§ 1374.57. Exclusion of dependent child

(a) No group health care service plan that provides hospital, medical, or surgical expense benefits for employees or subscribers and their dependents shall exclude a dependent child from eligibility or benefits solely because the dependent child does not reside with the employee or subscriber.

(b) A health care service plan that provides hospital, medical, or surgical expense benefits for employees or subscribers and their dependents shall enroll, upon application by the employer or group administrator, a dependent child of the noncustodial parent when the parent is the employee or subscriber, at any time the noncustodial or custodial parent makes an application for enrollment to the employer or group administrator when a court order for medical support exists. Except as provided in Section 1374.3, the application to the employer or group administrator shall be made within 90 days of the issuance of the court order. In the case of children who are eligible for

Medicaid, the State Department of Health Services or the district attorney in whose jurisdiction the child resides may make that application.

(c) This section shall not be construed to require that a health care service plan enroll a dependent who resides outside the plan's geographic service area, except as provided in Section 1374.3.

(d) Notwithstanding any other provision of this section, all health care service plans shall comply with the standards set forth in Section 1374.3.

HISTORY:
Added Stats 1991 ch 1152 § 1 (AB 2118). Amended Stats 1994 ch 147 § 9 (AB 2377), effective July 9, 1994.

§ 1374.58. Group health care service plan to offer coverage for registered domestic partner equal to that provided to spouse

(a) A group health care service plan that provides hospital, medical, or surgical expense benefits shall provide equal coverage to employers or guaranteed associations, as defined in Section 1357, for the registered domestic partner of an employee or subscriber to the same extent, and subject to the same terms and conditions, as provided to a spouse of the employee or subscriber, and shall inform employers and guaranteed associations of this coverage. A plan shall not offer or provide coverage for a registered domestic partner that is not equal to the coverage provided to the spouse of an employee or subscriber, and shall not discriminate in coverage between spouses or domestic partners of a different sex and spouses or domestic partners of the same sex. The prohibitions and requirements imposed by this section are in addition to any other prohibitions and requirements imposed by law.

(b) If an employer or guaranteed association has purchased coverage for spouses and registered domestic partners pursuant to subdivision (a), a health care service plan that provides hospital, medical, or surgical expense benefits for employees or subscribers and their spouses shall enroll, upon application by the employer or group administrator, a registered domestic partner of an employee or subscriber in accordance with the terms and conditions of the group contract that apply generally to all spouses under the plan, including coordination of benefits.

(c) For purposes of this section, the term "domestic partner" shall have the same meaning as that term is used in Section 297 of the Family Code.

(d)(1) A health care service plan may require that the employee or subscriber verify the status of the domestic partnership by providing to the plan a copy of a valid Declaration of Domestic Partnership filed with the Secretary of State pursuant to Section 298 of the Family Code or an equivalent document issued by a local agency of this state, another state, or a local agency of another state under which the partnership was created. The plan may also require that the employee or subscriber notify the plan upon the termination of the domestic partnership.

(2) Notwithstanding paragraph (1), a health care service plan may require the information described in that paragraph only if it also requests from the employee or subscriber whose spouse is provided coverage, verification of marital status and notification of dissolution of the marriage.

(e) Nothing in this section shall be construed to expand the requirements of Section 4980B of Title 26 of the United States Code, Section 1161, and

following, of Title 29 of the United States Code, or Section 300bb-1, and following, of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), and as those provisions may be later amended.

(f) A plan subject to this section that is issued, amended, delivered, or renewed in this state on or after January 2, 2005, shall be deemed to provide coverage for registered domestic partners that is equal to the coverage provided to a spouse of an employee or subscriber.

HISTORY:

Added Stats 2001 ch 893 § 10 (AB 25). Amended Stats 2004 ch 488 § 2 (AB 2208); Stats 2011 ch 722 § 2 (SB 757), effective January 1, 2012.