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 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 2014, which are not otherwise required to be covered

under the Act; (3) Required benefits for pediatric vision and dental care, for individuals 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).

(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 2014, which are not otherwise required to be covered under the Act;

(3)

Required benefits for pediatric vision and dental care, for individuals 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. (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, 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: (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; (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; 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 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) Behavioral health treatment for pervasive developmental disorder or autism; and (x) 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. (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 though 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.

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

(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.

(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.

(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.

(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, whether provided by the plan under the current or a previous contract in the same calendar year.

(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, 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: (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

(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: (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

(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

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

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; (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.

(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.

(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; (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.

(i)

Short-term hospital-based intensive outpatient care (partial hospitalization);

(ii)

Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program;

(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.

(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.

(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.

(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; 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.

(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; 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.

(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.

(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 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) Behavioral health treatment for pervasive developmental disorder or autism; and (x) Respiratory therapy.

(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 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) Behavioral health treatment for pervasive developmental disorder or autism; and (x) Respiratory therapy.

(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)

Behavioral health treatment for pervasive developmental disorder or autism; and

(x)

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.

(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).

(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. (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 though 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.

(A)

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

(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;

(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 though 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.

(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 though 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.

(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 though 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.

(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.

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

Services Benchmark Plan EHB Rule 1300.67.005(d)(1) Acupuncture Services Benchmark Plan EHB Rule 1300.67.005(d)(8) Ostomy, Urinary Supplies #2: Emergency Services Section 1345(b)(6) Rule 1300.67(g)(1) Emergency Services Section 1371.5 Rule 1300.67(g)(1) Emergency Response Ambulance Services Section 1345(b)(6) Rule 1300.67(g)(2) Out of Area Coverage and Urgently Needed Services #3: Hospitalization Section 1345(b)(2) Rule 1300.67(b-c) Inpatient Hospital Services Section 1345(b)(7) Section 1368.2 Rule 1300.67(h) Hospice Services Section 1367.635 Mastectomies and Lymph Node Dissections Section 1367.63 Reconstructive Surgery Section 1367.6 Breast Cancer Coverage, Including Surgery Section 1367.68 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 Section 1367.54 Alpha-Fetoprotein Testing Section 1373.4 Inpatient Hospital and Ambulatory Maternity Services 45 CFR 147.130 HRSA Guidelines for Women's Preventive Services Breastfeeding Support, Supplies, Counseling Benchmark Plan EHB Section 1367.7 Rule 1300.67.005(d)(11): Prenatal Diagnosis of Genetic Disorders of the Fetus #5: Mental Health and Substance Section 1345(b)(1) Use Disorder Services, Including Rule 1300.67(a) Behavioral Health Treatment Section

1374.72 Section 1367.005(a)(2)(D) Mental Health Services Section 1374.73 Section 1367.005(a)(2)(D) Benchmark Plan EHB Rule 1300.67.005(d)(12)(A) Behavioral Health Treatment ("BHT") for PDD or Autism Benchmark Plan EHB Section 1367.005(a)(2)(D) Rule 1300.67.005(d)(6) Mental Health Services for Mental Disorders Other than SMI and SED Section 1367.005(a)(2)(D) Benchmark Plan EHB: Rule 1300.67.005(d)(3) Chemical Dependency Services #6: Prescription Drugs Section 1367.25 Coverage for Contraceptive Methods Section 1367.45 Coverage for Approved AIDS Vaccine Section 1370.6 Cancer Clinical Trials EHB Benchmark Plan Rule 1300.67.005(d)(13) Other Clinical Trials Section 1367.21 Off Label Drug Use Section 1367.002 Section 1367.06 Pediatric Asthma Services Section 1374.56 Phenylketonuria Services Section 1367.215 Pain Management Medication for Terminally Ill Section 1367.22 Coverage for Previously Approved Prescription Section 1367.24 Prescription Authorization Process for Non Formulary Drugs Rule 1300.67.24 Outpatient Prescription Drug Coverage, Limitations and Exclusions #7: Rehabilitative and Habilitative Section 1345(b)(2) Services and Devices Rule 1300.67(c) Benchmark Plan EHB Rule 1300.67.005(d)(12) Outpatient Physical, Occupational, and Speech Therapy Section 1374.73 Section 1367.005(a)(3) Benchmark Plan EHB Rule 1300.67.005(d)(12)(A) Behavioral Health Treatment ("BHT") for PDD or Autism Section 1345(b)(4) Rule 1300.67(e) Section 1367.005(a)(2)(C) Home Health Services Section 1367.61 Prosthetics for Laryngectomy Section 1367.18 Orthotic and Prosthetic Devices and Services Section 1367.6 Section 1367.635 Prosthetic Devices Incident to Mastectomy Benchmark Plan EHB Rule 1300.67.005(d)(4) Contact Lenses to Treat Aniridia and Aphakia Benchmark Plan EHB Rule 1300.67.005(d)(5) Additional Durable

Medical Equipment Required to be Covered Benchmark Plan EHB Rule 1300.67.005(d)(9) Additional Prosthetic-Orthotics Devices Required 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 Benchmark Plan EHB Section 1367.7 Rule 1300.67.005(d)(11): Prenatal Diagnosis of Genetic Disorders of the Fetus #9: Preventive and Wellness Section 1345(b)(5) Services and Chronic Disease Rule 1300.67(f) Management Section 1367.002 45 CFR 147.130 75 Fed Reg 41726, 41728 HRSA Guidelines for Women's Preventive Services Preventive Health Services Section 1367.06 Pediatric Asthma Services Section 1367.35 Comprehensive Pediatric Preventive Services Section 1367.6 Breast Cancer Screening Section 1367.64 Prostate Cancer Screening Section 1367.665 General Cancer Screening Section 1367.66 Cervical Cancer Screening Section 1367.51 Diabetes Equipment and Supply Services Section 1367.65 Mammography Services Section 1367.46 Rule 1300.67.24 Coverage for HIV Testing Section 1367.67 Osteoporosis Services Section 1367.9 Diethylstilbestrol Services #10: Pediatric Services, Including Section 1367.005(a)(5) Oral and Vision Care 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, Diagnosis, and Treatment benefit pursuant to 42 U.S.C. Section 1396 d(r), and provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. Oral Care Section 1367.005(a)(4) BCBS Association, 2014 FEP BlueVision - High Option, including but not limited to low vision benefits. 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, 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 7

ANESTHETICS LOCAL ANESTHETICS 2 ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS ALCOHOL DETERRENTS/ANTI-CRAVING 3 ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS OPIOID DEPENDENCE TREATMENTS1 ANTI-ADDICITION/SUBSTANCE ABUSE TREATMENT AGENTS OPIOID REVERSAL AGENTS 1 ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS SMOKING CESSATION AGENTS 0 ANTI-INFLAMMATORY AGENTS GLUCOCORTICOIDS 20 ANTI-INFLAMMATORY AGENTS NONSTEROIDAL ANTI-INFLAMMATORY DRUGS 9 ANTIBACTERIALS AMINOGLYCOSIDES 5 ANTIBACTERIALS ANTIBACTERIALS, OTHER 14 ANTIBACTERIALS BETA-LACTAM, CEPHALOSPORINS 7 ANTIBACTERIALS BETA-LACTAM, OTHER 2 ANTIBACTERIALS BETA-LACTAM, PENICILLINS 5 ANTIBACTERIALS MACROLIDES 3 ANTIBACTERIALS QUINOLONES 6 ANTIBACTERIALS SULFONAMIDES 4 ANTIBACTERIALS TETRACYCLINES 4 ANTICONVULSANTS ANTICONVULSANTS, OTHER 3 ANTICONVULSANTS CALCIUM CHANNEL MODIFYING AGENTS 2 ANTICONVULSANTS GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS3 ANTICONVULSANTS GLUTAMATE REDUCING AGENTS 3 ANTICONVULSANTS SODIUM CHANNEL AGENTS 4 ANTIDEMENTIA AGENTS ANTIDEMENTIA AGENTS, OTHER 1 ANTIDEMENTIA AGENTS CHOLINESTERASE INHIBITORS 2 ANTIDEMENTIA AGENTS N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST1 ANTIDEPRESSANTS ANTIDEPRESSANTS, OTHER 6 ANTIDEPRESSANTS MONOAMINE OXIDASE INHIBITORS 2 ANTIDEPRESSANTS SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS9 ANTIDEPRESSANTS TRICYCLICS 9 ANTIEMETICS ANTIEMETICS, OTHER 9 ANTIEMETICS EMETOGENIC THERAPY ADJUNCTS 3 ANTIFUNGALS NO USP CLASS 9 ANTIGOUT AGENTS NO USP CLASS 5 ANTIMIGRAINE AGENTS ERGOT ALKALOIDS 2 ANTIMIGRAINE AGENTS PROPHYLACTIC 2 ANTIMIGRAINE AGENTS SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS 3 ANTIMYASTHENIC AGENTS

PARASYMPATHOMIMETICS 3 ANTIMYCOBACTERIALS ANTIMYCOBACTERIALS, OTHER 2 ANTIMYCOBACTERIALS ANTITUBERCULARS 8 ANTINEOPLASTICS ALKYLATING AGENTS 4 ANTINEOPLASTICS ANTIANDROGENS 3 ANTINEOPLASTICS ANTIANGIOGENIC AGENTS 3 ANTINEOPLASTICS ANTIESTROGENS/MODIFIERS 2 ANTINEOPLASTICS ANTIMETABOLITES 5 ANTINEOPLASTICS ANTINEOPLASTICS, OTHER 4 ANTINEOPLASTICS AROMATASE INHIBITORS, 3RD GENERATION 3 ANTINEOPLASTICS ENZYME INHIBITORS 3 ANTINEOPLASTICS MOLECULAR TARGET INHIBITORS 13 ANTINEOPLASTICS MONOCLONAL ANTIBODIES 0 ANTINEOPLASTICS RETINOIDS 2 ANTIPARASITICS ANTHELMINTICS 3 ANTIPARASITICS ANTIPROTOZOALS 10 ANTIPARASITICS PEDICULICIDES/SCABICIDES 2 ANTIPARKINSON AGENTS ANTICHOLINERGICS 3 ANTIPARKINSON AGENTS ANTIPARKINSON AGENTS, OTHER 2 ANTIPARKINSON AGENTS DOPAMINE AGONISTS 4 ANTIPARKINSON AGENTS DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS2 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 3 ANTIVIRALS ANTI-CYTOMEGALOVIRUS (CMV) AGENTS 1 ANTIVIRALS ANTI-HEPATITIS B (HBV) AGENTS 5 ANTIVIRALS ANTI-HEPATITIS C (HBC) AGENTS 7 ANTIVIRALS ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS5 ANTIVIRALS ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS12 ANTIVIRALS ANTI-HIV AGENTS, INTEGRASE INHIBITORS 2 ANTIVIRALS ANTI-HIV AGENTS, OTHER 3 ANTIVIRALS ANTI-HIV AGENTS, PROTEASE INHIBITORS 9 ANTIVIRALS ANTI-INFLUENZA AGENTS 4 ANTIVIRALS ANTIHERPETIC AGENTS 3 ANXIOLYTICS ANXIOLYTICS, OTHER 3 ANXIOLYTICS SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE

INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)5 ANXIOLYTICS BENZODIASEPINES 0 BIPOLAR AGENTS BIPOLAR AGENTS, OTHER 6 BIPOLAR AGENTS MOOD STABILIZERS 5 BLOOD GLUCOSE REGULATORSANTIDIABETIC AGENTS7 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 4 BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS COAGULANTS 0 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) INHIBITORS3 CARDIOVASCULAR AGENTS ANTIARRHYTHMICS 9 CARDIOVASCULAR AGENTS BETA-ADRENERGIC BLOCKING AGENTS 7 CARDIOVASCULAR AGENTS CALCIUM CHANNEL BLOCKING AGENTS 5 CARDIOVASCULAR AGENTS CARDIOVASCULAR AGENTS, OTHER 2 CARDIOVASCULAR AGENTS DIURETICS, CARBONIC ANHYDRASE INHIBITORS 2 CARDIOVASCULAR AGENTS DIURETICS, LOOP 3 CARDIOVASCULAR AGENTS DIURETICS, POTASSIUM-SPARING 2 CARDIOVASCULAR AGENTS DIURETICS, THIAZIDE 4 CARDIOVASCULAR AGENTS DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES 2 CARDIOVASCULAR AGENTS DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS4 CARDIOVASCULAR AGENTS DYSLIPIDEMICS, OTHER 3 CARDIOVASCULAR AGENTS VASODILATORS, DIRECT-ACTING ARTERIAL 2 CARDIOVASCULAR AGENTS VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS3 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 2 CENTRAL NERVOUS SYSTEM AGENTS FIBROMYALGIA AGENTS 1 CENTRAL NERVOUS SYSTEM AGENTS MULTIPLE SCLEROSIS AGENTS 3 DENTAL AND ORAL AGENTS NO USP CLASS 6 DERMATOLOGICAL AGENTS NO USP CLASS 50 ENZYME REPLACEMENT/MODIFIERS NO USP CLASS 2 GASTROINTESTINAL AGENTS ANTISPASMODICS, GASTROINTESTINAL 2 GASTROINTESTINAL AGENTS GASTROINTESTINAL AGENTS, OTHER 6 GASTROINTESTINAL AGENTS HISTAMINE2 (H2) RECEPTOR ANTAGONISTS 3 GASTROINTESTINAL AGENTS IRRITABLE BOWEL SYNDROME AGENTS 1 GASTROINTESTINAL AGENTS LAXATIVES 1 GASTROINTESTINAL AGENTS PROTECTANTS 2 GASTROINTESTINAL AGENTS PROTON PUMP INHIBITORS 2 GENITOURINARY AGENTS ANTISPASMODICS, URINARY 2 GENITOURINARY AGENTS BENIGN PROSTATIC HYPERTROPHY AGENTS 5 GENITOURINARY AGENTS GENITOURINARY AGENTS, OTHER 4 GENITOURINARY AGENTS PHOSPHATE BINDERS 2 HORMONAL AGENTS, STIMULANT/ REPLACEMENT/MODIFYING (ADRENAL) NO USP CLASS 23 HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY) NO USP CLASS4 HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS) NO USP CLASS 1 HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) ANABOLIC STEROIDS 1 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 PROGESTERONE (SEX HORMONES/MODIFIERS) AGONISTS/ANTAGONISTS 0 HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) PROGESTINS

5 HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS) SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS1 HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID) NO USP CLASS 2 HORMONAL AGENTS, SUPPRESSANT(ADRENAL) NO USP CLASS 1 HORMONAL AGENTS, SUPPRESSANT(PARATHYROID) NO USP CLASS 2 HORMONAL AGENTS, SUPPRESSANT(PITUITARY)NO USP CLASS5 HORMONAL AGENTS, SUPPRESSANT (THYROID) ANTITHYROID AGENTS 3 IMMUNOLOGICAL AGENTS ANDIOEDEMA (HAE) AGENTS 1 IMMUNOLOGICAL AGENTS IMMUNE SUPPRESSANTS 14 IMMUNOLOGICAL AGENTS IMMUNIZING AGENTS, PASSIVE 0 IMMUNOLOGICAL AGENTS IMMUNOMODULATORS 11 INFLAMMATORY BOWEL DISEASE AGENTS AMINOSALICYLATES 2 INFLAMMATORY BOWEL DISEASE AGENTS GLUCOCORTICOIDS 5 INFLAMMATORY BOWEL DISEASE AGENTS SULFONAMIDES 1 METABOLIC BONE DISEASE AGENTS NO USP CLASS 6 OPHTHALMIC AGENTS OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS2 OPHTHALMIC AGENTS OPHTHALMIC AGENTS, OTHER 14 OPHTHALMIC AGENTS OPHTHALMIC ANTI-ALLERGY AGENTS 2 OPHTHALMIC AGENTS OPHTHALMIC ANTI-INFLAMMATORIES 6 OPHTHALMIC AGENTS OPHTHALMIC ANTIGLAUCOMA AGENTS 12 OTIC AGENTSNO USP CLASS5 RESPIRATORY TRACT ANTI-INFLAMMATORIES, INHALED AGENTS/PULMONARY AGENTS CORTICOSTEROIDS 5 RESPIRATORY TRACT AGENTS/PULMONARY AGENTS ANTIHISTAMINES 5 RESPIRATORY TRACT AGENTS/PULMONARY AGENTS ANTILEUKOTRIENES 1 RESPIRATORY TRACT BRONCHODILATORS, AGENTS/PULMONARY AGENTS ANTICHOLINERGIC 2 RESPIRATORY TRACT PHOSPHDIESTERASE AGENTS/PULMONARY AGENTS INHIBITORS, AIRWAYS DISEASE 3 RESPIRATORY TRACT BRONCHODILATORS, AGENTS/PULMONARY AGENTS SYMPATHOMIMETIC 5 RESPIRATORY TRACT CYCSTIC FIBROSIS

AGENTS/PULMONARY AGENTS AGENTS 3 RESPIRATORY TRACT AGENTS/PULMONARY AGENTS MAST CELL STABILIZERS 1 RESPIRATORY TRACT PULMONARY AGENTS/PULMONARY AGENTS ANTIHYPERTENSIVES 5 RESPIRATORY TRACT RESPIRATORY AGENTS/PULMONARY AGENTS TRACT AGENTS, OTHER 1 SKELETAL MUSCLE RELAXANTS NO USP CLASS 2 SLEEP DISORDER AGENTS GABA RECEPTOR MODULATORS 1 SLEEP DISORDER AGENTS SLEEP DISORDERS, OTHER 1 THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES ELECTROLYTE/MINERAL MODIFIERS 4 THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES ELECTROLYTE/MINERAL REPLACEMENT 3 THERAPEUTIC NUTRIENTS/MINERALS/ELECTROLYTES VITAMINS 0