

TITLE 10: CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.6 MANAGED RISK MEDICAL INSURANCE BOARD
ACCESS FOR INFANTS AND MOTHERS

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Article 1. Definitions
Amend Sections 2699.100

Section 2699.100 is amended to read:

§ 2699.100. Definitions.

- (a) "Appellant" means an applicant or subscriber who has filed an appeal with the program.
- (b) "Applicant" means a pregnant woman 18 years of age or older who is applying on her own behalf, or a legal guardian or a natural parent, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child. "Applicant" also means a pregnant woman who is applying for coverage on her own behalf who is under 18 years of age, or who is an emancipated minor, or who is a minor not living in the home of a natural or adoptive parent, a legal guardian, foster parent or stepparent.
- (c) "Application Date" means the date an application is sent to the program as evidenced by the U.S. postmark date on the application envelope, or documentation from other delivery services including fax delivery.
- (d) "Board" means the Managed Risk Medical Insurance Board.
- (e) "Coverage" means the payment for benefits provided through the program.
- (f) Department of Health Care Services (DHCS) means the state department that oversees and administers the Medicaid program for the State of California (Medi-Cal).
- ~~(f)-(g)~~ "Disenroll" means to terminate coverage by the program.

~~(g)~~(h) "Eligible" means the applicant is qualified to be enrolled in a participating health plan.

~~(h)~~(i) "Enroll" means to accept an applicant as a subscriber by notifying a participating health plan to accept the applicant.

~~(i)~~(j) "Executive Director" means the executive director for the Board.

~~(j)~~(k) "Family member" means the following persons living in the individual's home:

- (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 sibling children.
- (4) The separate children of either an unmarried parent or a married parent or stepparent.
- (5) An unborn child of the pregnant woman who is applying for coverage on her own behalf or on whose behalf an application has been submitted.
- (6) Children under the age of 21, of married or unmarried parents, away at school who are claimed as tax dependents.
- (7) The spouse of the pregnant woman.

~~(k)~~(l) "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.

~~(l)~~(m) "First trimester" means the first 13 weeks starting with the first day of a pregnant woman's last menstrual period and ending at the end of the 13th week, or the first 13 weeks of a 40-week, full-term pregnancy as documented by a licensed health care professional.

~~(m)~~(n) "Gross household income" means the total annual gross income of all family members except dependent children. Income includes before tax earnings from a job, including cash, wages, salary, commissions and tips, self-employment net profits, Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability worker's compensation,

unemployment benefits, alimony, spousal support, pensions and retirement benefits, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings and interest income. Income excludes child support, 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.

~~(h)~~(o) "Healthy Families Program" (HFP) means the Federal/State funded program that is operated pursuant to Title XXI of the Social Security Act and Part 6.2 (commencing with Section 12693) of Division 2 of the California Insurance Code, and that provides low cost health, dental and vision insurance coverage to eligible children.

~~(e)~~(p) "Income deduction" means any of the following:

- (1) Work expenses of \$90 per month for each family member except dependent children working or receiving disability workers' 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 disabled dependent care expenses of up to \$175 for a disabled dependent living in the home.
- (3) The amount paid by a family member per month for any court ordered alimony or child support.
- (4) \$50 for alimony payments received by the pregnant woman. If a woman receives less than \$50, the deduction can only be for the amount received.

~~(p)~~(g) "Infant" means a subscriber's child born to a subscriber while the subscriber is enrolled in the program.

~~(q)~~(r) "Living in the home" means using the home as the primary place of residence.

~~(f)~~(s) "Medi-Cal" means the California health care services program under Title XIX of the Social Security Act.

~~(s)~~(t) "Medicare" means the Health Insurance for the aged and permanently disabled provided under Title XVIII of the Social Security Act; "Part A" means Hospital Insurance as defined in Title XVIII of the Social Security Act; and "Part B" means Medical Insurance as defined in Title XVIII of the Social Security Act.

~~(t)~~(u) "Participating health plan" means any of the following plans which are 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 program to provide coverage to program subscribers:

- (1) A private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.
- (2) A nonprofit hospital service plan qualifying under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.
- (3) A nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code).
- (4) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code.
- (5) A county or a city and county, in which case no license or approval from the Department of Insurance or the Department of Corporations shall be required to meet the requirements of this part.
- (6) A comprehensive primary care licensed community clinic that is an organized outpatient freestanding health facility and is not part of a hospital that delivers comprehensive primary care services, in which case, no license or approval from the Department of Insurance or the Department of Corporations shall be required to meet the requirements of this part.

~~(u)~~(v) "Program" means the Access for Infants and Mothers Program.

(w) "Provider" means any individual, partnership, group, association, corporation, institution, or entity and the officers, directors, owners, managing employees, or agents

of any partnership, group association, corporation, institution, or entity, that provides services, goods, supplies or merchandise, directly or indirectly, to a subscriber.

~~(v)~~(x) "Resident" means a person who is present in California with intent to remain present except when absent for transitory or temporary purposes.

~~(w)~~(y) "State supported services" mean abortion services provided to the subscribers through the program.

~~(x)~~(z) "Subscriber" means an individual who is eligible for and enrolled in the program.

~~(y)~~(aa) "Subscriber contribution" means the cost to the subscriber to participate in the program.

~~(z)~~(bb) "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.

~~(aa)~~(cc) "Time." Whenever in this chapter a time is stated in which an act is to be done, the time is computed by excluding the first day and including the last day. If the last day is a holiday it is also excluded.

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12695, 12695.06, 12695.08, 12695.18, 12695.20, 12695.22, 12695.24, 12696 and 12698, Insurance Code.

**Article 2. Eligibility, Application, and Enrollment
Amend Sections 2699.201, 2699.204, and 2699.210**

Section 2699.201 is amended in relevant part to read:

§ 2699.201. Application.

- (d) (1) The application, entitled Access for Infants and Mothers (AIM) Application (rev12.02.2008), which is incorporated by reference, shall contain the following:

(BB) An indication of the pregnant woman's first choice and second choice participating health plans, for subscribers enrolled in the program with an effective date of coverage prior to October 1, 2011.

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12698(b), 12698(c) and 12698.05, Insurance Code; and Maternal and Child Health Access, Petitioner, vs. Managed Risk Medical Insurance Board (Superior Court of the State of California, City and County of San Francisco, Case No. CPF-08-508296).

Section 2699.204 is amended to read:

§ 2699.204. Enrollment.

- (a) Applicants determined eligible, and enrolled in for the program with an effective date of coverage prior to October 1, 2011, shall be enrolled in their:
- (1) First choice participating health plan, unless that plan is currently serving the number of subscribers which it has contracted with the program to serve.
 - (2) Second choice participating health plan when the first choice plan is currently serving the number of subscribers which it has contracted with the program to serve.
- (b) An applicant enrolled in the program with an effective date of coverage prior to October 1, 2011 shall be notified in writing by the program of enrollment with a participating health plan and the beginning date of coverage by the participating health plan.

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12696.05, Insurance Code.

Section 2699.210 is amended in relevant part to read:

§ 2699.210. Transfer of Enrollment.

(a) A subscriber and/or infant, if any, enrolled in a participating health plan shall be transferred from one participating health plan to another if any of the following occurs:

- (1) A subscriber so requests, in writing, because the subscriber and/or infant, if any, has moved and no longer resides in an area served by the participating health plan in which the subscriber and/or infant, if any, is enrolled, and there is at least one participating health plan serving the area in which the subscriber and/or infant now resides that is accepting new enrollees.
- (2) The subscriber or the participating health plan so requests, in writing, because of failure to establish a satisfactory subscriber-plan relationship and the Executive Director determines that the transfer is in the best interests of the program, and there is at least one other participating health plan serving the area in which the subscriber resides that is accepting new enrollees.
- (3) The program contract with the participating health plan in which the subscriber is enrolled is canceled or not renewed.

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12697.10, Insurance Code.

Article 3. Scope of Benefits
Amend 2699.300 and 2699.301

Section 2699.300 is amended to read:

§ 2699.300. Minimum Scope of Benefits.

(a) ~~The basic scope of benefits offered by participating health plans to subscribers and infants must comply with all requirements of the Knox Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable~~

~~regulations, and~~ shall include all of the benefits and services listed in this section, subject to the exclusions listed in this section and Section 2699.301. No other benefits shall be permitted to be offered by a participating health plan unless specifically provided for in the program contract with the participating health plan. For subscribers enrolled in the program with an effective date before October 1, 2011, the basic scope of benefits offered by participating health plans must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable regulations. For subscribers enrolled in the program with an effective date on or after October 1, 2011, all benefits shall be provided through the Medi-Cal fee-for-service system and shall be subject to that system's prior authorization requirements and any other exclusions and limitations. The basic scope of benefits shall be as follows:

NOTE: The final version of the regulations presented to the Board on August 17, 2011 may include additional changes to account for differences in benefits between the current AIM delivery system and Medi-Cal fee-for-service.

(1) Health Facilities

- (A) Inpatient Hospital Services: General hospital services, in a room of two or more, with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. All medically necessary ancillary services such as: use of operating room and related facilities; intensive care unit and services; drugs, medications, and biologicals; anesthesia and oxygen; diagnostic laboratory and x-ray services; special duty nursing as medically necessary; physical, occupational, and speech therapy, respiratory therapy; administration of blood and blood products; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of such continuing care as may be necessary.

Exclusions: Personal or comfort items or a private room in a hospital are excluded unless medically necessary.

- (B) Outpatient Services: Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility. Includes physical, occupational, and speech therapy as appropriate; and those hospital services, which can reasonably be provided on an ambulatory basis. Related services and supplies in connection with these services including operating room, treatment room,

ancillary services, and medications which are supplied by the hospital or facility for use during the subscriber's stay at the facility.

- (2) Durable medical equipment: Medical equipment appropriate for use in the home which: 1) is intended for repeated use; 2) is generally not useful to a person in the absence of illness or injury; and 3) primarily serves a medical purpose. The health plan may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Oxygen and oxygen equipment; blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes; insulin pumps and all related supplies; visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin, and apnea monitors; podiatric devices to prevent or treat diabetes complications; pulmoaides and related supplies; nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers; ostomy bags and urinary catheters and supplies.

Exclusions: Coverage for comfort or convenience items; disposable supplies except ostomy bags and urinary catheters and supplies consistent with Medicare coverage guidelines; exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment; or more than one piece of equipment that serve the same function.

- (3) Medical Transportation Services: Emergency ambulance transportation in connection with emergency services to the first hospital, which actually accepts the subscriber for emergency care. Includes ambulance and ambulance transport services provided through "911" emergency response system.

Non-emergency transportation for the transfer of a subscriber from a hospital to another hospital or facility or facility to home when:

- (A) medically necessary, and
- (B) requested by a plan or provider, and
- (C) authorized in advance ~~by the participating health plan~~

Exclusions: Coverage for transportation by airplane, passenger car, taxi or other form of public conveyance.

- (4) Emergency Health Care Services: Twenty-four hour emergency care for a medical condition manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- (A) Placing the patient's health in serious jeopardy.
- (B) Serious impairment to bodily functions.
- (C) Serious dysfunction of any bodily organ or part.

This must be provided both in and out of the health plan service area and in and out of the health plan's participating facilities.

- (5) Professional Services: Medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. Surgery, assistant surgery and anesthesia (inpatient or outpatient); inpatient hospital and skilled nursing facility visits; professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment; and home visits when medically necessary. In addition, professional services include:

- (A) Eye Examinations: Eye refractions to determine the need for corrective lenses, and dilated retinal eye exams.
- (B) Hearing tests, hearing aids and services: Hearing tests, hearing aids and services: Audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid. Hearing aid: Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Visits for fitting, counseling, adjustments, repairs, etc., at no charge for a one-year period following the provision of a covered hearing aid.

Exclusions: The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial

hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss. Replacement parts for hearing aids, repair of hearing aid after the covered one-year warranty period, replacement of a hearing aid more than once in any period of thirty-six months, and surgically implanted hearing devices.

- (C) Immunizations for infants: Immunizations consistent with the most current version of the Recommended Childhood Immunization Schedule/United States adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Family Physicians. Immunizations required for travel as recommended by the ACIP, and other age appropriate immunizations as recommended by the ACIP.

Immunizations for Subscribers: Immunizations for adults as recommended by the ACIP. Immunizations required for travel as recommended by the ACIP. Immunizations such as Hepatitis B for individuals at occupational risk, and other age appropriate immunizations as recommended by the ACIP.

- (D) Periodic health examinations for infants: periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics; and the current version of the Recommended Childhood Immunization Schedule/United States, adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.

The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the infant including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

Periodic Health Examinations for Subscribers: Periodic health examinations including all routine diagnostic testing and laboratory services appropriate for such examinations.

The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the subscriber including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

(E) Well baby care during the first two years of life, including newborn hospital visits, health examinations and other office visits.

(6) Health education services: 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 plan or health care organizations affiliated with the plan. Health education services include services related to tobacco use and drug and alcohol abuse.

Health education services relating to tobacco use means tobacco use prevention and education services including tobacco use cessation services.

(7) Nutrition Services: Direct patient care nutrition services, including nutritional assessment.

(8) Prescription Drugs: Medically necessary prescription drugs, when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes injectable medication and needles and syringes necessary for the administration of the covered injectable medication. Also includes insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes. Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins, if such vitamins require a prescription. Medically necessary drugs administered while a subscriber is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when prescribed by a plan physician in connection with a covered service and

obtained through a ~~plan~~-designated pharmacy. Health plans may specify that generic equivalent prescription drugs must be dispensed if available, provided that no medical contraindications exist. The use of a formulary, maximum allowable cost (MAC) method, and mail order programs by health plans is encouraged.

Contraceptive Drugs and Devices: All FDA approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered including internally implanted time release contraceptives such as Norplant.

Exclusions: Experimental or investigational drugs, unless accepted for use by the standards of the medical community; drugs or medications for cosmetic purposes; patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc.; medicines not requiring a written prescription order (except insulin and smoking cessation drugs as previously described); and dietary supplements (except for formulas or special food products to treat phenylketonuria or PKU), and appetite suppressants or any other diet drugs or medications.

(9) **Reconstructive Surgery:** Reconstructive surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do any of the following:

(A) To improve function

(B) To create a normal appearance to the extent possible

(C) To restore and achieve symmetry incident to mastectomy.
Services for this purpose include reconstructive surgery and associated procedures following a mastectomy which resulted from disease, illness, or injury, and breast prosthesis required incidental to the surgery.

(10) **Transplants:**

Coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational in nature. Reasonable medical and hospital expenses of a donor or an individual

identified as a prospective donor if these expenses are directly related to the transplant for a subscriber.

Charges for testing of relatives for matching bone marrow transplants.
Charges associated with the search and testing of unrelated bone marrow donors through a recognized Donor Registry and charges associated with the procurement of donor organs through a recognized Donor Transplant Bank, if the expenses are directly related to the anticipated transplant of a subscriber.

- (11) Maternity Care: Medically necessary professional and hospital services relating to maternity care including: pre-natal and post-natal care and complications of pregnancy; newborn examinations and nursery care while the mother is hospitalized. Includes providing coverage for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program.
- (12) Family Planning: Voluntary family planning services including counseling and surgical procedures for sterilization as permitted by state and federal law, diaphragms, and coverage for other federal Food and Drug Administration approved devices and contraceptive drugs pursuant to the prescription drug benefit.
- (13) Diagnostic X-ray and laboratory Services: Diagnostic laboratory services, diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat, and follow-up on the care of subscribers. Other diagnostic services, which shall include, but not be limited to, electrocardiography, electro-encephalography, prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy, and mammography for screening or diagnostic purposes. Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).
- (14) Home Health Services: Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

Home health services are limited to those services that are prescribed or directed by the attending physician or other appropriate authority ~~designated by the plan~~. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority ~~designated by the plan~~ to choose the setting for providing the care. Plans shall exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost-effective when there is a choice among several medically appropriate alternative services or settings. Exclusions: Custodial care

- (15) Physical, Occupational, and Speech Therapy: Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. Plans may require periodic evaluations as long as therapy, which is medically necessary, is provided.
- (16) Blood and Blood Products: Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood when medically indicated.
- (17) Cataract Spectacles and Lenses: Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Also one pair of conventional eyeglasses or conventional contact lenses is covered if necessary after cataract surgery with insertion of an intraocular lens.
- (18) Skilled Nursing: Services prescribed by a ~~plan~~-physician or nurse practitioner and provided in a licensed skilled nursing facility when medically necessary. Skilled nursing on a 24-hour per day basis; bed and board; x-ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. This benefit shall be limited to a maximum of 100 days per benefit year.
- (19) Hospice: The hospice benefit shall include nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services. The benefit shall also include physical therapy; occupational therapy, speech therapy, short-term inpatient care, pain control and symptom management. The hospice benefit may include, ~~at the option of the health~~

~~plan, homemaker services; services of volunteers, and short-term inpatient respite care. The hospice benefit is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services covered by the plan.~~

Individuals who elect hospice care are not entitled to any other benefits ~~under the plan~~ for the terminal illness while the hospice election is in effect. The hospice election may be revoked at any time.

- (20) Orthotics and Prosthetics: Orthotics and prosthetics including medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her licensure, and medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her license. Coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetics. Also includes prosthetic devices to restore and achieve symmetry incident to mastectomy.

Exclusions: Corrective shoes and arch supports, except for therapeutic footwear and inserts for individuals with diabetes; non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts; dental appliances; electronic voice producing machines; or more than one device for the same part of the body. Also does not include eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).

- (21) Mental Health:

- (A) Inpatient: ~~Plans must provide services with a~~ No visit limits for severe mental illnesses including Schizophrenia, Schizoaffective disorder, Bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, Anorexia nervosa, Bulimia nervosa, and services for serious emotional disturbances in children. ~~Plans must provide coverage for u~~ Up to 30 inpatient days per benefit year for illnesses that do not meet the criteria for severe mental illnesses, and for conditions that do not meet the criteria for serious emotional disturbances of a child.

~~Plans with the agreement of the subscriber or applicant or other responsible adult if applicable, may substitute for e~~Each day of inpatient hospitalization may be substituted for any of the following: two (2) days of residential treatment, three (3) days of day care treatment, or four (4) outpatient visits.

- (B) Outpatient: ~~Plans must provide services with n~~No visit limits for severe mental illnesses including Schizophrenia, Schizoaffective disorder, Bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, Anorexia nervosa, Bulimia nervosa, and services for serious emotional disturbances in children.

~~Plans must provide u~~Up to 20 outpatient visits per benefit year for illnesses that do not meet the criteria for severe mental illness or serious emotional disturbances of a child. ~~Participating plans may elect to provide a~~Additional visits may be provided if medically necessary. ~~Plans may provide g~~Group therapy may be provided at a reduced copayment.

(22) Alcohol and Drug Abuse:

- (A) Inpatient: Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system.
- (B) Outpatient: Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate. ~~Participating health plans shall offer~~ A minimum of at least 20 outpatient visits per benefit year. ~~Participating health plans may elect to provide a~~Additional visits may be provided if medically necessary.

This part shall not be construed to prohibit a plan's ability to impose cost-control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698.30, Insurance Code.

Section 2699.301 is amended to read:

§ 2699.301. Excluded Benefits.

- (a) ~~The following benefits shall be excluded from the Program Plans offered under this program shall exclude the following benefits unless specifically provided for in the program contract with the participating health plan:~~
- (1) Services which are not medically necessary. "Medically necessary" as applied to the diagnosis or treatment of illness is an article or service that is not investigational and is necessary because:
 - (A) It is appropriate and is provided in accordance with accepted medical standards in the state of California, and could not be omitted without adversely affecting the patient's condition or the quality of medical care rendered; and
 - (B) As to inpatient care, it could not have been provided in a physician's office, in the outpatient department of a hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and
 - (C) If the proposed article or service is not commonly used, its application or proposed application has been preceded by a thorough review and application of conventional therapies; and
 - (D) The service or article has been demonstrated to be of significantly greater therapeutic value than other, less expensive, services or articles.
 - (2) Any services which are received prior to the enrollee's effective date of coverage, except as provided in Section 2699.303.
 - (3) Custodial care, domiciliary care, or rest cures, for which facilities of a general acute care hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.

- (4) Personal or comfort items, or a private room in a hospital unless medically necessary.
- (5) Emergency facility services for nonemergency conditions.
- (6) Those medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are either:
 - (A) Experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question.
 - (B) Outmoded or not efficacious.
- (7) Transportation except as specified in Section 2699.300(a)(3).
- (8) Implants, except cardiac pacemakers, intraocular lenses, screws, nuts, bolts, bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips; and except as specified in Section 2699.300(a)(9)(C).
- (9) Eyeglasses, except those eyeglasses or contact lenses necessary after cataract surgery, which are covered under Subsection 2699.300(a)(17).
- (10) Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except ~~as a participating health plan shall if it is determined~~ they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to Subsection 2699.300(a)(18) and (19).
- (11) Dental services, including dental treatment for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that the repair commences within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible. This language shall not be construed to exclude surgical procedures for any condition directly affecting the upper or lower jawbone, or associated bone joints.
- (12) Cosmetic surgery, including treatment for complications of cosmetic surgery, that is solely performed to alter or reshape normal structures of

the body in order to improve appearance, except as specifically provided in Section 2699.300(a)(9).

- (13) Any services or items specified as excluded within Section 2699.300.
- (14) Any benefits in excess of limits specified in Section 2699.300.
- (15) Treatment for infertility is excluded. Diagnosis of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.
- (16) Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain for which such benefits are provided or payable under any Worker's Compensation benefit plan. ~~The participating health plans shall provide the s~~Services shall be provided at the time of need, and the subscriber or applicant shall cooperate to assure that the ~~participating health plan~~ program is reimbursed for such benefits.
- (17) Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. ~~The participating health plan shall provide the s~~Services shall be provided at the time of need, and the subscriber or applicant shall cooperate to assure that the ~~participating health plan~~ program is reimbursed for such benefits.

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696.05, Insurance Code.

Article 5. Appeals

NOTE: Article 5 (Appeals) is under development.

§ 2699.501. Dispute Resolution.

Notwithstanding other sections in this Article, when a subscriber enrolled in a participating health plan is dissatisfied with any action, or inaction, of the program's participating health plan in which she is enrolled, the subscriber shall first attempt to resolve the dispute with the participating health plan according to its established policies and procedures.

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696, Insurance Code.