence and phone number(s), and the applicant's e-mail address (optional).

(E) An indication of whether the applicant is over the age of 18 years and applying on behalf of a child or children, and/or on behalf of a child-linked adult. An indication of whether the applicant is an 18 year old applying on his or her own behalf; the applicant is an emancipated minor applying on his or her own behalf; the applicant is a minor who is not living in the home of a parent, legal guardian, caretaker relative, foster parent, or stepparent and is applying on his or her own behalf; or the applicant is a minor who is applying on behalf of his or her child.

(F) For each person for whom the applicant is applying, the following information is requested:

1. name (first, middle and last) including full birth name if different (not required for a child not yet born)

2. marital status and spouse's name

3. birth date (not required for a child not yet born)

4. birth place (not required for a child not yet born)

5. mother's first and last name and whether living in the child's household (optional for a person age 19 or over)

6. father's first and last name if living in the child's household (optional for a person age 19 or over)

7. an indication of whether the mother and father are deceased or disabled (optional for a person age 19 or over)

8. gender (not required for a child not yet born)

9. Social Security Number (optional)

10. ethnicity (optional unless the person is an American Indian),

11. relationship to applicant.

12. if the person lives away from home (optional for a person age 19 or over)

13. if the person is going to school

14. if the person has a physical, mental or emotional disability

15. if any person in the home is pregnant and if so, the expected due date

(G) A declaration that the applicant is applying to enroll in the program all of the applicant's eligible children who are not already enrolled in the program, unless the applicant is applying only on his or her own behalf.

(H) An identification of individuals living together in the home and their relationships. <u>If an individual is pregnant, it should be indicated, along with the expected due date.</u>

<u>(I)</u> <u>A list of family members identified in (F) and (H) above, who live in the home and who had income in the previous or current calendar year.</u>

1. If the applicant is a parent or stepparent, an 18 year old applying on their own behalf, a child-linked adult applying on his or her own behalf or that of another child-linked adult or a minor applying on his or her own behalf or on behalf of his or her child, for the household of each person applied for, the first, middle initial, last name, gender and date of birth of all family members living in the household, each person's relationship to the person applied for and their monthly income. ~~The list(s) shall also indicate any family member living in the home that is pregnant and their expected due date.~~

2. If the applicant is applying as a foster parent, caretaker relative, or legal guardian applying only on behalf of an 18 year old or a child, a statement of the monthly income of each person applied for whom they are a foster parent, caretaker relative, or legal guardian.

3. If the person for whom application is being made is a qualified alien with an affidavit of support pursuant to section 213A of the Immigration and Naturalization Act, the calculation of household income must include

the sponsor's income as set forth in Section 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), unless the person is eligible pursuant to Insurance Code Section 12693.76.

(~~I~~J) Beginning one year after the parental coverage start date, for each child-linked adult for whom application is being made, an indication of his or her qualifying event as defined in Section 2699.6500.

(~~J~~K) Documentation of the total monthly gross household income ~~stated pursuant to (H)~~ for either the previous or current calendar year. For each ~~item of documentation, an indication of the type of income and the time period it relates to~~ person listed pursuant to subsections (F) and (H) above, provide social security number (optional) and documentation for each source of income. Such documentation shall ~~include either~~ be provided for the previous or current year as indicated below:

1. ~~For each person listed in (H) above as having income, social security number (optional) and copies of all of the following that are applicable:~~ For the previous calendar year:

   a. ~~An employee pay stubs or a signed statement from the employer reflecting gross earnings for a period which is within forty-five (45) days from when the program receives the document, for the most recent pay period, or a signed statement from the employer(s) showing gross earnings for the most recent pay period, or a federal personal income tax return from the previous calendar year.~~ Federal tax return. If self-employed, a schedule C must be included. If a person with reported income on the federal tax return is a step-parent, the step-parent's W-2 form is required to determine the amount of income associated with the financially responsible parent of the child being applied for.

   b. All of the following that are applicable and that reflect the current benefit amount: copies of

~~A~~award letters, checks, ~~or~~ bank statements, passbooks, or internal revenue service (IRS) 1099 forms showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or ~~a bank statement, passbook, or internal revenue service (IRS) Form 1099 showing~~ interest income.

~~c. If self employed, federal personal income tax return from the previous calendar year including the schedule C or a current statement of income and expenses showing net profit for the most recent three (3) month period; or~~

2. For the current calendar year:

a. Paystub or unemployment stub showing gross income for a period ending within 45 days of the date the program receives the document.

b. A letter from the person's current employer. The letter shall be dated and written on the employer's letterhead, and shall include the following:

i. The employee's name.

ii. The employer's business name, business address, and phone number.

iii. A statement of the person's current gross monthly income for a period ending within 45 days of the date the program receives the document.

iv. A statement that the information presented is true and correct to the best of the signer's knowledge.

v. A signature by someone authorized to sign such letters by the employer. The signer shall include his or her position name or job title and shall not be the person whose income is being disclosed.

c. If self employed, a profit and loss statement for the most recent three (3) month period prior to the date the program receives the document. A profit and loss statement must include the following:

i. Date.

ii. Name, address, and telephone number of the business.

iii. Gross income, gross expenses, and net profit itemized on a monthly basis.

iv. A statement on the profit and loss, signed by the person who earned the income, which states, “the information provided is true and correct.”

~~2~~d. A letter or Notice of Action from the County Welfare Office issued within the last two (2) months that includes:

~~a~~i. For each person for whom application is being made, a statement that the person is eligible for share-of-cost Medi-Cal,

~~b~~ii. A determination of total monthly household income and monthly household income after income deductions as defined in Section 2699.6500, and

~~c~~iii. A determination of the number of family members living in the household.

e. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, or passbooks showing the

amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income for the previous month.

3. If documentation pursuant to 1. or 2. cannot be provided, an affidavit of income written by hand by the recipient of the income. If the individual who receives the income is unable to write the affidavit by hand because of physical or literacy limitations, the individual will sign an affidavit written on his or her behalf with a mark (unless physically incapable) and include the printed name and signature of a witness. The affidavit of income shall include the following:

   a. A statement of the amount and frequency of the income received,

   b. A declaration that the individual cannot provide other documentation of his or her income at the time of application to the program and that the information provided is true and correct to the best of the individual's knowledge and belief,

   c. An acknowledgment that the individual understands that the information contained in his or her affidavit may be subject to a verification by the State, and

   d. The signature of the individual providing the affidavit of income and the date of signature.

(~~K~~L) The name of each family member living in the home who pays court ordered child support, court ordered alimony, or health insurance and the monthly amount paid. The name and age of each person for whom payments are made for child care and/or disabled dependent care by a family member living in the home and the monthly amount paid. Documentation of court ordered child support and/or alimony paid, health insurance paid, and child care and/or disabled

dependent care expenses paid. Documentation includes copies of court orders, cancelled checks, receipts, statements from the District Attorney's Family Support Division or other equivalent document.

(~~L~~M) A declaration that each person for whom application is being made is not eligible for Part A and Part B of Medicare.

(~~M~~N) A declaration that each person for whom application is being made is a resident of the State of California pursuant to Section 244 of the Government Code; or is physically present in California and entered the state with a job commitment or to seek employment.

(~~N~~O) A declaration that the applicant will notify the program within 30 days of any change of home or mailing address of any person applied for who is accepted into the program and any change in the applicant's home or mailing address.

(~~O~~P) A declaration that the applicant and each person for whom application is being made will abide by the rules of participation of the program.

(~~P~~Q) A declaration that the applicant and each person for whom application is being made will abide by the rules and adhere to the policies and procedures, including dispute resolution processes, of any participating plan in which such persons are enrolled.

(~~Q~~R) For each person for whom application is being made, indicate current employer sponsored health coverage or employer sponsored health coverage that was terminated in the last three months, including the reason for and date of the termination.

(~~R~~S) For each person for whom application is being made, the applicant's declaration that the person is:

1. a citizen or national of the United States, or

2. a qualified alien who entered the United States prior to August 22, 1996 or who entered on or after August 22, 1996 and meets one of the criteria listed in Subsection 2699.6607 (e)(2)(B), or

3. a qualified alien who does not meet the criteria specified in subsection (R)2. above.

(~~S~~T) For each declaration made pursuant to (~~R~~S), documentation of the individual's status. If documentation is unavailable at the time of application, persons declaring a status listed under subsection (~~R~~S) above may submit documentation within two months from the date of enrollment. If any person for whom application is being made was previously disenrolled pursuant to Section 2699.6611(a)(3), documentation for that person shall be submitted with the application.

(~~T~~U) A declaration that each person for whom application is being made is not eligible for any California Public Employees Retirement System Health Benefits Program(s) or is eligible for a California Public Employees Retirement Health Benefits Program but the employer contribution for dependent(s) is less than $10.

(~~U~~V) A declaration that each person for whom application is being made is not an inmate in a public correctional institution, or a patient in an institution for mental illness.

(~~V~~W) A declaration that the applicant gives permission for the program to verify family income, health coverage, immigration status of each person for whom application is being made, California residence and other facts stated in the application.

(~~W~~X) For each person for whom application is being made, an indication of whether the person has other health, dental or vision insurance.

(~~X~~Y) An indication of whether anyone has filed a lawsuit because of an accident or injury on behalf of any person for whom application is being made.

(~~Y~~Z) An indication of whether the applicant wants to apply for Medi-Cal coverage for any unpaid medical expenses in the last three months prior to application for any person for whom application is being made.

(~~Z~~AA) The applicant shall provide all of the following:

1. A declaration that the applicant has reviewed the benefits offered by the participating health, dental and vision plans.

2. The applicant's choice of participating health, dental, and vision plans.

3. A declaration that the applicant agrees to pay the required family contribution for a period of six months, unless the applicant has a family contribution sponsor.

(~~AA~~BB) The applicant may provide the following optional information:

1. The applicant's choice of primary care provider/clinic and provider/clinic code, and dentist/clinic and dentist/clinic code for the person(s) for whom application is being made.
2. An indication of whether there is more than one car in the children's household.

3. An indication of whether there is more than $3,150 cash in bank accounts in the children's household.

4. An indication if the applicant does not want the application reviewed for eligibility for Medi-Cal or the Program.

(~~BB~~CC) If assistance in completing the application was provided by an eligible individual, a statement by the applicant that such assistance was provided.

(~~CC~~DD) If applicable, a declaration that the applicant is a migratory worker or seasonal worker as defined in Section 2699.6500.

(~~DD~~EE) If applicable, the applicant's signed authorization that the program may release information over the telephone about the application status of the individual(s) applied for by the applicant to a representative of the enrollment entity designated by the applicant on the application. This permission will end on the date the program mails the results of the eligibility determination on this application.

(~~EE~~FF) If the applicant received assistance from a certified application assistant, the applicant's signed authorization (if applicable) that the program may release information notifying the entity with whom the certified application assistant is affiliated of the applicant's Annual Eligibility Review date.

(~~FF~~GG) If an applicant or the person for whom application is being made is American Indian or Alaska Native, acceptable documentation must be submitted to exempt the applicant from family contribution payments and benefit copayments. The exemption from family contributions and benefit copayments shall occur after receipt of such documentation. Notwithstanding the previous sentence, the exemption from family contributions will begin on the date of enrollment and continue for two months pending the receipt of acceptable documentation. If acceptable documentation is not received at the end of the two month exemption period, the appropriate family contribution will be assessed pursuant to Subsection 2699.6813(a). The applicant must indicate on the application that he or she is requesting a waiver of the family contributions. Acceptable documentation for the applicant or the child includes:

1. An American Indian or Alaska Native enrollment document from a federally recognized tribe, or

2. A Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs, or

3. A letter of Indian heritage from an Indian Health Service supported facility operating in the State of California.

(~~GG~~HH) An indication of how the applicant learned about Medi-Cal and the program.

(~~HH~~II) An indication whether the applicant would like information sent to them regarding the Child Health and Disability Prevention Program (CHDP) for children and youth or the Women, Infants and Children (WIC) program.

(2) The Social Security numbers and other personal information are needed for identification and administrative purposes.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.02, 12693.21, 12693.43, 12693.46, 12693.70, 12693.71, 12693.73, 12693.74, 12693.75 and 12693.755, Insurance Code.

2699.6606. Review of Applications for Completeness.

(a) All applications and Add a Person ~~Application~~ ~~f~~Forms shall be reviewed for completeness, except for applications, Add a Person ~~Application~~ ~~f~~Forms, and documentation solely applicable to childlinked adults if there is no funding available and the Board estimates that the program will be closed to new enrollment for six (6) consecutive weeks or more.

(b) An application that is complete except for documentation required by Section 2699.6600(c)(1)(~~S~~T) shall be considered complete.

(1) If the application is incomplete, a telephone call will be placed to the applicant to request the missing information and documentation. If the applicant is reached, the applicant will be asked to provide the necessary information and documentation. If the applicant is not reached by telephone, a notice indicating the required information and documentation will be mailed. The applicant must provide all information and documentation necessary for the application to be complete within seventeen (17) calendar days from the date the application was received by the program, and the applicant will be so notified.

(2) If the application submitted is not complete and it is not completed within seventeen (17) calendar days, the application shall be denied. The applicant shall be sent a notice indicating that their application is denied on the basis that the program could not make an eligibility determination because of missing information or documentation.

(3) If the application is complete or is completed within seventeen (17) calendar days, it will be reviewed for an eligibility determination.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Section 12693.21, Insurance Code.

2699.6607. Determination of Eligibility.

(a) Except as specified in Section 2699.6605, the program shall complete the application review process within ten (10) calendar days of receipt of the complete application or Add a Person ~~Application~~ ~~f~~Form unless the program is waiting for necessary information pursuant to Subsection

2699.6606 (b)(1) and (2). For those applications, the program shall complete the application review process within twenty (20) calendar days of receipt of the original application or Add a Person ~~Application~~ ~~f~~Form.

(1) The program shall determine eligibility for each person age 18 or under based upon the criteria specified in Insurance Code Sections 12693.70, 12693.73 and 12693.76 and this section.

(2) The program shall determine eligibility for each person age 19 and over based on the criteria specified in this section. Notwithstanding any other provision of this Chapter, the first date on which any person age 19 or over shall be eligible for the program is the parental coverage start date. In addition to the criteria applicable to all potential subscribers, to be a child-linked adult eligible to participate in the program, a person age 19 or over must meet all the following requirements:

(A) Is not eligible for no-cost full-scope, or pregnancy-related, Medi-Cal or Medicare Part A and B at the time of enrollment in the program.

(B) Is a resident of the State of California pursuant to Section 244 of the Government Code; or is physically present in California and entered the state with a job commitment or to seek employment.

(C) Is in a family with an annual or monthly household income after income deductions of up to and including 200 percent of the federal poverty level. Any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income.

(D) If a person age 19 or over for whom enrollment in the program is requested has an annual or monthly household income after income deductions of 100 percent of the federal poverty level or below, a letter or Notice of Action from the County Welfare Office issued within the last two (2) months must state that the individual is not eligible for no-cost Medi-Cal for a reason other than:

1. failure to provide information requested by Medi-Cal or

2. termination from no-cost Medi-Cal at his or her own request.

(E) Notwithstanding 2699.6607(a)(2)(D), legal guardians applying to the program for coverage with an annual household income after income deductions of 100 percent of the federal poverty level or below do not need to provide a Notice of Action from the County Welfare Office.

(F) Meets the definition of child-linked adult as defined in Section 2699.6500.

(G) Has a qualifying event as defined in Section 2699.6500 or applies pursuant to Section 2699.6631 for the first year following the parental coverage start date.

(3) If the program does not have the documentation required by Subsection 2699.6600(c)(1)(~~S~~T), the person shall be temporarily deemed to meet citizenship or immigration criteria until such documentation is submitted or until the time for submitting documentation established in Subsection 2699.6600(c)(1)(~~S~~T) has expired, whichever is sooner.

(b) The program shall disregard any stepparent's income in determining income eligibility for a stepchild.

(c) The program shall disregard any child's income in determining income eligibility for any other person.

(d) If any persons for whom application is being made currently have employer sponsored health coverage, these persons shall be determined ineligible. If employer sponsored health coverage was terminated for any persons for whom application is being made within the last three (3) months, these persons shall be determined ineligible, unless the reason for the termination is one of the following:

(1) The person through whom the employer sponsored coverage had been available either

(A) lost employment or experienced a change in employment status,

(B) changed address to a zip code that is not covered by the employer-sponsored coverage,

(C) lost health benefits because the person's employer discontinued health benefits to all employees or dependents, or ceased to provide coverage or contributions for one or

more categories of employees or dependents, or

(D) lost coverage because of death of the individual through whom the children or child-linked adults were covered, or a legal separation or divorce from the individual through whom the children or child-linked adults were covered.

(2) The person for whom application is being made was covered under a COBRA policy, and the COBRA coverage period has ended.

(3) The person for whom application is being made had coverage provided under an exemption authorized under subdivision (i) of Section 1367 of the Health and Safety Code.

(e) (1) Subject to paragraph (2) below, an alien shall only be eligible for the program if the alien is a qualified alien.

(2) (A) In any fiscal year that the annual Budget Act provides the necessary funding, a person who is a qualified alien shall not be determined ineligible solely on the basis on his or her date of entry into the United States. If the annual Budget Act does not provide the necessary funding, and except as provided in subparagraph (B) below, person who is a qualified alien and who entered or enters the United States on or after August 22, 1996, is not eligible for a period of five years beginning on the date of the alien's entry into the United States with a status within the meaning of the term qualified alien.

(B) The limitation under paragraph (2)(A) above shall not apply to the following aliens:

1. An alien who is admitted to the United States as refugee under Section 207 of the Immigration and Naturalization Act (INA).

2. An alien who is granted asylum under Section 208 of the INA.

3. An alien whose deportation is being withheld under Section 243(h) of the INA (8 U.S.C. Section 1230(h)) (as in effect immediately before the effective date (April 1, 1997) of Section 307 of Division (C) of Public Law 104-208) or Section 241(b)(3) of the INA (8 U.S.C. Section 1251(b)(3)

(as amended by Section 305(a) of Division C of Public Law 104-208).

4. An alien who is a Cuban and Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980.

5. An alien admitted to the United States as an Amerasian immigrant as described in Section 1612(a)(2)(A)(v.) of Title 8 of the United States Code.

6. An alien who is lawfully residing in any state and is any of the following:

   a. A veteran (as defined in Section 101, 1101, or 1301, or as described in Section 107 of Title 38 of the United States Code) with a discharge characterized as an honorable discharge and not on account of alienage and who fulfills the minimum active-duty service requirement of Section 5303A(d) of Title 38 of the United States Code.

   b. On active duty (other than active duty for training) in the Armed Forces of the United States.

   c. The spouse or unmarried dependent child of an individual described in subparagraph a. or b. or the unremarried surviving spouse of an individual described in subparagraph a. or b. who is deceased if the marriage fulfills the requirements of Section 1304 of Title 38 of the United States Code.

(3) The program shall verify the status of any person for whom application is being made to confirm that the person is a citizen, a non-citizen national of the United States, or a qualified alien.

(f) If application was made pursuant to Section 2699.6603(d), eligibility is contingent upon receipt by the program of documentation of the child's birth within thirty (30) days of the birth.

(g) Applicants will be notified in writing of the eligibility determination for each person applied for. If a person is determined ineligible the notice shall

include the reason for the determination of ineligibility and an explanation of the appeal process. The family contribution for any persons determined ineligible which was included with the application shall be refunded. If appropriate, and if permission is given by the applicant, the application shall be forwarded to the Medi-Cal program for eligibility determination.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.70, 12693.71, 12693.73 and 12693.755, Insurance Code.

2699.6608 Enrollment of AIM Infants.

(a) An AIM infant shall be enrolled when the program receives the required family child contribution beginning with the first full month of coverage pursuant to Section 2699.6613(g), and the following information about the infant from the AIM infant's mother at any time through the end of the eleventh month following the month of birth:

(1) Name; and

(2) Date of birth; and

(3) Sex.

(b) The program shall request information from the AIM infant's mother, on the AIM infant's weight at birth and primary care provider.

(c) In lieu of reporting by the AIM infant's mother, the program must also accept the information specified in subsections (a) and (b) from the AIM infant's mother's health plan or a health care provider that provided services to the AIM infant's mother or the AIM infant.

(d) Upon receipt of the family child contribution and the information specified in subsection (a), the program shall automatically enroll the infant in the same health plan within the Healthy Families Program that the AIM infant's mother is enrolled in through the AIM program.

(e) Automatic enrollment of AIM infants is subject to payment of family child contributions and timely notification of the infant's birth as provided in (a).

(f) Notwithstanding subsection (a) of this section, infants in need of immediate health care services will be immediately enrolled in the program if: (1) the AIM infant's mother's health plan notifies the program in writing of the need for services and provides the information specified in subsection (a) of this section; and (2) this written notification occurs no

later than the 10th day of the second full calendar month of the infant's life. For infants enrolled pursuant to this subsection (f), the required family child contribution shall be billed to the AIM mother. If the required family child contribution is not paid, the provisions of this article concerning disenrollment for failure to pay the required family child contribution shall govern.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.70, 12693.71, 12693.73 and 12693.755 and 12693.765, Insurance Code.

2699.6611. Disenrollment.

(a) A subscriber shall be disenrolled from participation in the program if any of the following occur:

(1) The subscriber is found by the program to no longer be eligible during the annual eligibility review period.

(2) The subscriber child attains the age of 19. A subscriber child who attains the age of 19 will not be disenrolled from the program if he or she applies to the program pursuant to Section 2699.6600 and is determined to be eligible for the program as a subscriber parent pursuant to Section 2699.6607 before his or her effective date of disenrollment.

(3) A subscriber is determined by the program to not be a citizen, non-citizen national, or a qualified alien eligible to participate in the program or fails to provide documentation required pursuant to Subsection 2699.6600(c)(1)(~~S~~T) within the required time period.

(4) The applicant fails to pay the required family contribution for the subscriber for two (2) consecutive calendar months.

(5) The applicant so requests in writing on behalf of himself or herself or on behalf of another subscriber for whom he or she applied.

(6) The applicant has intentionally made false declarations in order to establish program eligibility for any person.

(7) The applicant fails to provide the necessary information for the subscriber to be requalified.

(8) Death of a subscriber.

(9) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 is no longer enrolled in no-cost Medi-Cal and has not enrolled in the program.

(10) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 did not enroll in no-cost Medi-Cal, or the program, and the subscriber parent has no other children enrolled in the program or no-cost Medi-Cal.

(11) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 attains the age of 19 and the subscriber parent has no other children enrolled in the program or no cost Medi-Cal.

(12) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 no longer lives with the subscriber parent and another adult with whom the child now lives applies and is found eligible for enrollment as a child-linked adult through the same child.

(13) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 is no longer enrolled in the program, and the subscriber parent has no other children enrolled in the program or no-cost Medi-Cal.

(b) Prior to disenrolling a subscriber pursuant to (a)(4), the program shall provide written notification to the applicant no less than thirty (30) days prior to disenrollment. Such notice shall clearly indicate all of the following:

(1) The disenrollment will not occur if payment in full is made as required.

(2) If disenrollment for non-payment occurs, coverage will be terminated at the end of the second consecutive month for which the family contribution was not paid.

(c) When a subscriber is disenrolled pursuant to (a) above, the program shall notify the applicant of the disenrollment. The notice shall be in writing and include the following information:

(1) The reason for the disenrollment.

(2) The effective date of disenrollment.

(3) The final day of coverage provided through the program.

(4) An explanation of the appeals process including the right to request continued enrollment pursuant to Section 2699.6612.

(d) Disenrollment pursuant to (a)(4) shall be effective as of the end of the second consecutive calendar month for which the required monthly contributions were not paid in full.

(e) Disenrollment pursuant to (a)(7) shall be effective at the end of the month of the subscriber's anniversary date.

(f) Disenrollment pursuant to (a)(1) shall be effective two (2) months after the end of the month of the subscriber's anniversary date if the subscriber is no longer eligible for the program because his or her household income is below the program guidelines. Otherwise, disenrollment pursuant to (a)(1) shall be effective at the end of the month of the subscriber's anniversary date.

(g) Disenrollment pursuant to (a)(3) shall be effective at the end of the calendar month in which the conclusion of the two-month period falls pursuant to Subsection 2699.6600(c)(1)(~~S~~T).

(h) Disenrollment pursuant to (a)(5) shall be effective at the end of the month in which the applicant's request was received. The applicant will be notified of the amount of family contribution due to the program for coverage through the subscriber's effective date of disenrollment.

(i) Disenrollment pursuant to (a)(6) shall be effective at the end of the month in which the determination was made.

(j) Disenrollment pursuant to (a)(2) and (a)(11) shall be effective on the last day of the month the subscriber child or the child through whom the subscriber parent became eligible as a child-linked adult attains the age of 19.

(k) Disenrollment pursuant to (a)(8) shall be effective at the end of the month in which death occurred.

(l) Disenrollment pursuant to (a)(9) shall be effective at the end of the month following the program's notification of the subscriber child's disenrollment from no-cost Medi-Cal.

(m) Disenrollment pursuant to (a)(10) shall be effective at the end of the month following the second month from the date in which the application was

received.

(n) Disenrollment pursuant to (a)(12) shall be effective at the end of the month following the program's determination that the subscriber child has departed from the subscriber parent's household and is living with another adult who has applied for enrollment and is eligible as a child-linked adult through that same child.

(o) Disenrollment pursuant to (a)(13) shall be effective at the end of the month following the program's determination that the adult is no longer child linked.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.45, 12693.74, 12693.77, 12693.755, 12693.98 and 12693.981, Insurance Code.

2699.6613. Starting Date of Coverage For Subscribers.

(a) Coverage shall begin for subscribers no later than ten (10) calendar days from the date the person is determined to be eligible unless any of the following applies:

(1) A person for whom application is being made is eligible for continued eligibility under no-cost, full scope Medi-Cal and that eligibility will continue for more than ten (10) calendar days from the date the person is determined to be eligible.

(2) Application is being made on behalf of a child less than 12 months of age for coverage to begin on the child's first birthday pursuant to Section 2699.6603(a).

(3) Application is being made on behalf of a child who is currently enrolled in the Medi-Cal 133 percent program.

(4) Application is being made on behalf of a newborn prior to birth.

(5) Payment of in arrears family contributions is required prior to enrollment of the person pursuant to Section 2699.6600(a)(4) or (5).

<u>(6)</u> <u>The subscriber is an AIM infant.</u>

(b) Coverage shall begin for subscribers under (a)(1) on the first day after the end of the subscriber's continued eligibility period under Medi-Cal.

(c) Coverage shall begin for subscribers under (a)(2) on their first birthday.

(d) Coverage shall begin for subscribers under (a)(3) on their sixth birthday.

(e) Coverage shall begin for subscribers under (a)(4) no less than eleven (11) calendar days but within thirteen (13) calendar days after the program receives documentation of the birth.

(f) Coverage shall begin for subscribers under (a)(5) no later than thirteen 13 calendar days from the date the program receives a payment for the complete amount of family contributions owed by the applicant.

(g) Coverage shall begin for subscribers pursuant to (a)(6) on the infant's date of birth.

(~~g~~h) The program shall notify applicants in writing of the effective date of coverage for all persons determined to be eligible.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, Insurance Code.

2699.6617. Additional Enrollments.

(a) To apply to the program for additional persons, the applicant shall submit an application pursuant to Section 2699.6600 or the "Add a Person ~~Application~~ Form" ~~form~~ (HF FM 067 EN, ~~09/14/01 New~~ 11/17/2003), which requests information pursuant to Section 2699.6600(b), 6600(c)(1)(A), (D), (F)1., (F)3. ~~, (F)4.~~ - (F)~~10~~11., (F)~~13~~15., (I),~~(J)~~, (K), (L), ~~(M), (N), (O), (P), (Q),~~ (R), (S), and (T)~~,~~ . ~~(U), (Z)1., (Z)3., (Z)4., and (GG).~~

(b) Eligibility for the program will be determined pursuant to Section 2699.6607.

(c) The "Add a Person ~~Application~~ Form" ~~form~~ (HF FM 067 EN, ~~09/14/01 New~~ 11/17/2003), is hereby incorporated by reference.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6619. Transfer of Enrollment.

(a) A subscriber shall be transferred from one participating health, dental, or vision plan to another if any of the following occurs:

(1) The applicant so requests in writing because the subscriber no longer resides in an area served by the participating plan in which the subscriber is enrolled, and there is at least one participating plan serving the area in which the subscriber now resides.

(A) If the program learns that the subscriber no longer resides in an area served by the participating health plan in which the subscriber is enrolled, but the applicant does not choose a new health plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in the Community Provider Plan in the subscriber's county of residence.

(B) If the program learns that the subscriber no longer resides in an area served by the participating dental plan in which the subscriber is enrolled, but the applicant does not choose a new dental plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in a participating dental plan in the subscriber's county of residence. If there is more than one (1) participating dental plan in the subscriber's county of residence, the program will alternate assignments between the participating dental plans so that the transfers are evenly distributed among the participating dental plans.

(C) If the program learns that the subscriber no longer resides in an area served by the participating vision plan in which the subscriber is enrolled, but the applicant does not choose a new vision plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in a participating vision plan in the subscriber's county of residence. If there is more than one (1) participating vision plan in the subscriber's county of residence, the program will alternate assignments between the participating vision plans so that the transfers are evenly distributed among the participating vision plans.

(2) The applicant or the participating plan so requests in writing because of failure to establish a satisfactory subscriber-plan relationship and the Executive Director of the Board or designee determines that the transfer is in the best interests of the subscriber and the program, and there is at least one other participating plan serving the area in which the subscriber resides.

(3) The program contract with the participating plan in which the subscriber is enrolled is canceled or not renewed.

(A) If the applicant does not choose a new health plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in the Community Provider Plan in the subscriber's county of residence.

(B) If the applicant does not choose a new dental plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in a participating dental plan in the subscriber's county of residence. If there is more than one (1) participating dental plan in the subscriber's county of residence, the program will alternate assignments between the participating dental plans so that the transfers are evenly distributed among the participating dental plans.

(C) If the applicant does not choose a new vision plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in a participating vision plan in the subscriber's county of residence. If there is more than one (1) participating vision plan in the subscriber's county of residence, the program will alternate assignments between the participating vision plans so that the transfers are evenly distributed among the participating vision plans.

(4) An open enrollment request is submitted pursuant to Section 2699.6621.

<u>(5) An AIM infant subscriber has a sibling(s) that is enrolled in a different health plan and is transferred pursuant to subsection (f).</u>

(b) A subscriber shall be transferred from one participating health plan to another if the applicant so requests in writing once within the first three (3) months from the original effective date of coverage in the program, or the applicant so requests in writing once within the first thirty (30) days from the effective date of coverage in a new plan following open enrollment, for any reason.

(c) A subscriber shall be transferred from one participating dental or vision plan to another if the applicant so requests in writing once within the first thirty (30) days from the original effective date of coverage in the program,

or the applicant so requests in writing once within the first thirty (30) days from the effective date of coverage in a new plan following open enrollment, for any reason.

(d) If a subscriber is transferred pursuant to (a), (b), or (c) above, all other subscribers of the same applicant who live in the same household will also be transferred, unless the subscriber was transferred because the subscriber moved from the household.

(e) Transfer of enrollment shall take effect on the first day of a month and shall be within forty (40) days of approval of the request, or, if the transfer is pursuant to subsection (a)(3) above, shall take effect prior to the end of the contract. However, subscribers in inpatient facilities on the scheduled date of transfer shall not be transferred to a new health plan until the first day of the month following completion of their inpatient stay.

(f) The following provisions apply to the transfer of AIM infants from one participating health, dental, or vision plan to another:

(1) An AIM infant subscriber will be automatically transferred to the same health, dental, and vision plan that his or her sibling(s) is enrolled in, effective on the first day of the infant's third calendar month of birth, unless one of the following occurs:

(A) The applicant submits a letter stating that the infant has a physical, developmental, behavioral, or emotional condition that requires continuity of care, and requests that the infant's sibling(s) be transferred to the infant's health plan, or

(B) The applicant submits a letter stating that the infant has a physical, developmental, behavioral, or emotional condition that requires continuity of care, and requests that the infant remain with the current health plan and the sibling(s) remain with his or her current health plan. For siblings enrolled in different health plans, the applicant must choose the same health plan for all children living in the household during the Open Enrollment period after the AIM infant's first birthday.

(2) An AIM infant subscriber shall be transferred from one participating health, dental, or vision plan to another if the applicant so requests in writing once within the first three (3) months from the date of the infant's birth and the infant subscriber has no sibling(s) in the program. The transfer of enrollment shall take effect on the first day of a month and shall be within forty (40) days after the approval

of the request but not earlier than the third calendar month of the infant's enrollment in the program.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.326 and 12693.51, Insurance Code.

2699.6625. Annual Eligibility Review for Subscribers.

(a) Except as specified in (b), each subscriber will be re-evaluated annually prior to their anniversary date in the program to determine continued eligibility for the program. Applicants shall be notified of the annual eligibility review process at least sixty (60) calendar days prior to the anniversary date.

(b) If subscribers for whom an applicant has applied have different anniversary dates, the annual eligibility review will be based on the anniversary date of the last subscriber to be enrolled, except as described in Subsection 2699.6631(e).

(c) To requalify, an applicant must provide to the program all of the following information which is required to reestablish eligibility: the applicant's name and account number as stated on their billing statement; name and address of each enrolled person, documentation of gross income of each enrolled person's household as described in Subsection 2699.6600(c)(1)(~~J~~K), documentation of court ordered child support, and/or alimony paid, and child care and/or disabled dependent care expenses paid in order to determine income deductions as described in Subsection 2699.6600(c)(1)(~~K~~L), an indication of any pregnant family member living in the home and her expected due date, and a statement indicating which person(s) is currently enrolled in an employer sponsored health insurance plan. To avoid a break in coverage, all required information must be submitted at least ten (10) calendar days before the end of the month in which the anniversary date falls.

(d) Continued eligibility will be determined pursuant to Section 2699.6607.

(e) Unless disenrolled pursuant to Section 2699.6611, persons shall continue to be considered eligible for the program for one year from the effective date of coverage, or if a later annual eligibility review date is established under (b), until that date.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.74 Insurance Code.

2699.6631. Initial Enrollment Period for Child-linked Adults.

There shall be an initial enrollment period for child linked adults ending one year after the parental coverage start date. Thereafter, enrollment may only occur at a qualifying event as defined in Section 2699.6500.

(a) The program shall provide notification to the applicants of subscriber children enrolled prior to the parental coverage start date in households with incomes at or below 200 percent of the federal poverty level. Notification shall be sent to the address on record and shall include an explanation of program expansions to include child-linked adults, and instructions to complete and return to the program the form provided by the program, documentation of citizenship or immigration status pursuant to 2699.6600(c)(1)(~~S~~T), and the appropriate family contribution for enrollment.

(b) For the first year following the parental coverage start date, for all applications for the program for children only where one or more children enrolled in the program live in households with incomes at or below 200 percent of the federal poverty level, the applicant shall be notified of program expansions to include child-linked adults and shall be provided the opportunity to submit the additional information to the program. The notification shall include instructions to complete and return to the program the form provided by the program, documentation of citizenship or immigration status pursuant to 2699.6600(c)(1)(~~S~~T), and the appropriate family contribution for enrollment.

(c) For the first year following the parental coverage start date, the applicant shall be provided the opportunity to submit the form provided by the program pursuant to this section and the appropriate family contribution. Beginning one year after the parental coverage start date, applicants must use an application or an Add a Person ~~Application f~~Form to request enrollment for a child or child-linked adult in the program.

(d) Except as provided in this section, the program shall determine eligibility and enroll child-linked adults pursuant to the process established for application to the program.

(e) Notwithstanding Section 2699.6625(e), the annual eligibility review date for the subscriber parent enrolled pursuant to Section 2699.6631 shall be the same as for the subscriber child through whom the subscriber parent became eligible.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21 and 12693.755, Insurance Code.

ARTICLE 3: HEALTH, DENTAL AND VISION BENEFITS

2699.6705. Share of Cost for Health Benefits.

(a) Every participating health plan shall require copayments for benefits provided to subscribers, except as provided under federal law to subscribers who are American Indians receiving services at an Indian Health Service Facility, subject to the following:

(1) In any benefit year that the applicant has incurred $250 in health benefit copayments for services received by subscribers who live in one household and for whom the applicant applied to the program, the applicant shall be deemed to have met the copayment maximum.

(2) No deductibles shall be charged to subscribers for health benefits.

(3) The following specific copayments shall apply:

(A) Inpatient facility services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility: No copayment.

(B) Inpatient professional services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility: No copayment.

(C) Facility services on an outpatient basis for subscribers: No copayment, except for a $5 copayment per visit for Emergency Health Care Services. The emergency health care services copay is waived if the subscriber is hospitalized.

(D) Outpatient professional services: $5 copayment per office or home visit. No copayment for surgery or anesthesia; radiation, chemotherapy, or dialysis treatments.

(E) Outpatient mental health: $5 copayment per visit.

(F) Home health care: No copayment except for $5 per visit for physical, occupational, and speech therapy visits performed in the home.

(G) Alcohol and drug abuse: No copayment for inpatient services. $5 per visit for outpatient services.

(H) Hospice: No copayment for any services provided under this benefit.

(I) Transplants: No copayment for any services provided under this benefit.

(J) Physical, occupational, and speech therapy: No copayment for therapy performed on an inpatient basis. $5 copayment per visit for therapy performed in the home or other outpatient setting.

(K) Biofeedback, acupuncture, and chiropractic visits, when offered at the participating health plan's option: $5 copayment per visit. For subscriber parents, copayment of $5 for each biofeedback visit for mental health.

(L) Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services; durable medical equipment, prosthetics and orthotics; blood and blood products; medical transportation services: No copayment.

(M) Hearing Aids: No copayment.

(N) Prescription Drugs: No copayment for prescription drugs provided in an inpatient setting, or for drugs administered in the doctor's office or in an outpatient facility setting during the subscriber's stay at the facility. $5 per prescription for up to a 30-34 day supply for brand name or generic drugs, including tobacco use cessation drugs. For subscriber children, no copayment for FDA approved contraceptive drugs and devices including Norplant.

For subscriber parents, $5 copayment for 90 day supply of FDA approved oral and injectable contraceptives and contraceptive devices. No refund if the medication is removed. (Represents the copayment for oral contraceptives at $5 copay for each 90-day supply for the approximate number of months the medication will be effective).

Maintenance drugs: $5 copayment per 90-100 day supply either through a participating health plan's participating pharmacies or through its mail order program. Maintenance drugs are drugs that are prescribed for 60 days or longer

and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

(4) Preventive services, including services for the detection of asymptomatic diseases, as defined by applicable Department of Managed Health Care regulations. These include:

(A) Periodic health exams; no copayment for subscriber children; $5 copayment per exam for subscriber parents.

(B) A variety of voluntary family planning services; no copayment for subscriber children. For subscriber parents $5 copayment per office visit.

Contraceptive services – no copayment for subscriber children. $5 copayment per visit and $5 copayment per device for subscriber parents.

(C) Prenatal care; no copayment.

(D) Vision and hearing testing; no copayment for subscriber children. For subscriber parents, $5 copayment per visit.

Eye refraction to determine the need for corrective lenses- no copayment for subscriber children. For subscriber parents, optional with $5 copayment per exam and limited to one visit per year.

(E) Immunizations; no copayment for subscriber children. $5 copayment per visit for subscriber parent.

(F) Venereal disease tests; No copayment for subscriber children. $5 copayment for subscriber parents.

(G) Cytology examinations on a reasonable periodic basis; no copayment for subscriber children. For subscriber parents, $5 copayment per exam.

(H) Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the participating health plan or health care organizations affiliated with the participating health plan. No copayment for subscriber children.

For subscriber parents, up to $5 copayment for diabetes outpatient self-management training, education, and medical nutrition therapy services. Charge may vary for other education services.

(5) No copayment shall be charged to subscribers under 24 months of age for well baby care, health examinations and other office visits.

(6) No copayments shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(~~FF~~GG) that the applicant or the subscriber is American Indian or Alaska Native.

(7) Reconstructive Surgery – no copayment

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.615 and 12693.755, Insurance Code.

2699.6717. Share of Cost for Dental Benefits for Subscriber Parents.

(a) Every participating dental plan shall require copayments for the dental benefits provided to subscriber parents subject to the following:

(1) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(1), “Diagnostic and Preventive.”

(2) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(2), “Restorative Dentistry”, with the following exceptions:

(A) Micro filled resin restorations (non-cosmetic, acid etched, bonded, light cured):

1. $40 per surface

2. $65 for two or more surfaces

(3) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(3), “Oral Surgery”, with the following exceptions:

(A) Removal of impacted teeth is subject to a copayment per tooth as follows:

1. Partially bony impaction -- $15 copayment.

2. Complete bony impaction -- $15 copayment.

(B) Root recovery as a separate procedure -- $5 per root.

(4) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(4), “Endodontics” with the following exceptions:

(A) Root canal therapy (excluding restoration) is subject to copayments as follows:

1. 1 canal - $20

2. 2 canals - $40

3. 3 canals - $60

4. 4 canals - $80

(B) An apicoectomy performed in conjunction with filling or root canal therapy at the same time is subject to a copayment of $60 per canal. When performed as a separate procedure, an apicoectomy is subject to a copayment of $50 per canal.

(5) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(5), “Periodontics”, with the following exceptions:

(A) Osseous or muco-gingival surgery is subject to a copayment of $150 per quadrant (includes post surgical visits).

(B) Gingivectomy is subject to a $5 copayment per tooth (fewer than six teeth).

(6) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(6), “Crowns and Bridges” (per unit), with the following exceptions:

(A) Porcelain crowns; porcelain fused to metal crowns (excluding molars) full crowns, or 3/4 crowns; are each subject to a copayment of $50. Cast post and core are subject to $40 per unit copayment, and bonded Maryland Bridge is subject to $50 copayment per unit.

(B) Pontics are each subject to a copayment of $50.

(7) "Removable Prosthetics" as listed under Subsection 2699.6711(a)(7) are subject to the following copayments:

(A) Dentures are subject to copayments as follows:

1. Complete upper denture (3 adjustments within 60 days) - $65.

2. Complete lower denture (3 adjustments within 60 days) - $65.

3. Partial acrylic upper or lower denture with clasps - $5.

4. Partial acrylic upper or lower denture with 2 chrome cobalt allow clasps is subject to a base fee of $65.

5. Partial lower or upper denture with chrome cobalt allow, lingual or palatal bar, clasps and acrylic saddles - $65 base fee (included two clasps).

6. Removable unilateral partial denture - $50.

7. Stayplate (maximum two teeth included) - $60.

(B) Reline for an upper, lower or partial denture is subject to a copayment per unit as follows:

1. Office reline – No copayment.

2. Laboratory reline - $15 copayment.

(C) Denture duplication -- $20 copayment.

(D) Denture Repairs

1. Adding teeth to partial denture to replace natural tooth:

First tooth - $10 copayment.

Each additional tooth - $5 copayment.

2. Broken partial denture (no teeth involved)

Replacement broken clasp - $5 copayment.

3. Add clasp with rest - $5 copayment.

(8) Other Services

After hour visit - $35 copayment.

Broken appointment - $5 copayment.

(9) Implants – If implants are utilized, the plan will apply the cost of a standard full or partial denture towards the cost of implants and appliances constructed thereon, and if performed, subscriber parent must pay the difference plus any applicable copayment. Surgical removal of implants is not covered.

(b) No deductibles shall be charged to subscriber parents for dental benefits.

(c) No copayments or fees shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(~~FF~~GG)that the applicant or subscriber is American Indian or Alaska Native.

(d) Note: Any procedure not listed in the EOC is available on a fee-for service basis.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63 and 12693.755, Insurance Code.

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:

(1) Examinations: $5 copayment per examination.

(2) Frames and lenses: $5 copayment, for frames with lenses, frames or lenses.

A wholesale frame allowance of $30 will be provided by the vision plan. If a subscriber chooses a frame with a wholesale value above $30, the provider will bill the subscriber the difference between the standard retail value of $75 for a $30 wholesale frame and the retail cost of the frame the subscriber has selected.

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.

(3) Necessary contact lenses, as defined in Subsection 2699.6721(a)(3): no copayment.

(4) Elective contact lenses: an allowance of $110 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: Copayment is $5.

(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

(B) Each bifocal lens, up to $20.00

(C) Each trifocal lens, up to $25.00

(D) Each lenticular lens, up to $50.00

(E) Frame, up to $40.00

(F) Tint allowance, up to $5.00

(G) Each pair of necessary contact lenses, up to $250.00

(H) Each pair of elective contact lenses, up to $110.00. 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)(~~FF~~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 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65 and 12693.755, Insurance Code.

ARTICLE 4. RISK CATEGORIES AND FAMILY CONTRIBUTIONS

2699.6801. Risk Categories Health.

(a) Subscriber child rates are as follows:

(1) With the exception of rates applicable to AIM infants in the first two calendar months of life~~,~~ , ~~H~~health benefit plan rates shall be based on two risk categories; geographic region of the subscriber's residence and the age of the subscriber. Health plan benefit rates for subscribers entering the program as AIM infants shall initially be determined in accordance with subsection (c).

(2) The age categories for subscriber children shall be as follows:

(A) The first age category is subscribers under the age of one.

(B) The second age category is subscribers of the age of one and over.

(3) The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (4) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara**.**

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(4) The Board may allow one or more health plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(5) Health plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of the number of subscribers covered by one family contribution.

(b) Subscriber parent rates are as follows:

(1) Health benefit plan rates shall be based on two risk categories; geographic region of the subscriber's residence and age of the subscriber parent.

(2) The age categories for subscriber parents shall be as follows:

(A) The first age category is subscribers under the age of forty-five.

(B) The second age category is subscribers age forty-five and over.

(3) Health plans shall also be paid an additional lump sum payment for each delivery of one or more newborns to a subscriber parent while enrolled in the program.

(4) The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (5) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San

Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(5) The Board may allow one or more health plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(6) Health plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of number of subscribers covered by one family contribution.

(c) Subscriber Rates for AIM Infants

(1) The initial rate for subscribers entering the program as AIM infants shall be determined as follows:

(A) The rate shall be available only to health plans participating as contractors in the AIM Program and shall cover a health plan's entire service area.

(B) The rate shall cover the birth month through the end of the AIM infant's second month of life. After this period, a health plan shall be paid rates in accordance with the age and geographic region categories in subsections (a)(2), (3) and (4).

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.34, 12693.615 and 12693.755, Insurance Code.

2699.6809. Determination of Family Contribution for the Program.

(a) Family child contributions for the program shall consist of one of the following:

(1) A flat fee in each county for a family value package:

(A) Seven dollars ($7) per subscriber child with a maximum required contribution of fourteen dollars ($14) per month for subscriber children with annual household incomes after income deductions of up to and including 150 percent of the federal poverty level.

(B) Nine dollars ($9) per subscriber child with a maximum required contribution of twenty-seven dollars ($27) per month for subscriber children with annual household incomes after income deductions greater than 150 percent and up to and including 250 percent of the federal poverty level; <u>these rates are also applicable for subscribers who entered the program as AIM infants.</u>

(2) A flat fee in each county for a family value package that includes a community provider plan:

(A) Four dollars ($4) per subscriber child with a maximum required contribution of eight dollars ($8) per month for subscriber children with annual household incomes after income deductions of up to and including 150 percent of the federal poverty level.

(B) Six dollars ($6) per subscriber child with a maximum required contribution of eighteen dollars ($18) per month for subscriber children with annual household incomes after income deductions of greater than 150 percent and up to and including 250 percent of the federal poverty level; <u>these rates are also applicable for subscribers who entered the program as AIM infants.</u>

(b) Family parent contributions for the program shall consist of one of the following:

(1) A flat fee in each county for a family value package:

(A) Ten dollars ($10) per month per subscriber parent with an annual household income after income deductions of up to and including 150 percent of the federal poverty level.

(B) Twenty dollars ($20) per month per subscriber parent with an annual household income after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.

(2) A flat fee in each county for a family value package that includes a community provider plan:

(A) Seven dollars ($7) per month per subscriber parent with an annual household income after income deductions of 150 percent of the federal poverty level.

(B) Seventeen dollars ($17) per subscriber parent with an annual household income after income deductions of greater than 150 percent and up to and including 200 percent of the federal poverty level.

(c) Applicants who pay in advance the amount of three (3) months of family child contributions shall receive the fourth consecutive month of coverage for a subscriber child with no family child contributions required.

(d) Applicants who pay in advance the amount of three (3) months of family parent contributions shall receive the fourth consecutive month of coverage for a subscriber parent with no family parent contributions required if the subscriber child contributions (if applicable) are also paid in advance, at the same time for the same three month period.

(e) Applicants who pay the family child contributions (if applicable) and the family parent contributions (if applicable) by electronic fund transfer shall receive a twenty-five (25) percent discount off the monthly combined total of the family child contributions and family parent contributions.

(f) If the applicant is applying for children in more than one household, the income of the household with the lowest annual income after income deductions will be used to determine the family contributions.

(g) If an applicant has a family contribution sponsor, family child contributions and/or family parent contributions that are to be paid by the family contribution sponsor for any twelve (12) consecutive months in the program shall be established based on subsections (a) and (b) above.

(h) If an AIM infant is enrolled in a different health plan from his or her siblings until the Open Enrollment period after the AIM infant's first birthday, the family child contribution will be the family child contribution for the siblings, plus the contribution rate for one more child at the same rate, up to the maximum required contribution.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.43, 12693.53 and 12693.755, Insurance Code.

2699.6813. Family Contribution Payment for the Program.

Family contribution payment procedures for applicants shall be as follows unless the applicant or person for whom application is being made is an American Indian or Alaska Native and submits acceptable documentation as described in Subsection 2699.6600(c)(1)(~~FF~~GG), or unless the applicant has a family contribution sponsor:

(a) Applicants shall submit their initial family contributions pursuant to Subsection 2699.6600(a). The family child contributions and family parent contributions will be applied for one (1) month or four (4) months, as applicable, starting with the first day of the first full month of coverage. If the applicant or person for whom application is being made is an American Indian or Alaska Native, the family contributions shall not be assessed until the first day of the first full month following the end of the second month of enrollment during which the applicant has not provided acceptable documentation as described in Subsection 2699.6600(c)(1)(~~F~~GG).

(b) Applicants shall submit their subsequent family contributions to the program so that they are received no later than the monthly due date set by the program.

(c) The program shall apply monies paid first to the family child contributions due, then to the family parent contributions due. Remaining monies shall be applied first to the family child contribution up to the level necessary to earn a free month of coverage, then to the family parent contribution up to the level necessary to earn a free month of coverage, except as provided under Subsection 2699.6605(b)(1).

(d) Applicants who want to receive the one month family contribution discount pursuant to Subsection 2699.6809(c) and (d) must submit their family child contributions, if applicable, and/or family parent contributions, if applicable, at the same time and for the same three (3) month period so that they are received no later than the due date set by the program for the first of the three (3) months.

(e) For each month any family contributions are due, the program shall notify the applicant of the amount of the family contributions due to the program, the due date, and the subscribers for whom the family contributions are being paid. This notification shall be made at least fifteen (15) calendar days in advance of the family contributions due date.

(f) The applicant's obligation to submit the family contributions is not contingent upon receipt of the notice specified in subdivision (d) above. If the applicant does not receive the notice specified in subdivision (d) above, the applicant shall call the program to determine the amount of the family contributions and shall submit a payment of that amount.

(g) Applicants shall make family contributions in one or more of the following ways: personal check, cashiers check, money order, credit card, debit card, electronic fund transfer, or in cash at designated locations. If a family contribution is paid by a personal check that has been returned for non-sufficient funds, the Program may specify the form of payment that it will accept for the overdue family contribution.

(h) If a subscriber is disenrolled pursuant to Subsection 2699.6611(a), the applicant will be refunded the unused portion of the family contributions, except as provided in Section 2699.6815(e) and Section 2699.6819(c).

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.43 and 12693.755, Insurance Code.