TITLE 10: CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.6 ACCESS FOR INFANTS AND MOTHERS PROGRAM

Article 3. Scope of Benefits
Amends Section 2699.301

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Section 2699.301 is amended to read:

§ 2699.301. Excluded Benefits

(a) 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 determine 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 plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such 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 services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such benefits.

(18) Maternity care for a subscriber who (a) enrolled in the program with an effective date on or after February 1, 2012, and (b) has entered into an agreement to serve as a paid surrogate mother. For purposes of this section, an agreement to serve as a paid surrogate mother is an agreement entered into, in advance of the pregnancy, under which the subscriber agrees to become pregnant and deliver a child for another person as the intended parent, in exchange for monetary compensation other than actual medical or living expenses.

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