§ 1374.195. Covered dental services; Contracts; Charge for services; Evidence of coverage and disclosure form; Required statement

(a) With respect to a contract between a health care service plan or specialized health care service plan and a dentist to provide covered dental services to enrollees of the plan, the contract shall not require a dentist to accept an amount set by the plan as payment for dental care services provided to an enrollee that are not covered services under the enrollee's plan contract. This subdivision shall only apply to provider contracts issued, amended, or renewed on or after January 1, 2011.

(b) A provider shall not charge more for dental services that are not covered services under a plan contract than his or her usual and customary rate for those services. The department shall not be required to enforce this subdivision.

(c) The evidence of coverage and disclosure form, or combined evidence of coverage and disclosure form, for every health care service plan contract covering dental services, or specialized health care service plan contract covering dental services, that is issued, amended, or renewed on or after July 1, 2011, shall include the following statement:

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at [insert appropriate telephone number] or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

(d) For purposes of this section, "covered services" or "covered dental services" means dental care services for which the plan is obligated to pay pursuant to an enrollee's plan contract, or for which the plan would be obligated to pay pursuant to an enrollee's plan contract but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, or alternative benefit payments.

HISTORY:
Added Stats 2010 ch 673 § 1 (AB 2275), effective January 1, 2011.

§ 1374.196. Establishment and maintenance of application programming interfaces

(a) Commencing January 1, 2024, to facilitate patient and provider access to health information, a health care service plan shall establish and maintain the following application programming interfaces (API) for the benefit of enrollees and contracted providers, as applicable:

(1) Patient access API, as described in Section 422.119 (a) to (e), inclusive, of Title 42 of the Code of Federal Regulations.

(2) Provider directory API, as described in Section 422.120 of Title 42 of the Code of Federal Regulations.

(3) Payer-to-payer exchange API, as described in Section 422.119(f) of Title 42 of the Code of Federal Regulations.

(b) In addition to the API described in subdivision (a), the department may require a health care service plan to establish and maintain the following API if and when final rules are published by the federal government:

(1) Provider access API.

(2) Prior authorization support API.

(c) API described in subdivision (b) shall be in accordance with standards published in a final rule issued by the federal Centers for Medicare and Medicaid Services and published in the Federal Register, and shall align with federal effective dates, including enforcement delays and suspensions, issued by the federal Centers for Medicare and Medicaid Services.

(d) This section does not limit existing requirements under this chapter, including, but not limited to, Section 1367.27.

HISTORY:
Added Stats 2022 ch 888 § 1 (SB 1419), effective January 1, 2023.

§ 1374.197. Verification of health care provider credentialing application by health care service plan or disability insurer

(a) For provider contracts issued, amended, or renewed on and after January 1, 2023, a health care service plan that provides coverage for mental health and substance use disorders and that credentials health care providers of those services for its networks shall assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application. Upon receipt of the application by the credentialing department, the health care service plan shall notify the applicant within seven business days, to verify receipt and inform the applicant whether the application is complete. The 60-day timeline shall apply only to the credentialing process and does not include contracting completion.

(b) For the purposes of this section, "mental health and substance use disorder" and "health care provider" have the same meanings as defined in Section 1374.72.

HISTORY:
Added Stats 2022 ch 533 § 1 (AB 2581), effective January 1, 2023.

ARTICLE 5.5

Health Care Service Plan Coverage Contract Changes

Section

HISTORY: Added Stats 1990 ch 949 § 1. The heading of Article 5.5, which formerly read, "Health Care Service Plan Coverage Contract Notification," amended to read as above by Stats 2002 ch 336 § 2 (AB 2052).