

NOTICE PUBLICATION REGULATIONS SUBMISSION

EMERGENCY

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER Z-	REGULATORY ACTION NUMBER	EMERGENCY NUMBER 2016-1117-01E
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For use by Office of Administrative Law (OAL) only

<p>NOTICE</p>	<p>REGULATIONS</p>
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2016 NOV 17 P 12:02
OFFICE OF ADMINISTRATIVE LAW

AGENCY WITH RULEMAKING AUTHORITY
Department of Managed Health Care

AGENCY FILE NUMBER (if any)
Control No. 2016-5191

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE
3. NOTICE TYPE <input type="checkbox"/> Notice re Proposed Regulatory Action <input type="checkbox"/> Other	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
OAL USE ONLY ACTION ON PROPOSED NOTICE <input type="checkbox"/> Approved as Submitted <input type="checkbox"/> Approved as Modified <input type="checkbox"/> Disapproved/Withdrawn	NOTICE REGISTER NUMBER	PUBLICATION DATE	

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S) Essential Health Benefits	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)
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SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)
	ADOPT
	AMEND Section 1300.67.005
	REPEAL
TITLE(S) 28	

3. TYPE OF FILING

<input type="checkbox"/> Regular Rulemaking (Gov. Code §11346)	<input type="checkbox"/> Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.	<input type="checkbox"/> Emergency Readopt (Gov. Code, §11346.1(h))	<input type="checkbox"/> Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
<input type="checkbox"/> Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)	<input type="checkbox"/> Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)	<input type="checkbox"/> File & Print	<input type="checkbox"/> Print Only
<input checked="" type="checkbox"/> Emergency (Gov. Code, §11346.1(b))	<input type="checkbox"/> Other (Specify) _____		

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

<input type="checkbox"/> Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))	<input checked="" type="checkbox"/> Effective on filing with Secretary of State	<input type="checkbox"/> \$100 Changes Without Regulatory Effect	<input type="checkbox"/> Effective other (Specify) _____
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6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

<input type="checkbox"/> Department of Finance (Form STD. 399) (SAM §6660)	<input type="checkbox"/> Fair Political Practices Commission	<input type="checkbox"/> State Fire Marshal
<input type="checkbox"/> Other (Specify) _____		

7. CONTACT PERSON Jennifer Willis	TELEPHONE NUMBER (916) 324-9014	FAX NUMBER (Optional) (916) 322-3968	E-MAIL ADDRESS (Optional) jennifer.willis@dmhc.ca.gov
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8. I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.

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SIGNATURE OF AGENCY HEAD OR DESIGNEE <i>Michelle Rouillard</i>	DATE 11/17/16
TYPED NAME AND TITLE OF SIGNATORY Michelle Rouillard, Director	

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§ 1300.67.005. Essential Health Benefits.

(a) All health plans that offer individual and small group contracts subject to Health and Safety Code Section 1367.005 shall comply with the requirements of this section.

(b) In addition to any other requirements set forth in the Knox-Keene Health Care Service Plan Act of 1975 (hereinafter the "Act"), to demonstrate compliance with Health and Safety Code Section 1367.005 and this section, health plans shall electronically file through the Department's Efile application the Essential Health Benefits Filing Worksheet (EHB Filing Worksheet) no later than ~~July 15, 2013~~ the date that qualified health plan product filings are required to be submitted, and thereafter as necessary for new or amended plan contracts.

(c) The EHB Filing Worksheet shall include:

(1) The benefits specified in Health and Safety Code Section 1367.005 and the federal Patient Protection and Affordable Care Act (PPACA) at section 1302(b) (42 U.S.C. § 18022) and 45 Code of Federal Regulations (CFR) parts 156.100 and 156.115;

(2) Pursuant to Health and Safety Code Section 1367.005(a)(2)(A)(v), any "other health benefits" covered by the base-benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, in the first quarter of ~~2012~~2014, which are not otherwise required to be covered under the Act;

(3) Required benefits for pediatric vision and dental care, for individuals ~~under 19 years of age~~ until at least the end of the month in which the enrollee turns 19 years of age, consistent with benefits described in Health and Safety Code Section 1367.005(a)(4) - (5); and

(4) Prescription drug benefits required by Health and Safety Code Section 1367.005(d) and 45 CFR part 156.122, including the plan's prescription drug list and/or formulary. The EHB Filing Worksheet shall include a certification that the plan's drug list meets or exceeds the prescription drug formulary requirements specified in 45 CFR part 156.122, subparagraph (a)(1).

(d) "Other health benefits" are essential health benefits and are required to be covered as follows:

(1) Acupuncture services that are typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.

(2) Nonemergency ambulance and psychiatric transport services inside the service area if:

(A) The plan or plan-contracted physician determines the enrollee's condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide; and

(B) The use of other means of transportation would endanger the enrollee's health.

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(C) These services must be covered only when the vehicle transports the enrollee to or from covered services.

(3) Chemical dependency services, which shall be in compliance with federal parity requirements set forth in the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”), as follows:

(A) Inpatient detoxification - Hospitalization for medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education, and counseling.

(B) Outpatient evaluation and treatment for chemical dependency:

(i) Day-treatment programs;

(ii) Intensive outpatient programs;

(iii) Individual and group chemical dependency counseling; and

(iv) Medical treatment for withdrawal symptoms.

(C) Transitional residential recovery services - Chemical dependency treatment in a nonmedical transitional residential recovery setting. This setting provides counseling and support services in a structured environment.

(D) Chemical dependency services exclusion - Services in a specialized facility for alcoholism, drug abuse, or drug addiction are not required to be covered except as otherwise specified above.

(4) Special contact lenses to treat aniridia (missing iris) or aphakia, (absence of the crystalline lens of the eye), as follows:

(A) Aniridia: Up to two medically necessary contact lenses per eye (including fitting and dispensing) in any 12-month period, whether provided by the plan during the current or a previous 12-month contract period.

(B) Aphakia: Up to six medically necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year for enrollees ~~through age 9~~, whether provided by the plan under the current or a previous contract in the same calendar year.

(5) Durable medical equipment for home use.

(A) In addition to durable medical equipment otherwise required to be covered by the Act, the plan shall cover durable medical equipment for use in the enrollee's home (or another location used as the enrollee's home).

Durable medical equipment for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

(B) The plan may limit coverage to the standard equipment or supplies that adequately meet the enrollee's medical needs. Coverage includes repair or replacement of covered equipment. The plan may decide whether to rent or purchase the equipment, and may select the vendor. The enrollee may be required to return the equipment to the plan or pay the fair market price of the equipment or any unused supplies when they are no longer medically necessary.

(C) The plan shall cover durable medical equipment for home use, substantially equal to the following:

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- (i) Standard curved handle or quad cane and replacement supplies
- (ii) Standard or forearm crutches and replacement supplies
- (iii) Dry pressure pad for a mattress
- (iv) IV pole
- (v) Enteral pump and supplies
- (vi) Bone stimulator
- (vii) Cervical traction (over door)
- (viii) Phototherapy blankets for treatment of jaundice in newborns
- (ix) Dialysis care equipment as follows:
 - a. The plan shall cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis.
 - b. The following dialysis care services are not required to be covered:
 - 1. Comfort, convenience, or luxury equipment, supplies and features
 - 2. Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

(6) Mental Health Services in addition to services required under the Act, as follows:

(A) Mental Health Services for Mental Disorders Other than SMI and SED. In addition to the coverage required under Health and Safety Code sections 1374.72 and 1374.73, the plan shall cover any mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV). All coverage of mental health services must comply with federal mental health parity requirements, as set forth in the MHPAEA:

(B) The plan is not required to cover services for conditions the DSM IV identifies as something other than a "mental disorder," such as relational problems (e.g. couples counseling or family counseling).

(C) Outpatient mental health services. The plan shall cover the following services when provided by licensed health care professionals acting within the scope of their license:

- (i) Individual and group mental health evaluation and treatment;
- (ii) Psychological testing when necessary to evaluate a mental disorder; and
- (iii) Outpatient services for the purpose of monitoring drug therapy.

(D) Inpatient psychiatric hospitalization. Coverage shall include room and board, drugs, and services of physicians and other providers who are licensed health care professionals acting within the scope of their license.

(E) Intensive psychiatric treatment programs as follows:

- (i) Short-term hospital-based intensive outpatient care (partial hospitalization);
- (ii) Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program;

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(iii) Short-term treatment in a crisis residential program in a licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis; and

(iv) Psychiatric observation for an acute psychiatric crisis.

(7) Organ Donation Services for actual or potential living donors, in addition to transplant services of organs, tissue, or bone marrow required under the Act, as follows:

(A) Coverage for donation-related services for a living donor, or an individual identified by the plan as a potential donor, whether or not the donor is an enrollee. Services must be directly related to a covered transplant for the enrollee, which shall include services for harvesting the organ, tissue, or bone marrow and for treatment of complications, pursuant to the following guidelines:

(i) Services are directly related to a covered transplant service for an enrollee or are required for evaluating potential donors, harvesting the organ, bone marrow, or stem cells, or treating complications resulting from the evaluation or donation, but not including blood transfusions or blood products.

(ii) Donor receives covered services no later than 90 days following the harvest or evaluation service;

(iii) Donor receives services inside the United States, with the exception that geographic limitations do not apply to treatment of stem cell harvesting;

(iv) Donor receives written authorization for evaluation and harvesting services;

(v) For services to treat complications, the donor either receives non-emergency services after written authorization, or receives emergency services the plan would have covered if the enrollee had received them; and

(vi) In the event the enrollee's plan membership terminates after the donation or harvest, but before the expiration of the 90 day time limit for services to treat complications, the plan shall continue to pay for medically necessary services for donor for 90 days following the harvest or evaluation service.

(B) The plan is not required to cover:

(i) Treatment of donor complications related to a stem cell registry donation;

(ii) HLA blood screening for stem cell donations, for anyone other than the enrollee's siblings, parents, or children;

(iii) Services related to post-harvest monitoring for the sole purpose of research or data collection; or

(iv) Services to treat complications caused by the donor failing to come to a scheduled appointment or leaving a hospital before being discharged by the treating physician.

(8) Ostomy and urological supplies substantially equal to the following:

(A) Ostomy supplies: adhesives; adhesive remover; ostomy belt; hernia belts; catheter; skin wash/cleaner; bedside drainage bag and bottle; urinary leg bags; gauze pads; irrigation faceplate; irrigation sleeve; irrigation bag; irrigation cone/catheter; lubricant; urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; gloves; stoma caps; colostomy plug; ostomy inserts; urinary and ostomy pouches; barriers;

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pouch closures; ostomy rings; ostomy face plates; skin barrier; skin sealant; and waterproof and non-waterproof tape.

(B) Urological supplies: adhesive catheter skin attachment; catheter insertion trays with and without catheter and bag; male and female external collecting devices; male external catheter with integral collection chamber; irrigation tubing sets; indwelling catheters; foley catheters; intermittent catheters; cleaners; skin sealants; bedside and leg drainage bags; bedside bag drainage bottle; catheter leg straps; irrigation tray; irrigation syringe; lubricating gel; sterile individual packets; tubing and connectors; catheter clamp or plug; penile clamp; urethral clamp or compression device; waterproof and non-waterproof tape; and catheter anchoring device.

(C) Incontinence supplies for hospice patients: disposable incontinence underpads; adult incontinence garments.

(D) Ostomy and urological supplies required under this section do not include supplies that are comfort, convenience, or luxury equipment or features.

(9) Prosthetic and orthotic services and devices in addition to those services and devices required to be covered under the Act.

(A) Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services to determine whether the enrollee needs a prosthetic or orthotic device. If the plan covers a replacement device, the enrollee pays the cost sharing the enrollee would pay for obtaining that device.

(B) The plan shall cover the prosthetic and orthotic services and devices substantially equal to the following:

(i) Enteral and Parenteral Nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing;

gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; and supplies for self-administered injections;

(ii) Up to three brassieres required to hold a breast prosthesis every 12 months;

(iii) Compression burn garments and lymphedema wraps and garments; and

(iv) Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.

(10) Skilled nursing facility services as follows:

(A) For up to 100 days per benefit period (including any days covered under the prior subscriber contract issued by the plan to the enrollee or enrollee's group) of skilled inpatient services in a skilled nursing facility. The skilled inpatient services must be customarily provided by a skilled nursing facility, and above the level of custodial or intermediate care.

(B) A benefit period begins on the date the enrollee is admitted to a hospital or skilled nursing facility at a skilled level of care. A benefit period ends on the date the enrollee has not been an inpatient in a hospital or

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skilled nursing facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required to commence a benefit period.

(C) The following services are covered as part of the skilled nursing services:

- (i) Physician and nursing services;
- (ii) Room and board;
- (iii) Drugs prescribed by a physician as part of the plan of care in the plan skilled nursing facility in accord with the plan's drug formulary guidelines if they are administered in the skilled nursing facility by medical personnel;
- (iv) Durable medical equipment in accord with the plan's durable medical equipment formulary if skilled nursing facilities ordinarily furnish the equipment;
- (v) Imaging and laboratory services that skilled nursing facilities ordinarily provide;
- (vi) Medical social services;
- (vii) Blood, blood products, and their administration;
- (viii) Medical supplies;
- ~~(ix) Physical, occupational, and speech therapy;~~
- ~~(xix)~~ Behavioral health treatment for pervasive developmental disorder or autism; and
- (xi) Respiratory therapy.

(11) Procedures for the prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling is available.

(12) Rehabilitative/habilitative health care services and devices.

(A) Coverage shall be in accordance with subdivisions (a)(3) and (p)(1) of section 1367.005, and as follows:

- (i) Individual and group outpatient physical, occupational, and speech therapy related to pervasive developmental disorder or autism;
- (ii) All other individual and group outpatient physical, occupational, and speech therapy;
- (iii) Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program, a skilled nursing facility; and in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitation program).

(B) The plan shall include in its Evidence of Coverage and Schedule of Benefits a disclaimer that limits for rehabilitative and habilitative service shall not be combined.

(13) Coverage in connection with a clinical trial in accordance with section 1370.6, and as follows:

(A) The plan would have covered the services if they were not related to a clinical trial.

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(B) The enrollee is eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:

(i) a plan provider makes this determination;

(ii) the enrollee provides the plan with medical and scientific information establishing this determination;

(C) If any plan providers participate in the clinical trial and will accept the enrollee as a participant in the clinical trial, the enrollee must participate in the clinical trial through a plan provider unless the clinical trial is outside the state where the enrollee lives; or

(D) The clinical trial is an approved clinical trial, meaning it is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:

(i) The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;

(ii) The study or investigation is a drug trial that is exempt from having an investigational new drug application, or

(iii) The study or investigation is approved or funded by at least one of the following:

(I) The National Institutes of Health;

(II) The Centers for Disease Control and Prevention;

(III) The Agency for Health Care Research and Quality;

(IV) The Centers for Medicare & Medicaid Services;

(V) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

(e) In the event the list of "other health benefits" in subdivision (d) omits benefits otherwise required pursuant to Health and Safety Code Section 1367.005, the provisions of Health and Safety Code Section 1367.005 shall control.

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(f) If a stand-alone dental plan described in the PPACA at section 1311(d)(2)(B)(ii) (42 U.S.C. § 18031(d)(2)(B)(ii)) is offered on the California Health Benefit Exchange (Exchange), then, pursuant to the PPACA section 1302(b)(4)(F) (42 U.S.C. § 18022(b)(4)(F)), health plan contracts offered in the Exchange may, but are not required to, omit coverage of pediatric dental care benefits described in Health and Safety Code Section 1367.005(a)(5). A health plan shall not omit coverage of the pediatric dental EHB for health plan contracts sold outside the Exchange.

(g) The worksheet shall be in the following form:

CALIFORNIA ESSENTIAL HEALTH BENEFITS FILING WORKSHEET

For Individual Plan Subscriber Contracts and Evidence of Coverage (“EOC”), Small Group Plan EOCs, or Combined Individual or Small Group EOC/Disclosure Forms (“DF”)

This EHB Worksheet requires plans to record how their coverage, as disclosed in EOCs, Subscriber Contracts, and DFs, complies with EHB requirements set forth in Health and Safety Code section 1367.005. The alignment of certain provisions of the Act with federal EHB categories is not meant to be legally definitive, but is offered as a way to organize required benefits as plans frequently organize them within their EOCs. Note that some benefits may be listed under multiple federal EHB categories because benefits and categories overlap in many plan EOCs. The plans must utilize the boxes in the third column to identify where the required EHB is located in plan documents and supply the necessary information to describe the benefit. For the purposes of the EHB Worksheet, “Section” refers to a provision of the Health and Safety Code and “Rule” refers to a section of Title 28 of the California Code of Regulations.

<p>Federal Essential Health Benefits Categories (“EHB”)</p>	<p>Required pursuant to § 1367.005(a)</p>	<p><input type="checkbox"/> Individual EOC, Subscriber Contract <input type="checkbox"/> Group, EOC, Subscriber Contract <input type="checkbox"/> Combined Individual or Group DF/EOC <input type="checkbox"/> Qualified Health Plan in the Exchange <input type="checkbox"/> Multi-State Plan <input type="checkbox"/> Check all that</p>
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		<p>apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.</p>
<p>#1: Ambulatory Patient Services</p>	<p>Section 1345(b)(2) Rule 1300.67(b-c) Ambulatory Care Services</p>	
	<p>Section 1345(b)(1) Rule 1300.67(a) Outpatient Physician Services</p>	
	<p>Section 1345(b)(4) Rule 1300.67(e) Section 1367.005(a)(2)(C) Home Health Services</p>	
	<p>Section 1345(b)(2) Rule 1300.67(c) Outpatient Physical, Occupational, and Speech Therapy</p>	
	<p>Section 1370.6 Cancer Clinical Trials</p>	
	<p><u>Benchmark Plan EHB</u> <u>Rule 1300.67.005(d)(13)</u> Other Clinical Trials</p>	
	<p>Section 1373(b) Sterilization Services</p>	
	<p><u>Benchmark Plan EHB</u></p>	

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	<p>Rule 1300.67.005(d)(1): Acupuncture Services</p>	
	<p>Benchmark Plan EHB Rule 1300.67.005(d)(8): Ostomy, Urinary Supplies</p>	
#2: Emergency Services	<p>Section 1345(b)(6) Rule 1300.67(g)(1) Emergency Services</p>	
	<p>Section 1371.5 Rule 1300.67(g)(1) Emergency Response Ambulance Services</p>	
	<p>Section 1345(b)(6) Rule 1300.67(g)(2) Out of Area Coverage and Urgently Needed Services</p>	
#3: Hospitalization	<p>Section 1345(b)(2) Rule 1300.67(b-c) Inpatient Hospital Services</p>	
	<p>Section 1345(b)(7) Section 1368.2 Rule 1300.67(h) Hospice Services</p>	
	<p>Section 1367.635 Mastectomies and Lymph Node Dissections</p>	
	<p>Section 1367.63 Reconstructive Surgery</p>	
	<p>Section 1367.6 Breast Cancer Coverage, Including Surgery</p>	
	<p>Section 1367.68</p>	

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	Jawbone Surgery	
	Section 1367.71 Dental Anesthesia	
	Section 1373(b) Sterilization Services	
	Section 1374.17 Organ Transplant Services for HIV	
	Benchmark Plan EHB Rule 1300.67.005(d)(2): Ambulance and Psychiatric Transport Services- Nonemergency (N2)	
	Benchmark Plan EHB Rule 1300.67.005(d)(7): Organ Donation Services	
	Benchmark Plan EHB Rule 1300.67.005(d)(10): Skilled Nursing Facility Services	
#4: Maternity and Newborn Care	Section 1345(b)(1-2) Rule 1300.67(a-b) Inpatient Maternity Care	
	Section 1345(b)(5) Rule 1300.67(f)(3) Prenatal Care	
	Rule 1300.67(g)(2) Urgently Needed Services, Including Maternity Services	
	Section 1367.62 Maternity Hospital Stay	

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	<p>Section 1367.54 Alpha-Fetoprotein Testing</p>	
	<p>Section 1373.4 Inpatient Hospital and Ambulatory Maternity Services</p>	
	<p>45 CFR 147.130 HRSA Guidelines for Women's Preventive Services Breastfeeding Support, Supplies, Counseling</p>	
	<p>Section 1367.7 Benchmark Plan EHB Rule 1300.67.005(d)(11): Prenatal Diagnosis of Genetic Disorders of the Fetus</p>	
<p>#5: Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment</p>	<p>Section 1345(b)(1) Rule 1300.67(a)</p>	
	<p>Section 1374.72 Section 1367.005(a)(2)(D) Mental Health Services</p>	
	<p>Section 1374.73 Section 1367.005(a)(2)(D) <u>Benchmark Plan EHB</u> <u>Rule 1300.67.005(d)(12)(A)</u> Behavioral Health Treatment (“BHT”) for PDD or Autism</p>	
	<p>Section 1367.005(a)(2)(D) Benchmark Plan EHB: Rule 1300.67.005(d)(6) Mental Health Services for Mental Disorders Other than SMI and SED</p>	

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	<p>Section 1367.005(a)(2)(D) Benchmark Plan EHB : Rule 1300.67.005(d)(3): Chemical Dependency Services</p>		
#6: Prescription Drugs	<p>Section 1367.25 Coverage for Contraceptive Methods</p>		
	<p>Section 1367.45 Coverage for Approved AIDS Vaccine</p>		
	<p>Section 1370.6 Cancer Clinical Trials</p>		
	<p><u>EHB Benchmark Plan Rule 1300.67.005(d)(13)</u> <u>Other Clinical Trials</u></p>		
	<p>Section 1367.21 Off Label Drug Use</p>		
	<p>Section 1367.002 Section 1367.06 Pediatric Asthma Services</p>		
	<p>Section 1374.56 Phenylketonuria Services</p>		
	<p>Section 1367.215 Pain Management Medication for Terminally Ill</p>		
	<p>Section 1367.22 Coverage for Previously Approved Prescription</p>		
	<p>Section 1367.24 Prescription Authorization Process for Non Formulary Drugs</p>		

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	<p>Rule 1300.67.24 Outpatient Prescription Drug Coverage, Limitations and Exclusions</p>	
<p>#7: Rehabilitative and Habilitative Services and Devices</p>	<p>Section 1345(b)(2) Rule 1300.67(c) <u>Benchmark Plan EHB</u> <u>Rule 1300.67.005(d)(12)</u> Outpatient Physical, Occupational, and Speech Therapy</p>	
	<p>Section 1374.73 Section 1367.005(a)(3) <u>Benchmark Plan EHB</u> <u>Rule 1300.67.005(d)(12)(A)</u> Behavioral Health Treatment (“BHT”) for PDD or Autism</p>	
	<p>Section 1345(b)(4) Rule 1300.67(e) Section 1367.005(a)(2)(C) Home Health Services</p>	
	<p>Section 1367.61 Prosthetics for Laryngectomy</p>	
	<p>Section 1367.18 Orthotic and Prosthetic Devices and Services</p>	
	<p>Section 1367.6 Section 1367.635 Prosthetic Devices Incident to Mastectomy</p>	
	<p>Benchmark Plan EHB Rule 1300.67.005(d)(4): Contact Lenses to Treat Aniridia and Aphakia</p>	
	<p>Benchmark Plan EHB Rule 1300.67.005(d)(5): Additional Durable Medical Equipment Required to be Covered</p>	
	<p>Benchmark Plan EHB Rule 1300.67.005(d)(9): Additional Prosthetic-Orthotics Devices Required</p>	

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	to be Covered		
#8: Laboratory Services	Section 1345(b)(3) Rule 1300.67(d) Diagnostic Laboratory and Therapeutic Radiologic Services		
	Section 1367.65 Mammography Services		
	Section 1367.46 Rule 1300.67.24 Coverage for HIV Testing		
	Section 1367.54 Alpha-Fetoprotein Testing		
	Section 1367.6 Breast Cancer Screening		
	Section 1367.64 Prostate Cancer Screening		
	Section 1367.66 Cervical Cancer Screening		
	Section 1367.665 Cancer Screening Tests		
	Section 1367.67 Osteoporosis Services		
	Section 1367.9 Diethylstilbestrol Services		
	Section 1367.7 Benchmark Plan EHB Rule 1300.67.005(d)(11); Prenatal Diagnosis of Genetic Disorders of the Fetus		
	#9: Preventive and Wellness Services and Chronic Disease Management	Section 1345(b)(5) Rule 1300.67(f) Section 1367.002 45 CFR 147.130 75 Fed Reg 41726, 41728	

Changes in text are noted by underline and strikeout

	<p>HRSA Guidelines for Women's Preventive Services Preventive Health Services</p>	
	<p>Section 1367.06 Pediatric Asthma Services</p>	
	<p>Section 1367.35 Comprehensive Pediatric Preventive Services</p>	
	<p>Section 1367.6 Breast Cancer Screening</p>	
	<p>Section 1367.64 Prostate Cancer Screening</p>	
	<p>Section 1367.665 General Cancer Screening</p>	
	<p>Section 1367.66 Cervical Cancer Screening</p>	
	<p>Section 1367.51 Diabetes Equipment and Supply Services</p>	
	<p>Section 1367.65 Mammography Services</p>	
	<p>Section 1367.46 Rule 1300.67.24 Coverage for HIV Testing</p>	
	<p>Section 1367.67 Osteoporosis Services</p>	
	<p>Section 1367.9 Diethylstilbestrol Services</p>	
<p>#10: Pediatric Services, Including Oral and Vision Care</p>	<p>Benefits offered by the Healthy Families Program 2012</p> <p>Dental Plan</p> <p>Section 1367.005(a)(5), 10 CCR 2699.6709</p> <p><u>Benefits for pediatric oral care covered under the dental benefit received by children under the Medi-Cal program as of 2014, pursuant to the Medi-Cal Dental Program Provider Handbook in effect during the first quarter of 2014, including coverage pursuant to the Early Periodic Screening,</u></p>	

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<u>Diagnosis, and Treatment benefit pursuant to 42 U.S.C. Section 1396d(r), and the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009.</u> Oral Care	
Benefits offered by the FEDVIP Blue Cross Blue Shield 2012 FEP BlueVision Plan Section 1367.005(a)(4) <u>BCBS Association, 2014 FEP BlueVision – High Option, including but not limited to low vision benefits.</u> Vision Care	
Section 1345(b)(5) Rule 1300.67(f)(4) Pediatric Vision and Hearing Services	
Section 1345(b)(5) Rule 1300.67(f)(5) Pediatric Immunization Services	
Section 1367.002 Section 1367.06 Pediatric Asthma Services	
Section 1367.002 Section 1367.35 Comprehensive Pediatric Preventive Services	

PRESCRIPTION DRUG BENEFITS

Directions for Plan Completion of Prescription Drug EHB-Benchmark Plan Benefits Chart

To demonstrate compliance with the prescription drug essential health benefits required under the PPACA at section 1302(b) (42 U.S.C. § 18022) and at 45 CFR § 156.122, please complete the form below indicating the number of prescription drugs offered by the Plan in each class and category of prescription drugs listed below. Plans must make whatever modifications are necessary to their current formularies so that the number of prescription drugs they cover equal or exceed the number listed in the “EHB Submission Count” column. Please attach the Plan's prescription drug list and/or formulary to this worksheet.

The plan must demonstrate it provides at least the greater of one (1) drug per category and class or the same number of drugs provided by the base-benchmark plan as indicated in the EHB Submission Count column,

Changes in text are noted by underline and strikeout

pursuant to 45 Code of Federal Regulations part 156.122, subparagraph (a). (78 Fed. Reg. 12834, 12867, February 25, 2013.)

CATEGORY	CLASS	EHB SUBMISSION COUNT	PLAN SUBMISSION COUNT
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	10	
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	3	
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	<u>87</u>	
ANESTHETICS	LOCAL ANESTHETICS	2	
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3	
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID ANTAGONISTS <u>OPIOID DEPENDENCE TREATMENTS</u>	<u>21</u>	
<u>ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS</u>	<u>OPIOID REVERSAL AGENTS</u>	1	
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	0	
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICIDS	<u>120</u>	
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	<u>109</u>	
ANTIBACTERIALS	AMINOGLYCOSIDES	<u>75</u>	
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	<u>1314</u>	
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	<u>147</u>	
ANTIBACTERIALS	BETA-LACTAM, OTHER	<u>42</u>	

Changes in text are noted by underline and strikeout

ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	4 <u>5</u>	
ANTIBACTERIALS	MACROLIDES	3	
ANTIBACTERIALS	QUINOLONES	5 <u>6</u>	
ANTIBACTERIALS	SULFONAMIDES	4	
ANTIBACTERIALS	TETRACYCLINES	4	
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	1 <u>3</u>	
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	2	
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	4 <u>3</u>	
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3	
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	5 <u>4</u>	
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	0 <u>1</u>	
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	2	
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1	
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	5 <u>6</u>	
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	2	
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	6 <u>9</u>	
ANTIDEPRESSANTS	TRICYCLICS	8 <u>9</u>	
ANTIEMETICS	ANTIEMETICS, OTHER	9	
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	3	
ANTIFUNGALS	NO USP CLASS	1 <u>0</u> <u>9</u>	
ANTIGOUT AGENTS	NO USP CLASS	4 <u>5</u>	
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2	
ANTIMIGRAINE AGENTS	PROPHYLACTIC	3 <u>2</u>	
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	2 <u>3</u>	
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	2 <u>3</u>	
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2	
ANTIMYCOBACTERIALS	ANTITUBERCULARS	6 <u>8</u>	

Changes in text are noted by underline and strikeout

ANTINEOPLASTICS	ALKYLATING AGENTS	<u>74</u>	
ANTINEOPLASTICS	ANTIANDROGENS	<u>3</u>	
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	<u>23</u>	
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	2	
ANTINEOPLASTICS	ANTIMETABOLITES	<u>25</u>	
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	<u>54</u>	
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3	
ANTINEOPLASTICS	ENZYME INHIBITORS	3	
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	4 <u>213</u>	
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	<u>40</u>	
ANTINEOPLASTICS	RETINOIDS	2	
ANTIPARASITICS	ANTHELMINTICS	3	
ANTIPARASITICS	ANTIPROTOZOALS	10	
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	1 <u>2</u>	
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3	
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	2	
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4	
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2	
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	2	
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10	
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	5	
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1	
ANTISPASTICITY AGENTS	NO USP CLASS	<u>43</u>	
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	<u>31</u>	
ANTIVIRALS	ANTI-HEPATITIS B (HBV) AGENTS	<u>5</u>	
ANTIVIRALS	ANTI-HEPATITIS C (HBC) AGENTS	<u>7</u>	
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE	5	

Changes in text are noted by underline and strikeout

	INHIBITORS		
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	11 12	
<u>ANTIVIRALS</u>	<u>ANTI-HIV AGENTS, INTEGRASE INHIBITORS</u>	<u>2</u>	
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3	
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9	
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4	
ANTIVIRALS	ANTIHEPATITIS AGENTS	11	
ANTIVIRALS	ANTIHERPETIC AGENTS	4 3	
ANXIOLYTICS	ANXIOLYTICS, OTHER	3	
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	3 5	
<u>ANXIOLYTICS</u>	<u>BENZODIASEPINES</u>	<u>0</u>	
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	5 6	
BIPOLAR AGENTS	MOOD STABILIZERS	5	
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	5 7	
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	1	
BLOOD GLUCOSE REGULATORS	INSULINS	6	
BLOOD PRODUCTS/MODIFIERS/ VOLUME EXPANDERS	ANTICOAGULANTS	3	
BLOOD PRODUCTS/MODIFIERS/ VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	5 4	
BLOOD PRODUCTS/MODIFIERS/			

Changes in text are noted by underline and strikeout

VOLUME EXPANDERS	COAGULANTS	10	
BLOOD PRODUCTS/MODIFIERS/ VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	6	
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4	
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4	
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	1	
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	23	
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	9	
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	67	
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	65	
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	2	
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2	
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	3	
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	12	
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	4	
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2	
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	4	
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	3	
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	2	

Changes in text are noted by underline and strikeout

CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3	
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	3	
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	1	
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	4 <u>2</u>	
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	0 <u>1</u>	
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	5 <u>3</u>	
DENTAL AND ORAL AGENTS	NO USP CLASS	6	
DERMATOLOGICAL AGENTS	NO USP CLASS	20 <u>50</u>	
ENZYME REPLACEMENT/MODIFIERS	NO USP CLASS	8 <u>2</u>	
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	4 <u>2</u>	
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	3 <u>6</u>	
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	3	
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	0 <u>1</u>	
GASTROINTESTINAL AGENTS	LAXATIVES	1	
GASTROINTESTINAL AGENTS	PROTECTANTS	2	
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	2	
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	4 <u>2</u>	
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	5	

Changes in text are noted by underline and strikeout

GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	<u>34</u>	
GENITOURINARY AGENTS	PHOSPHATE BINDERS	2	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFYING (ADRENAL)	GLUCOCORTICOID/MINERALOCORTICOID <u>NO USP CLASS</u>	1623	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFYING (PITUITARY)	NO USP CLASS	<u>34</u>	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	<u>01</u>	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	2	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)	<u>PROGESTERONE</u> <u>AGONISTS/ANTAGONISTS</u>	<u>0</u>	

Changes in text are noted by underline and strikeout

(SEX HORMONES/MODIFIERS) HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFY ING	PROGESTINS	5	
(SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFY ING (THYROID)	NO USP CLASS	2	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1	
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	4 2	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	5	
HORMONAL AGENTS, SUPPRESSANT (SEX HORMONES/MODIFIERS)	ANTIANDROGENS	3	
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	2 3	
<u>IMMUNOLOGICAL AGENTS</u>	<u>ANGIOEDEMA (HAE) AGENTS</u>	<u>1</u>	
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	4 <u>14</u>	
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	<u>20</u>	
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	<u>711</u>	
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	2	

Changes in text are noted by underline and strikeout

INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5	
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1	
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	<u>76</u>	
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	2	
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	<u>314</u>	
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	2	
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	6	
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	<u>912</u>	
OTIC AGENTS	NO USP CLASS	<u>25</u>	
RESPIRATORY TRACT AGENTS/ <u>PULMONARY AGENTS</u>	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	5	
RESPIRATORY TRACT AGENTS/ <u>PULMONARY AGENTS</u>	ANTIHISTAMINES	<u>45</u>	
RESPIRATORY TRACT AGENTS/ <u>PULMONARY AGENTS</u>	ANTILEUKOTRIENES	1	
RESPIRATORY TRACT AGENTS/ <u>PULMONARY AGENTS</u>	BRONCHODILATORS, ANTICHOLINERGIC	2	
RESPIRATORY TRACT AGENTS/ <u>PULMONARY AGENTS</u>	BRONCHODILATORS, PHOSPHODIESTERASE INHIBITORS (XANTHINES)PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE	<u>23</u>	
RESPIRATORY TRACT AGENTS/ <u>PULMONARY AGENTS</u>	BRONCHODILATORS, SYMPATHOMIMETIC	5	

Changes in text are noted by underline and strikeout

<u>RESPIRATORY TRACT AGENTS/PULMONARY AGENTS</u>	<u>CYSTIC FIBROSIS AGENTS</u>	<u>3</u>	
<u>RESPIRATORY TRACT AGENTS/PULMONARY AGENTS</u>	MAST CELL STABILIZERS	1	
<u>RESPIRATORY TRACT AGENTS/PULMONARY AGENTS</u>	PULMONARY ANTIHYPERTENSIVES	<u>45</u>	
<u>RESPIRATORY TRACT AGENTS/PULMONARY AGENTS</u>	RESPIRATORY TRACT AGENTS, OTHER	<u>31</u>	
<u>SKELETAL MUSCLE RELAXANTS</u>	NO USP CLASS	2	
<u>SLEEP DISORDER AGENTS</u>	GABA RECEPTOR MODULATORS	1	
<u>SLEEP DISORDER AGENTS</u>	SLEEP DISORDERS, OTHER	1	
<u>THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES</u>	ELECTROLYTE/MINERAL MODIFIERS	4	
<u>THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES</u>	ELECTROLYTE/MINERAL REPLACEMENT	<u>73</u>	
<u>THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES</u>	<u>VITAMINS</u>	<u>0</u>	

Note: Authority cited: Sections 1341, 1344, 1346 and 1367.005, Health and Safety Code. Reference: Section 1367.005, Health and Safety Code.

DEPARTMENT OF MANAGED HEALTH CARE
ADOPTION OF EMERGENCY REGULATIONS

California Code of Regulations
Title 28, Article 7, Section 1300.67.005

Essential Health Benefits

(Control No. 2016-5191)

AUTHORITY

Under the authority established in the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act),¹ specifically Health and Safety Code Sections 1341, 1344, and 1367.005, the Director of the Department of Managed Health Care (Department) proposes to amend as an emergency regulation section 1300.67.005, “Essential Health Benefits,” located in Title 28 of the California Code of Regulations (CCR).

REFERENCE

This regulation is intended to implement, interpret, and/or make specific Health and Safety Code Section 1367.005.

FINDING OF EMERGENCY

The Director of the Department has determined that an emergency exists. Health and Safety Code section 1367.005(o)(3) states that the initial adoption of emergency regulations implementing this section made during the 2015-16 Regular Session of the Legislature and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The 2015-16 Regular Session of the Legislature ends on November 30, 2016.

These emergency regulations implement provisions of the federal Patient Protection and Affordable Care Act (ACA) (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), any rules, regulations, or guidance issued thereunder, and they amend the existing Title 28 Essential Health Benefit (EHB) regulations in accordance with statutory changes enacted through Senate Bill (SB) 43 (Hernandez, 2015).

¹ California Health and Safety Code Sections 1340 et seq. References herein to “Section” are to sections of the Knox-Keene Act unless otherwise specified.

INFORMATIVE DIGEST

Under existing law, the Knox-Keene Act provides for the licensure and regulation of health care service plans by the Department and makes a willful violation of the Knox-Keene Act a crime. The Department, as regulator of individual and small group health plans, is responsible for reviewing health plan filings to ensure its licensees meet EHB coverage requirements. Additionally, the Department is responsible for certifying licensed health plans seeking to be Qualified Health Plans (QHP)² on the California Health Benefits Exchange (Exchange).

The ACA requires nongrandfathered individual and small group health insurance issuers and health plans to provide the EHB outlined in ACA section 1302(b) (42 U.S.C. § 18022). In December of 2011, the federal Department of Health and Human Services (HHS) issued guidance authorizing each state to select a benchmark plan from specified options offered in the first quarter of 2012. The benchmark plan defines the specific benefits required to be covered within each of the broad, federally-defined EHB categories of benefits. In September 2012, under Assembly Bill (AB) 1453 and its companion legislation, SB 951, California selected the Kaiser Small Group HMO 30 plan (Kaiser Small Group plan) as the base-benchmark plan. California also supplemented the base-benchmark plan to achieve coverage of the pediatric oral and vision care EHB. The Kaiser Small Group benchmark plan, as supplemented, defines EHB within California.

In 2015, federal regulators directed states to select a new benchmark plan from among defined options. Through SB 43, California again chose the Kaiser Small Group HMO 30, as that plan was offered during the first quarter of 2014. SB 43 similarly updated the pediatric oral and vision EHB; for the pediatric vision EHB, the bill retained the FEDVIP vision benefit, as of 2014. For the pediatric oral EHB, the bill updated the reference from 2011-12 Healthy Families (CHIP) dental benefits to the dental benefit received by children under the Medi-Cal program as of 2014.

These proposed regulations are intended to provide the necessary guidance for health plans to comply with both state and federal EHB requirements.

SPECIFIC PURPOSE OF THE REGULATION

Section 1300.67.005(b) is amended to update the deadline for filing the EHB Filing Worksheet. This implements existing law by establishing an appropriate deadline for the compliance filings.

² “The term ‘qualified health plan’ means a health plan that-- (A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 18031(c) of this title issued or recognized by each Exchange through which such plan is offered; (B) provides the essential health benefits package described in section 18022(a) of this title; and (C) is offered by a health insurance issuer that-- (i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title; (ii) agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange; (iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and (iv) complies with the regulations developed by the Secretary under section 18031(d) of this title and such other requirements as an applicable Exchange may establish.” 42 U.S.C. § 18021.

Section 1300.67.005(c)(2) is amended to update the reference to California's base-benchmark plan. This change implements existing law.

Section 1300.67.005(c)(3) is amended to clarify the date on which an enrollee ages out of "pediatric" oral and vision benefits, consistent with related federal law.

Section 1300.67.005(d)(4)(B) is amended to strike the per se age limit on aphakia contact lenses, consistent with federal law and guidance regarding impermissible discrimination. It has also been amended to relocate a comma.

Section 1300.67.005(d)(10)(C)(ix) is amended to strike the description of "physical, occupational, and speech therapy" benefits from the regulation's subdivision regarding Skilled Nursing Facility care, and to move this benefit to the newly proposed subdivision regarding Habilitative and Rehabilitative services. This clarifying change reflects the structure of the new base-benchmark plan.

Section 1300.67.005(d)(12) is added to implement the updated definition of the habilitative and rehabilitative services EHB, and to describe the required coverage required according to the new base benchmark plan and SB 43's provisions related to habilitative services.

Section 1300.67.005(d)(13) is added to clarify the existing requirement for coverage in connection with a clinical trial, and to reflect the description of that coverage in the new base benchmark plan.

Section 1300.67.005(g), containing the EHB Filing Worksheet, is amended to align with the amendments in the rest of the regulation. For greater clarity, subdivision (g) has a nonsubstantive amendment for consistent formatting.

Section 1300.67.005(g), section #10, is amended to reference the updated pediatric oral and vision care EHB, which supplement the base benchmark plan. This amendment implements existing law. This subdivision clarifies that the pediatric vision EHB includes but is not limited to low-vision benefits. This subdivision also clarifies that, with regard to the pediatric oral EHB, the required coverage includes the Medi-Cal "Early Periodic Screening, Diagnosis, and Treatment" (EPSDT) benefit. The proposed language clarifies and implements the statutory requirement for the pediatric dental EHB to include "the same health benefits for pediatric oral care covered under the dental benefit received by children under the Medi-Cal program as of 2014 [...]."

Section 1300.67.005(g), regarding the Prescription Drug Benefit chart, is amended to reflect the base benchmark plan's number of drugs in each drug category and class, as determined by federal regulators.

BROAD OBJECTIVES AND BENEFITS OF THE PROPOSED EMERGENCY REGULATIONS

Pursuant to Government Code section 11346.5(a)(3)(C), the broad objectives and benefits of this proposed regulation, 1300.67.005, are that health plans and stakeholders will receive accurate and consistent guidance regarding the EHB requirement and that the Department's EHB regulation will be consistent with the underlying statute, as amended by SB 43. The broad objectives and benefits of each amendment of section 1300.67.005 are further described below.

The amendment of 1367.005, subdivision (b), requires health plans to submit compliance filings by no later than the date that QHP product filings are due. This requirement implements the updated EHB requirement and clarifies the process the Department will use to conduct its compliance review. This amendment also ensures that the Department completes its compliance review in an efficient manner that does not interfere with Covered California activities. The amendment of section 1367.005, subdivision (c)(2), implements SB 43 by referencing California's new base benchmark plan. This will ensure that the regulation is consistent with the underlying statute.

The amendment of section 1300.67.005, subdivision (c)(3), clarifies the specific end date for "pediatric" EHB benefits, relative to an enrollee's nineteenth birthday. Clarifying that pediatric oral and vision EHB benefits at the end of the month in which the enrollee turns 19 years of age will ensure consistency with federal law and resolve ambiguity regarding when an enrollee ages out of pediatric EHB coverage.

The amendment of section 1300.67.005, subdivision (d)(4)(B), implements federal guidance regarding discriminatory benefit limits on EHB. An age limit on an EHB must be clinically justified to avoid violating state and federal antidiscrimination laws. Removing this limit on aphakia lens coverage will ensure that if the plan imposes an age limit on this EHB, the limit is clinically justified, consistent with federal law and guidance. Additionally, relocating the comma will clarify the regulation.

The amendment of section 1300.67.005, subdivision (d)(10)(C)(ix), relocates the reference to the physical, occupational, and speech therapy benefit. This clarifying change reflects the structure of the new base benchmark plan; updating the structure of the regulation to reflect the new base benchmark plan's description of "habilitative and rehabilitative services" will provide greater clarity and implement the EHB requirement in accordance with the benchmark plan's coverage, as required by state and federal law.

The addition of section 1300.67.005, subdivision (d)(12), implements and clarifies the habilitative and rehabilitative services and devices EHB. Specifying that the habilitative and rehabilitative services coverage must comport with the statutory definition, as amended by SB 43, and specifying that limits for habilitative and rehabilitative services shall not be combined, and specifying that the health plan must include related disclaimers in the plan documents, implements the statutory requirements by ensuring that plans give the Department the information necessary to determine compliance efficiently, using the EHB Filing Worksheet.

The addition of section 1300.67.005, subdivision (d)(13), clarifies the existing requirement for coverage in connection with a clinical trial, and reflects the description of this benefit, as set forth in the new base benchmark plan.

The amendments of section 1300.67.005, subdivision (g), clarifies the regulation by ensuring that the Worksheet is consistently formatted, and ensuring that the Worksheet reflects the amendments to the rest of the regulation. This will make the Worksheet more clear and user-friendly, and will help to ensure efficient review by the Department.

The amendments of section 1300.67.005, subdivision (g), section #10, implement existing law by clarifying the benefits that supplement the base benchmark plan and define California's pediatric oral and vision care EHB. The amendments to this subdivision also clarify that the pediatric vision EHB includes but is not limited to low-vision benefits, which has been a subject of confusion among some health plans. The amendments also clarify that, with regard to the pediatric oral EHB, the required coverage includes the Medi-Cal EPSDT benefit. This new language clarifies and implements the statutory requirement for the pediatric dental EHB to include "the same health benefits for pediatric oral care covered under the dental benefit received by children under the Medi-Cal program as of 2014 [...]."³ EPSDT benefits can result in coverage notwithstanding a benefit limit, such as a frequency limit, when the service is medically necessary for the child, so this clarification will ensure appropriate, medically necessary pediatric dental coverage, as required by SB 43.

The amendment of the section 1300.67.005, subdivision (g), Prescription Drug Benefit chart, implements SB 43 by reflecting the new base benchmark plan's drug count in each drug category and class, as determined by federal regulators. This amendment will ensure that health plans understand the required EHB drug coverage, and that the Department's compliance review is efficient and based on the operative standard. This amendment does not impose any additional costs because it simply reflects the changes to the benchmark plan selected by the Legislature.

DOCUMENTS RELIED UPON

- Health and Safety Code sections 1344, 1367.005;
- 28 C.C.R. section 1300.67.005;
- 45 C.F.R. sections 156.115, 156.122, 156.125,
- Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Proposed Rule;
- Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule;
- Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017- Final Rule;
- Kaiser Small Group HMO 30: Kaiser Permanente for Small Businesses Evidence of Coverage for Sample Group Agreement, EOC Number: 4;
- Kaiser California Soft Goods Formulary;
- Kaiser California Durable Medical Equipment Formulary;

³ Health & Saf. Code § 1367.005, subdivision (a)(5).

- Kaiser Permanente Living Donor Guidelines – California Regions;
- Kaiser Foundation Health Plan – California, Utilization Management (UM) Criteria for Transgender Surgery;
- Health Family Program/CHIP Regulation Benefits vs. Medi-Cal Dental Services Scope of Benefits;
- BCBS Association 2014 FEP BlueVision- High Option;
- Medi-Cal Dental Program Provider Handbook; and,
- Centers for Medicare and Medicaid Services, Prescription Drug EHB-Benchmark Plan Benefits By Category And Class.

COST TO LOCAL AGENCIES AND SCHOOL DISTRICTS

The proposed regulation does not impose a mandate on local agencies and school districts. No other direct or indirect costs or savings to local agencies or school districts required to be reimbursed under Part 7 (commencing with section 137500) of Division 4 of the Government Code, or other non-discretionary costs or savings imposed on local agencies are applicable. There is no cost or savings in federal funding to the state.

COSTS OR SAVING TO STATE AGENCY

There are no costs or savings to a state agency as a result of the proposed regulation.

COST OR SAVINGS IN FEDERAL FUNDING

Pursuant to Government Code section 11346.5, subdivision (a)(6), the Department has determined that this regulation will have no cost or savings in federal funding to the state.

CONSISTENCY WITH STATE LAW

Pursuant to Government Code section 11346.5, subdivision (a)(3)(D), the proposed regulation was evaluated and was not found to be inconsistent or incompatible with existing state regulations contained in Title 28 of the California Code of Regulations.

COMPARABLE FEDERAL LAW

Existing federal statutes and regulations are comparable to the proposed regulation including section 1302 of Patient Protection and Affordable Care Act (42 U.S.C. Section 18022) and portions of sections 156.20, 156.110, 156.115, 156.125, 156.130, 156.135, 156.140, 156.150 and 156.155 of Title 45 of the Code of Federal Regulations.

DETERMINATION

The Department has not identified any reasonable alternative nor has any stakeholder brought to the attention of the Department any alternative that would be more effective in carrying out the purpose for which the above action is proposed, or that would be as effective and less burdensome to affected private persons, than the proposed action.

REQUIRED NOTICE OF PROPOSED EMERGENCY RULEMAKING ACTION

This statement confirms that the Department complied with the requirement to provide notice of the proposed emergency action pursuant to Government Code section 11346.1, subdivision (a)(2).

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