

§ 1374.76. Provision of covered mental health and substance use disorder benefits

(a) No later than January 1, 2015, a large group health care service plan contract shall provide all covered mental health and substance use disorder benefits in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(b) No later than January 1, 2015, an individual or small group health care service plan contract shall provide all covered mental health and substance use disorder benefits in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), all rules, regulations, and guidance issued pursuant to Section 2726 of the

federal Public Health Service Act (42 U.S.C. Sec. 300gg-26), and Section 1367.005.

(c) Until January 1, 2016, the director may issue guidance to health care service plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Any guidance issued pursuant to this subdivision shall be effective only until the director adopts regulations pursuant to the Administrative Procedure Act. The department shall consult with the Department of Insurance in issuing guidance under this subdivision.

HISTORY:

Added Stats 2014 ch 31 § 8 (SB 857), effective June 20, 2014.

ARTICLE 6

Operation and Renewal Requirements and Procedures

Section

1375. [Section repealed 1978.]

1375.1. Contents of plan.

1375.2. Transitionally licensed plans.

1375.3. Meet and confer with director prior to filing petition for bankruptcy; Information to ensure continuity of care.

1375.4. Required provisions for contract between health care service plan and risk-bearing organization; Regulations; Sanctions for plan's failure to comply with contractual requirements; Report; Exemption.

1375.5. Contract provision requiring risk-bearing organization to be at financial risk for provision of health care services.

1375.6. Contract provision requiring provider to accept certain rates or methods of payment.

1375.61. Termination of contract due to judgment by another state.

1375.7. Health Care Providers' Bill of Rights.

1375.8. Written request by provider to assume financial risk allowed when negotiating initial contract or renewing existing contract.

1375.9. Health care service plan; Primary care physician to enrollee ratios.

1376. Rules and regulations; Surety bond.

1376.1. Exemption of county or city plan from deposit requirements related to financial responsibility.

1377. Reserves or insurance to be maintained by certain plans for payments to subscribers or providers.

1378. Administrative costs.

1379. Contracts with health care providers.

1379.5. Contract between plan and health care provider who provides health care services in Mexico; Requirements; Plan's obligations.

1380. Surveys of health delivery systems.

1380.1. Legislative findings and declarations; Standards for uniform medical quality audit system.

1380.3. Coordination of surveys.

1381. Records; Location and inspection.

1382. Examinations of fiscal and administrative affairs of plans.

1383. Annual report to department.

1383.1. Policy on second medical opinion.

1383.15. Second opinion.

1384. Audit reports and financial statements.

1385. Books of account.

HISTORY: Added Stats 1975 ch 941 § 2, operative July 1, 1976.

§ 1375. [Section repealed 1978.]

HISTORY:

Added Stats 1975 ch 941 § 2, operative July 1, 1976. Amended Stats 1976 ch 652 § 3.2, effective August 28, 1976, operative July 1,

1976; Stats 1977 ch 818 § 11, effective September 16, 1977. Repealed Stats 1978 ch 285 § 6, effective June 23, 1978. The repealed section related to subsequent provider of services.