

TITLE 10. INVESTMENT
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD HEALTHY
FAMILIES PROGRAM
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.
- (2) 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.
- (3) 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.
- (4) The program application, entitled "Family Health Coverage Mail-In Application, for Medi-Cal and Healthy Families" (MC321 HFP, 4/06), is hereby incorporated by reference. Alternatively, the program shall utilize the on-line application submitted electronically via the internet and the school lunch application and any supplemental forms received pursuant to Section 14005.41 of the Welfare and Institutions Code to make an eligibility determination.
- (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. If an individual is pregnant, it should be indicated, along with the expected due date.
- (I) 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.
 - 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.
 - 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, 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.
- (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.
- (K) Documentation of the total monthly gross household income for either the previous or current calendar year. For each person

listed pursuant to subsections (F) and (H) above, provide social security number (optional) and documentation for each source of income. Such documentation shall be provided for the previous or current year as indicated below:

1. For the previous calendar year:
 - a. 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 award letters, checks, 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 interest income.
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."
- d. A letter or Notice of Action from the County Welfare Office issued within the last two (2) months that includes:
- i. For each person for whom application is being made, a statement that the person is eligible for share-of-cost Medi-Cal,
 - ii. A determination of total monthly household income and monthly household income after income deductions as defined in Section 2699.6500, and

- 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.
- (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.

- (M) A declaration that each person for whom application is being made is not eligible for Part A and Part B of Medicare.
- (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.
- (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.
- (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.
- (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.
- (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.
- (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 (S)2. above.

- (T) For each declaration made pursuant to (S), documentation of the individual's status. If documentation is unavailable at the time of application, persons declaring a status listed under subsection (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.
- (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.
- (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.
- (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.
- (X) For each person for whom application is being made, an indication of whether the person has other health, dental or vision insurance.
- (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.
- (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.

- (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. 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.
- (BB) The applicant may provide the following optional information:
1. The applicant's choice of participating health, dental and/or vision plans.
 2. 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.
 3. An indication of whether there is more than one car in the children's household.
 4. An indication of whether there is more than \$3,150 cash in bank accounts in the children's household.
 5. An indication if the applicant does not want the application reviewed for eligibility for Medi-Cal or the Program.
- (CC) If assistance in completing the application was provided by an eligible individual, a statement by the applicant that such assistance was provided.
- (DD) If applicable, a declaration that the applicant is a migratory worker or seasonal worker as defined in Section 2699.6500.
- (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.

- (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.

 - (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 Alaskan 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.

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

 - (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.

- (d) For children referred pursuant to Section 14005.41 of the Welfare and Institutions Code, the program shall use the following to make an eligibility determination:
- (1) For each child for whom the applicant is applying, the child's school lunch application forwarded pursuant to Section 49557.2 of the Education Code and Section 14005.41 of the Welfare and Institutions Code; and
 - (2) Supplemental Form for Express Enrollment Applicants (MC 368 (06/05)); and
 - (3) A letter or Notice of Action from the County Welfare Office issued within the last two (2) months that includes:
 - (A) For each person for whom application is being made, a statement that the person is eligible for share-of-cost Medi-Cal; and
 - (B) A determination of total monthly household income and monthly household income after income deductions as defined in Section 2699.6500; and
 - (C) A determination of the number of family members living in the household; and
 - (4) Any additional information requested by the program pursuant to Subsection 2699.6600(c)(1)(C), (F)15., (G), (M)-(Q), (U)-(W), (AA), (BB)1.-2., (DD), (GG).

Note: Authority cited: Sections 12693.21, 12693.75 and 12693.755, Insurance Code; and Section 14005.41, Welfare and Institutions 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.

§ 2699.6607. 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 Form unless the program is waiting for necessary information pursuant to Subsection 2699.6606(b)(1) and (2) or is requesting information pursuant to Subsection 2699.6600(c)(1)(BB)(1). 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 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)(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)(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, a 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 or 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 the applicant does not select a health, dental and/or vision plan and the person being applied for is eligible for the program, the program shall assign the health, dental and/or vision plan as follows:
- (1) Automatic assignment of the health plan to the community provider plan. If the community provider plan is not available, alternate assignment to an available health plan; and/or
 - (2) Alternate assignment of the dental and/or vision plan.

- (g) If application was made pursuant to Section 2699.6602(d), eligibility is contingent upon receipt by the program of documentation of the child's birth within thirty (30) days of the birth.
- (h) 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.

§ 2699.6619. 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 other 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.

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

(b) A 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 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) If a subscriber is transferred pursuant to (a) or (b) 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.

(d) 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.

(e) 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.

§ 2699.6621. Open Enrollment Period.

(a) The program shall provide for an annual open enrollment period of at least forty-five (45) calendar days. During this period, applicants may for any reason request that subscribers be transferred from one participating health, dental, or vision plan to another. Plan selection rules set forth in Section 2699.6623 apply for open enrollment.

(b) For each subscriber for whom an applicant is requesting to change plans during an open enrollment period, the applicant shall provide the following:

- (1) Full name
- (2) Address
- (3) Social Security Number (optional)
- (4) Home telephone number
- (5) Current participating plan(s)
- (6) New participating plan(s)

(7) The applicant's choice of primary care provider/clinic (optional) and dentist (optional) for each child for whom application is being made.

(8) A declaration that the applicant understands that a change of participating plans may result in a change in the required family contribution.

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

TITLE 10. INVESTMENT
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD HEALTHY
FAMILIES PROGRAM
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 Services: 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) 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. For subscriber children, no copayment for FDA approved contraceptive drugs.

\$5 copayment per prescription for up to 30 day supply for brand name or generic drugs, including tobacco use cessation drugs. \$5 copayment per 90 day supply of maintenance drugs purchased 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.

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).

(4) Preventive services

(A) Periodic Health Exams; No copayment for subscriber children; \$5 copayment per exam for subscriber parents.

(B) A variety of voluntary family planning services; including contraceptive services: No copayment for subscriber children. For subscriber parents \$5 copayment per office visit and \$5 copayment per device.

(C) Maternity Services: No copayment.

(D) Vision Services: 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) Hearing Services and Hearing Aids: No copayment.

(F) Immunizations; No copayment for subscriber children. \$5 copayment per visit for subscriber parent.

(G) Sexually Transmitted Disease Testing: No copayment for subscriber children. \$5 copayment for subscriber parents.

(H) Cytology Examinations on a reasonable periodic basis: No copayment for subscriber children. For subscriber parents, \$5 copayment per exam.

(I) Health Education Services: 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.

(J) Well Baby Care, Health Examinations and Other Office Visits for subscribers 24 months of age and under: No copayment.

(K) Gynecological Examinations and Cancer Screening: No copayment.

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

(6) 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.

§ 2699.6715. Share of Cost for Dental Benefits for Subscriber Children.

(a) Every participating dental health plan shall require copayments for the dental benefits listed in Subsection 2699.6709 (a) of these regulations provided to subscribers subject to the following:

(1) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(1), "Diagnostic and Preventive Benefits."

(2) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(2), "Restorative Dentistry."

(3) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(3), "Oral Surgery", with the following exceptions:

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

1. Soft tissue impaction - No copayment.
2. Bony impaction - \$5 copayment per tooth.

(B) Root recovery - \$5 per root.

(4) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(4), "Endodontics", with the following exceptions:

(A) Root canal therapy - \$5 per canal. \$5.00 copayment per canal for retreatment of previous root canal.

(B) An apicoectomy performed in conjunction with root canal therapy is subject to a copayment of \$5 per canal. When performed as a separate procedure, an apicoectomy is subject to a copayment of \$5 per canal.

(5) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(5), "Periodontics", with the following exceptions:

(A) Osseous or muco-gingival surgery - \$5 per quadrant.

(B) Gingivectomy - no copayment.

(6) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(6), "Crowns and Fixed Bridges" with the following exceptions:

(A) Porcelain crowns; porcelain fused to metal crowns; full metal crowns; and gold onlays or 3/4 crowns; are each subject to a copayment of \$5.

(B) Pontics are each subject to a copayment of \$5.

(7) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(7), "Removable Prosthetics", with the following exceptions:

(A) Dentures are subject to copayments as follows:

1. Complete maxillary denture - \$5.
2. Complete mandibular denture - \$5.
3. Partial acrylic upper or lower denture with clasps - \$5.
4. Partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles - \$5.
5. Removable unilateral partial denture - \$5.

(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 - \$5.

(C) Denture duplication - \$5.

(8) No copayments shall be charged for benefits listed under Subsection 2699.6709(c)(8), "Orthodontia."

(9) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(9), "Other".

(10) The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.

(11) Notwithstanding any other provision in this section, an alternative copayment shall apply under the following circumstances: For children under six years of age, who are unable to be treated by their panel provider, and who have been referred to a pedodontist/pediatric dentist, the copayment is \$5.

(b) A fee of \$5 shall be charged for failure to cancel an appointment without 24 hours prior notification.

(c) No deductibles shall be charged to subscriber children for dental benefits.

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

Note: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21 and 12693.63, 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, or for frames or lenses when purchased separately. No additional copayment for tinted or photochromic lenses when otherwise deemed medically necessary, or polycarbonate lenses.

A frame allowance of \$75 is provided by the vision plan. The subscriber is responsible for any costs exceeding this allowance.

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

A) Blended lenses (bifocals which do not have a visible dividing line).

(B) Contact lenses except as specified in Section 2699.6721(a)(3).

(C) Oversized lenses (larger than standard lens blank to accommodate prescriptions).

(D) Progressive multifocal lenses.

(E) Coated or laminated lenses.

(F) UV protected lenses.

(G) Other optional cosmetic processes.

(H) A frame that costs more than the plan's allowance.

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

(4) Elective contact lenses: an allowance of \$110 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: \$5 copayment.

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

When a subscriber obtains services from a provider not included in the vision plan's panel of approved providers, the applicant will be responsible for paying

the provider for all services and materials received at the time of their appointment. The participating vision plan will reimburse the applicant within fourteen (14) calendar days after receipt of the paid itemized bill or statement, according to the schedule of allowances as follows:

(1) Professional fees:

(A) Vision exams, up to \$35.00

(2) Materials:

(A) Each single vision lens - up to \$12.50 or a pair of single vision lenses up to \$25.00.

(B) Each bifocal lens - up to \$20.00 or a pair of bifocal lenses up to \$40.00.

(C) Each trifocal lens - up to \$25.00 or a pair of trifocal lenses up to \$50.00.

(D) Each lenticular lens - up to \$50.00 or a pair of lenticular lenses up to \$100.00.

(E) Frame up to \$40.00.

(F) Tinted or photochromic lenses when otherwise deemed medically necessary - up to \$5.00.

(G) Polycarbonate lenses - up to \$10.00.

(H) Each pair of necessary contact lenses - up to \$250.00.

(I) Each pair of elective contact lenses - up to \$110.00.

Determination of whether contact lenses are necessary or elective when obtained from providers not included in the vision plan's panel of approved providers will be the responsibility of the vision plan. Reimbursement for elective contact lenses is in lieu of all benefits, including examination and materials.

(3) Low vision benefits: Low vision benefits obtained from a provider not included in the vision plan's panel of approved providers will be reimbursed in accordance with what the participating vision plan would pay a provider included in the vision plan's panel of approved providers for this benefit.

(c) No deductibles shall be charged to subscribers for vision benefits.

(d) For subscriber parents who receive vision services from one of the participating member doctors, covered services as described are provided with no additional out-of-pocket costs after an applicable copayment. Additional services selected for cosmetic purposes are the financial responsibility of the patient.

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

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

FINDING OF EMERGENCY AND ADOPTION OF REGULATIONS

The Board finds that the State's fiscal crisis calls for the immediate action of adopting the proposed amendments to the Healthy Families Program regulations to increase the subscriber share of cost for health, dental and vision benefits; the action is necessary to avoid serious harm to the public, peace, health, safety, or general welfare; and the foregoing constitutes an emergency under Government Code section 11342.545. Therefore, the Board hereby adopts the proposed amendments, which are attached hereto.

* * * * *

CERTIFICATION

I, Lesley Cummings, Executive Director of the Managed Risk Medical Insurance Board, do hereby certify that the foregoing action was duly passed and adopted by the Managed Risk Medical Insurance Board at an official meeting thereof on August 27, 2009.

Dated this 27th day of August, 2009.

Lesley Cummings, Executive Director
Managed Risk Medical Insurance Board

TITLE 10. INVESTMENT
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD HEALTHY
FAMILIES PROGRAM
ARTICLE 3. HEALTH, DENTAL AND VISION BENEFITS
Amend Sections 2699.6705, 2699.6715, and 2699.6725.

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

Section 2699.6705 is amended to read:

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:

- (3) The following specific copayments shall apply:

* * *

- (D) Outpatient Professional Services: \$510 copayment per office or home visit. No copayment for surgery or anesthesia; radiation, chemotherapy, or dialysis treatments.
- (E) Outpatient Mental Health: \$510 copayment per visit.
- (F) Home Health Care: No copayment except for \$510 per visit for physical, occupational, and speech therapy visits performed in the home.
- (G) Alcohol and Drug Abuse Services: No copayment for inpatient services. \$510 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. \$510 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: \$510 copayment per visit. For subscriber parents, copayment of \$510 for each biofeedback visit for mental health.

* * *

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

Section 2699.6715 is amended to read:

Section 2699.6715. Share of Cost for Dental Benefits for Subscriber Children.

- (a) Every participating dental health plan shall require copayments for the dental benefits listed in Subsection 2699.6709 (a) of these regulations provided to subscribers subject to the following:
 - (1) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(1), "Diagnostic and Preventive Benefits."
 - (2) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(2), "Restorative Dentistry."
 - (3) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(3), "Oral Surgery", with the following exceptions:
 - (A) Removal of impacted teeth is subject to a copayment per tooth as follows:
 - 1. Soft tissue impaction -- No copayment.
 - 2. Bony impaction -- \$510 copayment per tooth.

- (B) Root recovery -- \$510 per root.
- (4) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(4), "Endodontics", with the following exceptions:
- (A) Root canal therapy -- \$510 per canal. ~~\$5.00~~\$10 copayment per canal for retreatment of previous root canal.
 - (B) An apicoectomy performed in conjunction with root canal therapy is subject to a copayment of \$510 per canal. When performed as a separate procedure, an apicoectomy is subject to a copayment of \$510 per canal.
- (5) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(5), "Periodontics", with the following exceptions:
- (A) Osseous or muco-gingival surgery -- \$510 per quadrant.
 - (B) Gingivectomy -- no copayment.
- (6) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(6), "Crowns and Fixed Bridges" with the following exceptions:
- (A) Porcelain crowns; porcelain fused to metal crowns; full metal crowns; and gold onlays or 3/4 crowns; are each subject to a copayment of \$510.
 - (B) Pontics are each subject to a copayment of \$510.
- (7) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(7), "Removable Prosthetics", with the following exceptions:
- (A) Dentures are subject to copayments as follows:
 - 1. Complete maxillary denture --\$510.

2. Complete mandibular denture -- \$510.
 3. Partial acrylic upper or lower denture with clasps --\$510.
 4. Partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles -- \$510.
 5. Removable unilateral partial denture -- \$510.
- (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 -- \$510.
- (C) Denture duplication -- \$510.
- (8) No copayments shall be charged for benefits listed under Subsection 2699.6709(c)(8), "Orthodontia."
- (9) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(9), "Other".
- (10) The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.
- (11) Notwithstanding any other provision in this section, an alternative copayment shall apply under the following circumstances: For children under six years of age, who are unable to be treated by their panel provider, and who have been referred to a pedodontist/pediatric dentist, the copayment is \$510.
- (b) A fee of \$510 shall be charged for failure to cancel an appointment without 24 hours prior notification.
- (c) No deductibles shall be charged to subscriber children for dental benefits.

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

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

Section 2699.6725 is amended to read:

Section 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: \$510 copayment per examination.
- (2) Frames and lenses: \$510 copayment, for frames with lenses, or for frames or lenses when purchased separately. No additional copayment for tinted or photochromic lenses when otherwise deemed medically necessary, or polycarbonate lenses.

A frame allowance of \$75 is provided by the vision plan. The subscriber is responsible for any costs exceeding this allowance.

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

A) Blended lenses (bifocals which do not have a visible dividing line).

(B) Contact lenses except as specified in Section 2699.6721(a)(3).

(C) Oversized lenses (larger than standard lens blank to accommodate prescriptions).

(D) Progressive multifocal lenses.

(E) Coated or laminated lenses.

(F) UV protected lenses.

(G) Other optional cosmetic processes.

(H) A frame that costs more than the plan's allowance.

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

(4) Elective contact lenses: an allowance of \$110 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: \$510 copayment.

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

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

(1) Professional fees:

(A) Vision exams, up to \$35.00

(2) Materials:

(A) Each single vision lens - up to \$12.50 or a pair of single vision lenses up to \$25.00.

(B) Each bifocal lens - up to \$20.00 or a pair of bifocal lenses up to \$40.00.

(C) Each trifocal lens - up to \$25.00 or a pair of trifocal lenses up to \$50.00.

(D) Each lenticular lens - up to \$50.00 or a pair of lenticular lenses up to \$100.00.

(E) Frame up to \$40.00.

(F) Tinted or photochromic lenses when otherwise deemed medically necessary - up to \$510.

* * *

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

FINDING OF EMERGENCY AND ADOPTION OF REGULATIONS

The Board finds that the State's fiscal crisis calls for the immediate action of adopting the proposed amendments to the Healthy Families Program regulations to increase the subscriber share of cost for health, dental and vision benefits; the action is necessary to avoid serious harm to the public, peace, health, safety, or general welfare; and the foregoing constitutes an emergency under Government Code section 11342.545. Therefore, the Board hereby adopts the proposed amendments, which are attached hereto.

* * * * *

CERTIFICATION

I, Lesley Cummings, Executive Director of the Managed Risk Medical Insurance Board, do hereby certify that the foregoing action was duly passed and adopted by the Managed Risk Medical Insurance Board at an official meeting thereof on August 27, 2009.

Dated this 27th day of August, 2009.

Lesley Cummings, Executive Director
Managed Risk Medical Insurance Board

TITLE 10. INVESTMENT
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD HEALTHY
FAMILIES PROGRAM
ARTICLE 3. HEALTH, DENTAL AND VISION BENEFITS
Amend Section 2699.6705.

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

Section 2699.6705 is amended to read:

2699.6705. Share of Cost for Health Benefits.

* * *

(a)(3)(C) Facility Services on an Outpatient Basis for Subscribers: No copayment, except for a \$515 copayment per visit for Emergency Health Care Services. The emergency health care services copay is waived if the subscriber is hospitalized.

* * *

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

FINDING OF EMERGENCY AND ADOPTION OF REGULATIONS

The Board finds that the State's fiscal crisis calls for the immediate action of adopting the proposed amendments to the Healthy Families Program regulations to increase the subscriber share of cost for health, dental and vision benefits; the action is necessary to avoid serious harm to the public, peace, health, safety, or general welfare; and the foregoing constitutes an emergency under Government Code section 11342.545. Therefore, the Board hereby adopts the proposed amendments, which are attached hereto.

* * * * *

CERTIFICATION

I, Lesley Cummings, Executive Director of the Managed Risk Medical Insurance Board, do hereby certify that the foregoing action was duly passed and adopted by the Managed Risk Medical Insurance Board at an official meeting thereof on August 27, 2009.

Dated this 27th day of August, 2009.

Lesley Cummings, Executive Director
Managed Risk Medical Insurance Board

TITLE 10. INVESTMENT
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD HEALTHY
FAMILIES PROGRAM
ARTICLE 3. HEALTH, DENTAL AND VISION BENEFITS
Amend Section 2699.6705.

Text proposed to be added is in underline type.

Text proposed to be deleted is in ~~strikeout~~ type.

Section 2699.6705 is amended to read:

2699.6705. Share of Cost for Health Benefits.

* * *

(a)(3)(M) 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. For subscriber children, no copayment for FDA approved contraceptive drugs.

~~\$510~~ copayment per prescription for up to 30 day supply for ~~brand name or~~ generic drugs, including tobacco use cessation drugs. ~~\$510~~ copayment per 90 day supply of generic maintenance drugs purchased either through a participating health plan's participating pharmacies or through its mail order program.

\$15 copayment per prescription for up to 30 day supply for brand name drugs, including tobacco use cessation drugs. \$10 copayment if no generic equivalent is available for the drug prescribed or if the use of a brand name drug is medically necessary.

\$15 copayment per 90 day supply of brand name maintenance drugs purchased either through a participating health plan's participating pharmacies or through its mail order program. \$10 copayment per 90 day supply of brand name maintenance drugs purchased either through a participating health plan's participating pharmacies or through its mail order

program, if no generic equivalent is available for the drug prescribed or if the use of a brand name drug is medically necessary.

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.

* * *

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

FINDING OF EMERGENCY AND ADOPTION OF REGULATIONS

The Board finds that the State's fiscal crisis calls for the immediate action of adopting the proposed amendments to the Healthy Families Program regulations to modify applicant choice of participating dental plans; the action is necessary to avoid serious harm to the public, peace, health, safety, or general welfare; and the foregoing constitutes an emergency under Government Code section 11342.545. Therefore, the Board hereby adopts the proposed amendments, which are attached hereto.

* * * * *

CERTIFICATION

I, Lesley Cummings, Executive Director of the Managed Risk Medical Insurance Board, do hereby certify that the foregoing action was duly passed and adopted by the Managed Risk Medical Insurance Board at an official meeting thereof on August 27, 2009.

Dated this 27th day of August, 2009.

Lesley Cummings, Executive Director
Managed Risk Medical Insurance Board

TITLE 10. INVESTMENT
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM
ARTICLE 2. ELIGIBILITY, APPLICATION, AND ENROLLMENT
Amend Sections 2699.6600, 2699.6607, 2699.6619, and 2699.6621.

Section 2699.6600 is amended to read:

Section 2699.6600. Application.

* * *

(c) The application shall contain the following:

* * *

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

1. The applicant's choice of participating health, dental and/or vision plans.

(a) The program may designate one or more participating dental plans as the only available dental plans for households where no subscriber has been enrolled in the program for two consecutive years or more.

(b) The designated dental plans shall be those with the lowest per-subscriber cost to the program.
2. 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.
3. An indication of whether there is more than one car in the children's household.
4. An indication of whether there is more than \$3,150 cash in bank accounts in the children's household.
5. An indication if the applicant does not want the application reviewed for eligibility for Medi-Cal or the Program.

* * *

Note: Authority cited: Sections 12693.21, 12693.75 and 12693.755, Insurance Code; and Section 14005.41, Welfare and Institutions 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.

Section 2699.6607 is amended to read:

Section 2699.6607. Determination of Eligibility.

* * *

(f) If the applicant does not select a health, dental and/or vision plan and the person being applied for is eligible for the program, the program shall assign the health, dental and/or vision plan as follows:

(1) Automatic assignment of the health plan to the community provider plan. If the community provider plan is not available, alternate assignment to an available health plan; and/or

(2) Alternate assignment of the dental and/or vision plan.

(3) Assignment of the dental plan shall be made pursuant to Section 2699.6600(c)(1)(BB)(1).

* * *

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.

Section 2699.6619 is amended to read:

Section 2699.6619. Transfer of Enrollment.

* * *

(f) The transfers of enrollment shall comply with Sections 2699.6600(c)(1)(BB)(1).and 2699.6623.

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

Section 2699.6621 is amended to read:

Section 2699.6621. Open Enrollment Period.

(a) The program shall provide for an annual open enrollment period of at least forty-five (45) calendar days. During this period, applicants may for any reason request that subscribers be transferred from one participating health, dental, or vision plan to another. Plan selection ~~rules set forth in~~ shall comply with Sections 2699.6600(c)(1)(BB)(1) and 2699.6623 apply for open enrollment.

* * *

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