

**ATTACHMENT 6: HEALTHY FAMILIES BENEFIT  
PACKAGE AND COPAYMENTS**

## Healthy Families Benefit Package and Copayments

### Overview of the Comprehensive Healthy Families Benefit Package

California plans to have a comprehensive, coordinated benefit package for its Healthy Families enrollees. The central component is the health plan benefits under the benchmark coverage, CalPERS, the state employee benefit package. The benchmark plan will be augmented with comprehensive dental and vision benefits. Furthermore, the coordinated benefit package includes screening and initial treatment services provided through the CHDP program. Services needed by “special needs” children, but not provided by health plans, will be provided through a specialized delivery system under the CCS program. Mental health services provided to severely emotionally disabled children will be provided through the county mental health departments with referral and coordination with the health plans. This component is similar to the provisions of the Federal Balanced Budget Act which excluded severely ill children from mandatory enrollment in Medi-Cal managed care. California will also provide comprehensive benefits to targeted low-income children who are eligible for Medi-Cal or the Access for Infants and Mothers (AIM) program. AIM's health benefit package resembles the CalPERS benchmark plan while Medi-Cal's benefit package is consistent with coverage currently provided under the state's Title XIX plan.

### Healthy Families Insurance Component

#### *Purchasing pool health benefits.*

California will use the state employees health benefit package - CalPERS - as the benchmark plan under Title XXI. The basic scope of benefits offered by participating health plans will include all of the benefits and services listed in this section, subject to the identified exclusions. No other benefits will be permitted to be offered by a participating health plan as part of the program. There will be no annual or lifetime financial benefit maximums for any health benefits covered. The basic scope of benefits includes:

- Health Facilities
  - Inpatient Hospital Services: General hospital services, in a room of two or more, with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. Includes all medically necessary ancillary services such as: use of operating room and related facilities; intensive care unit and services; drugs, medications, and biologicals; anesthesia and oxygen; diagnostic laboratory and x-ray services; special duty nursing as medically necessary; physical, occupational, and speech therapy (subject to visit limitations under the Physical/Occupational/Speech Therapy benefit), respiratory therapy;

administration of blood and blood products; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of such continuing care as may be necessary.

Includes inpatient hospital services in connection with dental procedures when hospitalization is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. Excludes services of the dentist or oral surgeon .

Excludes: Personal or comfort items or a private room in a hospital unless medically necessary.

- Outpatient Services: Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility. Includes: physical, occupational, and speech therapy as appropriate; and those hospital services which can reasonably be provided on an ambulatory basis. Includes related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the subscriber's stay at the facility.

Includes outpatient services in connection with dental procedures when the use of a hospital or outpatient facility is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. Excludes services of the dentist or oral surgeon.

- Professional Services: Medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. Includes surgery, assistant surgery and anesthesia (inpatient or outpatient); inpatient hospital and skilled nursing facility visits; professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment; and home visits when medically necessary.
- Hearing tests and eye examinations, including eye refractions to determine the need for corrective lenses, and dilated retinal eye exams for the treatment of diabetes.
- Immunizations: Immunizations consistent with the most current Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics, and the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Immunizations required for travel as recommended by the US Public Health Services. Other

immunizations for adults as recommended by US Public Health Services. Immunizations, such as Hepatitis B, for subscribers at occupational risk as recommended by the Immunizations Practice Committee, US Public Health Services.

- Periodic health examinations; including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics; and the current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.

The frequency of such examinations shall not be increased for reasons which are not related to the medical needs including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

- Well baby care: Care up to the age of 24 months, including newborn hospital visits, health examinations and other office visits.
- Diagnostic X-ray and Laboratory Services: Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services, which shall include, but not be limited to, electrocardiography, electro-encephalography, and mammography for screening or diagnostic purposes.

Includes laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).

- Prescription Drugs: Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes injectable medication (including insulin), needles and syringes necessary for the administration of the covered injectable medication, blood glucose testing strips in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes, ketone urine testing strips for type I diabetes, and lancets. Also includes prenatal vitamins and vitamins with fluoride which require a physician's prescription.

Includes laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).

Medically necessary drugs administered while a subscriber is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when provided through a participating pharmacy.

Health plans may specify that generic equivalent prescription drugs must be dispensed if available, provided that no medical contraindications exist. The Program encourages formulary, maximum allowable cost (MAC), and mail order programs.

Coverage must be provided for one cycle or course of treatment of smoking cessation drugs per benefit year. The health plan must also require the member to attend smoking cessation classes or programs in conjunction with the use of smoking cessation drugs.

Contraceptive Drugs and Devices: Oral and injectable contraceptive drugs are covered including internally implanted time release contraceptives such as Norplant. Contraceptive devices such as diaphragms are covered.

Excludes: Experimental or investigational drugs, unless accepted for use by the standards of the medical community; drugs or medications for cosmetic purposes; patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc.; or medicines not requiring a written prescription order (except insulin); and dietary supplements, appetite suppressants or any other diet drugs or medications.

- Durable Medical Equipment: Medical equipment appropriate for use in the home which: 1) is intended for repeated use; 2) is generally not useful to a person in the absence of illness or injury; and 3) primarily serves a medical purpose. Rental or purchase as determined by the plan for standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Includes oxygen and oxygen equipment, blood glucose monitors, and apnea monitors, insulin pumps and all related necessary supplies, ostomy bags and urinary catheters and supplies consistent with Medicare coverage guidelines.

Excludes coverage for comfort or convenience items; disposable supplies except ostomy bags and urinary catheters and supplies consistent with Medicare coverage guidelines; exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment; or more than one piece of equipment that serves the same function.

Orthotics and prosthetics are covered, including medically necessary replacement prosthetic devices as prescribed by a physician, and medically necessary replacement orthotic devices when prescribed by a physician or ordered by a licensed health care provider acting within the scope of his or her license. Includes coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetics consistent with Medicare coverage guidelines.

Excludes: Corrective shoes and arch supports, except for therapeutic footwear for diabetics consistent with Medicare coverage guidelines; non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts; dental appliances; electronic voice producing machines; or more than one device for the same part of the body.

Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Also one pair of conventional eyeglasses or conventional contact lenses are covered if necessary after cataract surgery with insertion of an intraocular lens. The benefit shall be consistent with Medicare coverage guidelines.

- Maternity Care: Medically necessary professional and hospital services relating to maternity care including: pre-natal and post-natal care and complications of pregnancy; newborn examinations and nursery care while the mother is hospitalized.
- Family Planning: Voluntary family planning services including counseling, surgical procedures for sterilization, and the provision of diaphragms and other contraceptive devices. Contraceptive drugs are covered under the prescription drug benefit.
- Medical Transportation Services: Emergency ambulance transportation in connection with life threatening emergency services to the first hospital or urgent care center which actually accepts the subscriber for emergency care.

Non-emergency ambulance transportation for the transfer of a subscriber from a hospital to another hospital or facility or facility to home when:

- medically necessary, and
- requested by a plan provider, and
- authorized in advance by the participating health plan.

Excludes: Coverage for transportation by airplane, passenger car, taxi or other form of public conveyance.

- Emergency Health Care Services: Twenty-four hour emergency care for alleviation of sudden, serious and unexpected illness, injury or condition requiring immediate diagnosis and treatment both in and out of health plan service area.
- Mental Health
  - Inpatient: Mental health care when ordered and performed by a participating mental health professional for the treatment of an acute phase of a mental health condition during a certified confinement in a participating hospital. Limit of 30 days per benefit year. Participating health plans may substitute two days of day

care for one day of hospitalization, or three or four outpatient visits for one day of hospitalization at their discretion. Plans may provide a mechanism for inpatient hospital care provided under the Mental Health benefit through which applicants may agree to a treatment plan in which each inpatient day may be substituted for two residential treatment days or three day treatment program days.

- Outpatient: Mental health care when ordered and performed by a participating mental health professional. Mental health services are limited to evaluation, crisis intervention, and treatment for conditions which are subject to significant improvement through relatively short term therapy. Up to 20 visits per benefit year. Participating health plans may elect to provide additional visits at their option.

Excludes: Services for conditions not subject to significant improvement through relatively short-term therapy including chronic psychosis, chronic brain syndrome, intractable personality disorder and mental retardation.

- Alcohol and Drug Abuse:

- Inpatient: Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system.
- Outpatient: Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate. Up to 20 visits per benefit year. Participating health plans may elect to provide additional visits at their option.

- Home Health Services: Health services provided at the home by health care personnel. Includes visits by RNs, LVNs, home health aides and short term physical, occupational and speech therapy (subject to visit limitations under the Physical/ Occupational/ Speech Therapy benefit); and respiratory therapy when prescribed by a plan physician.

Home health services are limited to those services that are prescribed or directed by the responsible physician or other authority designated by the plan. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the plan to choose the setting for providing the care. Plans should exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost-effective when there is a choice among several medically appropriate alternative services or settings.

Excludes: Custodial care and long term physical therapy and rehabilitation.

- Skilled Nursing Care: Services prescribed by a plan physician and provided in a licensed skilled nursing facility when medically necessary. Includes: skilled nursing on a 24-hour per day basis; bed and board; x-ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy (subject to visit limitations under the Physical/Occupational/ Speech Therapy benefit); medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. Limited to a maximum of 100 days per benefit year.

Excludes: Custodial care.

- Physical, Occupational, and Speech Therapy: May be provided in medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. Limited to short-term therapy for a period not exceeding 60 consecutive calendar days per condition following the date of the first therapy session. Plans must provide additional therapy beyond the 60 days if medically necessary and if the condition will improve significantly.
- Acupuncture and Chiropractic: Optional benefits which plans may offer. If offered, the plan must provide a self referral benefit, and cannot require referral from a primary care or other physician or health professional. Limited to a maximum of 20 visits each per benefit year for acupuncture and chiropractic.
- Biofeedback: Optional benefit which plans may offer.
- Hearing Aids and Services: Audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Includes visits for fitting, counseling, adjustments, repairs, etc. at no charge for a one year period following the provision of a covered hearing aid.

Excludes: The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss. Excludes replacement parts for hearing aids, repair of a hearing aid after the covered one year warranty period, and replacement of a hearing aid more than once in any period of thirty-six months. Also excludes surgically implanted hearing devices.

- Blood and Blood Products: Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood.

- Health Education: Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.
- Hospice: The hospice benefit shall include: nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services. The benefit shall also include: physical therapy, occupational therapy, speech therapy, and short-term inpatient care for pain control and symptom management.

The benefit may include, at the option of the health plan: homemaker services, services of volunteers, and short-term inpatient respite care.

The hospice benefit is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of six months or less and who elect hospice care for such illness instead of the restorative services covered by the plan.

Individuals who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. The hospice election may be revoked at any time.

- Transplants: Coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational in nature. Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a subscriber.

Charges for testing of relatives for matching bone marrow transplants are covered. Charges associated with the search and testing of unrelated bone marrow donors through a recognized Donor Registry and charges associated with the procurement of donor organs through a recognized Donor Transplant Bank are covered.

- Any other or enhanced benefits required in Section 1300.67 of Title 10 of the California Code of Regulations.

Excluded Health Benefits. Health benefit plans offered under this program exclude all of the following:

- Any services or items specified as excluded in the basic scope of benefits.
- Any benefits in excess of limits specified in the basic scope of benefits.
- Services, supplies, items, procedures or equipment, which are not medically necessary, unless otherwise specified in the basic scope of benefits.

- Any services which are received prior to the subscriber's effective date of coverage except those covered through the CHDP retroactive enrollment.
- Those medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are either:
  - Experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, or
  - Outmoded or not efficacious.
- Emergency facility services for non-emergency conditions.
- Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery.
- Treatment for infertility. Infertility is defined as a diminished or absent ability to conceive, and subsequently produce, offspring after unprotected sexual relations on a regular basis in excess of a period of twelve months. This section does not exclude treatments of medical conditions of the reproductive system.
- Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except as a participating health plan shall determine they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided in the basic scope of benefits.
- Conditions resulting from acts of war (declared or not).
- Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any Worker's Compensation benefit plan.
- Services which are eligible for reimbursement by insurance or reimbursable under any other group or health service plans. The participating health plan shall provide the services at the time of need, but the subscriber or applicant shall execute such documents as necessary to assure that the participating health plan is reimbursed for such benefits.

Enrollee Share of Cost for Health Benefits. Enrollees in the purchasing pool are subject to the following cost-sharing rules:

- In any benefit year that the applicant has paid \$250 in health benefit copayments for services received by subscribers for whom the applicant applied to the program on behalf of, the children shall be deemed to have met the copayment maximum.
- No deductibles shall be charged to subscribers for health benefits.
- The following specific copayments shall apply:
  - Inpatient facility services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility: No copayment.
  - Inpatient professional services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility: No copayment.
  - Facility services on an outpatient basis: No copayment, except for a \$5 copayment per visit for Emergency Health Care Services.
  - Outpatient professional services: \$5 copayment per office or home visit. No copayment for surgery or anesthesia; radiation, chemotherapy, or dialysis treatments.
  - Outpatient mental health: \$5 copayment per visit. Participating health plans may provide mental health group therapy at a reduced copayment.
  - Home health care: No copayment except for \$5 per visit for physical, occupational, and speech therapy visits performed in the home.
  - Alcohol and drug abuse: No copayment for inpatient services. \$5 per visit for outpatient services.
  - Hospice: No copayment for any services provided under this benefit.
  - Transplants: No copayment for any services provided under this benefit.
  - Physical, occupational, and speech therapy: No copayment for therapy performed on an inpatient basis. \$5 copayment per visit for therapy performed on an outpatient basis.
  - Biofeedback, acupuncture, and chiropractic visits, when offered at the participating health plan's option: \$5 copayment per visit.

- Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services; durable medical equipment, prosthetics and orthotics; blood and blood products; medical transportation services: No copayment.
- Hearing Aids: No copayment.
- Prescription Drugs: No copayment for prescription drugs provided in an inpatient setting, or for drugs administered in the doctor's office or in an outpatient facility setting during the subscriber's stay at the facility. \$5 per prescription for up to a 30-34 day supply for brand name or generic drugs, including smoking cessation drugs.

Maintenance drugs, including oral and injectable contraceptives: \$5 per 90-100 day supply either through a participating health plans participating pharmacies or through its mail order program. Maintenance drugs are drugs that are prescribed for 60 days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

Norplant - \$100 copayment. No refund if medication is removed.

Contraceptive devices - \$5 copayment per device.

- Preventive services, including services for the detection of asymptomatic diseases, as defined by Title 10, Section 1300.67 (f) of the California Code of Regulations, shall be provided with no copayment. These include:
  - Periodic health exams;
  - A variety of voluntary family planning services;
  - Prenatal care;
  - Vision and hearing testing for persons through age 16;
  - Immunizations;
  - Venereal disease tests;
  - Cytology examinations on a reasonable periodic basis; and

- Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the participating health plan or health care organizations affiliated with the participating health plan.
- No copayment shall be charged to subscribers under 24 months of age for well baby care, health examinations and other office visits.

*Purchasing Credit Coverage.*

Health benefits provided under the insurance purchasing credit will have at least 95% actuarial equivalence to the benefits available to subscribers through the purchasing pool (exclusive of dental and vision) and the coverage can cost the family no more than coverage through the pool. The determination of actuarial equivalence will be made by an actuary under contract to the MRMIB who is certified by the American Academy of Actuaries. Health plan's actuaries will be consulted during the actuarial equivalence evaluation. Where the dependent coverage available to an employee has less than 95% actuarial equivalence, the program will provide the employee with supplemental coverage to adjust the coverage to at least the 95% level. The supplemental coverage will adjust cost-sharing levels if an adjustment is necessary to assure that cost-sharing levels are equivalent to those charged through the purchasing pool. Dental and vision coverage will be provided through the purchasing pool.

*Dental Benefit Package*

The basic scope of benefits offered by a participating dental plan shall include all of the benefits and services listed in this section, subject to the identified exclusions. The covered dental benefit is limited to the benefit level for the least costly dentally appropriate alternative. If a more costly, optional alternative is chosen by the applicant, the applicant will be responsible for all charges in excess of the covered dental benefit. Participating dental plans may not subject enrollees to waiting periods for receipt of specified benefits.

No other dental benefits shall be permitted to be offered by a participating dental plan as part of the program. The basic scope of dental benefits shall be as follows:

- Diagnostic and Preventive Benefits
  - Initial and periodic oral examinations.
  - Consultations, including specialist consultations.

- Roentgenology, limited as follows:
  - Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
  - Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.
  - Panoramic film x-rays are limited to once every 24 consecutive months.
- Prophylaxis services, limited as follows:
  - Not to exceed two in a twelve month period.
- Topical fluoride treatment.
- Dental sealant treatments, limited as follows:
  - Permanent first and second molars only.
- Space maintainers, including removable acrylic and fixed band type.
- Preventive dental education and oral hygiene instruction.
- Restorative Dentistry
  - Restorations, limited as follows:
    - Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.
    - Composite resin or acrylic restorations in posterior teeth are optional.
    - Micro filled resin restorations which are non-cosmetic.
    - Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

- Use of pins and pin build-up in conjunction with a restoration.
- Sedative base and sedative fillings.
- Oral Surgery
  - Extractions, including surgical extractions
  - Removal of impacted teeth, limited as follows:
    - Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
  - Biopsy of oral tissues
  - Alveolectomies
  - Excision of cysts and neoplasms
  - Treatment of palatal torus
  - Treatment of mandibular torus
  - Frenectomy
  - Incision and drainage of abscesses.
  - Post-operative services including exams, suture removal and treatment of complications.
  - Root recovery (separate procedure).
- Endodontics
  - Direct pulp capping
  - Pulpotomy and vital pulpotomy
  - Apexification filling with calcium hydroxide
  - Root amputation

- Root canal therapy, including culture canal, limited as follows:
  - Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.
- Apicoectomy
- Vitality tests
- Periodontics
  - Emergency treatment, including treatment for periodontal abscess and acute periodontitis.
  - Periodontal scaling and root planing, and subgingival curettage, limited as follows:
    - Five quadrant treatments in any 12 consecutive months.
  - Gingivectomy
  - Osseous or muco-gingival surgery
- Crowns and Fixed Bridges
  - Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:
    - Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the dental plan.
    - Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.

- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:
  - Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
  - A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a subscriber under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
  - Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
  - Fixed bridges are optional when provided in connection with a partial denture on the same arch.
  - Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
- The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction which is optional treatment.
- Recementation of crowns, bridges, inlays and onlays.
- Cast post and core, including cast retention under crowns.
- Repair or replacement of crowns, abutments or pontics.

- Removable Prosthetics
  - Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:
    - Partial dentures are not to be replaced within 36 consecutive months, unless:
      - . It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
      - . The denture is unsatisfactory and cannot be made satisfactory
    - The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.
    - A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
    - Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by relines or repair.
    - The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges.
  - Office or laboratory relines or rebases, limited as follows:
    - One per arch in any 12 consecutive months.
  - Denture repair
  - Denture adjustment.
  - Tissue conditioning, limited to two per denture.
  - Denture duplication.

- Implants are considered an optional benefit.
- Stayplates, limited as follows:
  - Stayplates are a benefit only when used as anterior space maintainers for children and to replace extracted anterior teeth for adults during a healing period.
- Orthodontic Treatment, limited as follows:
  - Orthodontic treatment shall only be a benefit when it is determined to be medically necessary according to Medi-Cal guidelines. The orthodontic benefit shall include all benefits required under Medi-Cal.
- Other Dental Benefits
  - Local anesthetics.
  - Emergency treatment, palliative treatment.

Excluded Dental Benefits. The following benefits will be excluded from coverage:

- Services which, in the opinion of the attending dentist, are not necessary to the subscriber's or purchasing credit member's dental health.
- Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in the scope of benefits.
- Cosmetic dental care.
- General anesthesia or intravenous/conscious sedation and the services of a special anesthesiologist.
- Experimental procedures.
- Dental conditions arising out of and due to a subscribers employment or for which Worker's Compensation is payable.
- Services which are provided without cost to the subscriber by State government or an agency thereof, or any municipality, county or other subdivisions.
- Treatment required by reason of war.

- Hospital charges of any kind.
- Major surgery for fractures and dislocations.
- Loss or theft of dentures or bridgework.
- Dental expenses incurred in connection with any dental procedures started after termination of coverage.
- Any service that is not specifically listed as a covered benefit.
- Malignancies.
- Dispensing of drugs not normally supplied in a dental office.
- Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the subscriber.
- The cost of precious metals used in any form of dental benefits.
- The removal of implants.
- Services of a pedodontist for children under six years of age unless they are unable to be treated by their panel provider or unless their panel provider is a pedodontist.
- Services which are eligible for reimbursement by insurance or reimbursable under any other group or health service plans. The participating dental plan shall provide the services at the time of need, but the subscriber or applicant shall execute such documents as necessary to assure that the participating dental plan is reimbursed for such benefits.

Enrollee Share of Cost for Dental Benefits. Every participating dental health plan will change copayments for the dental benefits listed in the scope of benefits, as follows:

- No copayments shall be charged for benefits listed under Diagnostic and Preventive Benefits.
- No copayments shall be charged for benefits listed under Restorative Dentistry, with the following exceptions:
  - Micro filled resin restorations (non-cosmetic, acid etched, bonded, light cured):
    - One surface --\$40

- Two or more surfaces -- \$65
- No copayments shall be charged for benefits listed under Oral Surgery, with the following exceptions:
  - Removal of impacted teeth is subject to a copayment per tooth as follows:
    - Soft tissue impaction -- No copayment.
    - Partially bony impaction -- \$15 copayment per tooth.
    - Completely bony impaction -- \$15 copayment per tooth.
  - Root recovery as a separate procedure -- \$5 per root.
- No copayments shall be charged for benefits listed under Endodontics, with the following exceptions:
  - Root canal therapy is subject to copayments as follows:
    - Single root canal--\$20
    - Bi-root canal--\$40
    - Tri-root canal --\$60
    - Quad-root canal --\$80
  - An apicoectomy performed in conjunction with root canal therapy is subject to a copayment of \$60 per canal. When performed as a separate procedure, an apicoectomy is subject to a copayment of \$50 per canal.
- No copayments shall be charged for benefits listed under Periodontics, with the following exceptions:
  - Osseous or muco-gingival surgery is subject to a copayment of \$150 per quadrant.
  - Gingivectomy is not subject to a copayment by quadrant or by tooth.
- No copayments shall be charged for benefits listed under Crowns and Fixed Bridges, with the following exceptions:

- Porcelain crowns; porcelain fused to metal crowns; full metal crowns; and gold onlays or 3/4 crowns; are each subject to a copayment of \$50.
- Pontics: Tru-pontic type; cast (sanitary); and porcelain baked with metal; are each subject to a copayment of \$50. No copayment shall be charged for pontics made of plastic processed to gold.
- No copayments shall be charged for benefits listed under Removable Prosthetics, with the following exceptions:
  - Dentures are subject to copayments as follows:
    - Complete maxillary denture --\$65.
    - Complete mandibular dentures -- \$65.
    - Partial acrylic upper or lower dentures with clasps--\$65.
    - Partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles -\$65.
    - Removable unilateral partial denture -- \$50.
  - Reline for an upper, lower or partial denture is subject to a copayment per unit as follows:
    - Office reline -- No copayment.
    - Laboratory reline --\$15.
  - Denture duplication-- \$20.
- No copayments shall be charged for benefits listed under Orthodontia.
- No copayments shall be charged for benefits listed under Other.
- The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.
- Notwithstanding any other provision in this section, an alternative copayment shall apply under the following circumstances: For children under six years of age, who are unable to be treated by their panel provider, and who have been referred to a pedodontist, the copayment is equal to 50% of the pedodontist's fee.

- A fee of \$5 shall be charged for failure to cancel an appointment with 24 hours prior notification.

### *Vision Benefit Package*

The basic scope of benefits offered by a participating vision plan as a vision benefit plan shall include all of the benefits and services listed in this section, subject to the identified exclusions. No other vision benefits shall be permitted to be offered by a participating vision plan as part of the program. The basic scope of vision benefits shall be as follows:

- Examinations: Each subscriber or purchasing credit member shall be entitled to a comprehensive vision examination, including a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities as follows:
  - Case history: Review of subscriber's or purchasing credit member's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.
  - Evaluation of the health status of the visual system; including:
    - External and internal examination, including direct and/or indirect ophthalmoscopy;
    - Assessment of neurological integrity, including that of pupillary reflexes and extraocular muscles;
    - Biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes;
    - Screening of gross visual fields; and
    - Pressure testing through tonometry.
  - Evaluation of refractive status, including:
    - Evaluation for visual acuity;
    - Evaluation of subjective, refractive, and accommodative function; and
    - Objective testing of a patient's prescription through retinoscopy.

- Binocular function test.
- Diagnosis and treatment plan, if needed.
- Examinations are limited to once each twelve month period, which begins with the date of the last exam.
- When the vision examination indicates that corrective lenses are necessary, each subscriber or purchasing credit member is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, and lenticular lenses as appropriate.

Frames and lenses are limited to once each twelve month period, which begins with the date of the last exam.

- Contact lenses shall be covered as follows:
  - Necessary contact lenses shall be covered in full upon prior authorization from the vision plan, for the following conditions:
    - Following cataract surgery;
    - To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
    - Certain conditions of Anisometropia; and
    - Keratoconus.
  - Elective contact lenses may be chosen instead of corrective lenses and a frame at an alternative copayment level.
  - Contact lenses are limited to once each twelve month period, which begins with the date of the last exam.
- A low vision benefit shall be provided to subscribers or purchasing credit members who have severe visual problems that are not correctable with regular lenses. This benefit requires prior approval from the participating vision plan. With this prior approval, supplementary testing and supplemental care, including low vision therapy as visually necessary or appropriate, shall be provided.

The maximum benefit available to a subscriber or purchasing credit member for low vision benefits is \$1,000 (excluding any copayment) in each two year period.

Excluded Vision Benefits. A vision benefits plan offered under this program shall exclude:

- Benefits which are neither necessary nor appropriate.
- Benefits which are not obtained in compliance with the rules and policies of the subscriber's or purchasing credit member's vision plan.
- Vision training.
- Aniseikonic lenses.
- Plano lenses.
- Two pairs of glasses in lieu of bifocals, unless medically necessary and with the prior authorization of the vision plan.
- Replacement or repair of lost or broken lenses or frames.
- Medical or surgical treatment of the eyes.
- Services or materials for which the subscriber or purchasing credit member is covered under a Worker's Compensation policy.
- Eye examinations required as a condition of employment.
- Services or materials provided by any other group benefit providing for vision care.

Share of Cost for Vision Benefits. A participating vision plan shall require copayments for benefits provided to subscribers or purchasing credit members utilizing the services of the vision plan's panel of approved providers subject to the following:

- Examinations: \$10 copayment per examination.
- Frames and lenses: \$25 copayment, for frames with lenses, frames or lenses.

A wholesale frame allowance of \$30 will be provided by the vision plan. If a subscriber or purchasing credit member chooses a frame with a wholesale value above \$30, the provider will bill the subscriber or purchasing credit member the difference between the standard retail value of \$75 for a \$30 wholesale frame and the retail cost of the frame the subscriber or purchasing credit member has selected.

The following options are considered cosmetic and any costs associated with the selection of these options will be the financial responsibility of the applicant.

- Blended lenses (bifocals which do not have a visible dividing line);
  - Contact lenses except as specified in the scope of benefits;
  - Oversized lenses (larger than standard lens blank to accommodate prescriptions);
  - Progressive multifocal lenses;
  - Coated or laminated lenses;
  - UV protected lenses.
  - Other optional cosmetic processes.
- Necessary contact lenses, as defined in the scope of benefits: no copayment.
  - Elective contact lenses: an allowance of \$110 will be provided by the vision plan toward the cost of an examination, contact lens evaluation, fitting costs and materials. This allowance will be in lieu of all benefits including examination and material costs. The subscriber is responsible for any costs exceeding this allowance.
  - Low vision benefits:
    - Supplementary testing: No copayment; and
    - Supplemental care: Copayment is 25% of the cost.
  - Services from providers not included in the vision plan's panel of approved providers:

When a subscriber or purchasing credit member obtains services from a provider not included in the vision plan's panel of approved providers, the applicant will be responsible for paying the provider for all services and materials received at the time of their appointment. The participating vision plan will reimburse the applicant within fourteen days after receipt of the paid itemized bill or statement, when accompanied by the benefit form, according to the schedule of allowances as follows:

- Professional fees:
  - Vision exams, up to \$35.00

- Materials:
  - Each single vision lens, up to \$12.50
  - Each bifocal lens, up to \$20.00
  - Each trifocal lens, up to \$25.00
  - Each lenticular lens, up to \$50.00
  - Frame, up to \$40.00
  - Tint allowance, up to \$5.00
  - Each pair necessary contact lenses, up to \$250.00
  - Each pair elective contact lenses, up to \$110.00
- Low vision benefits: Low vision benefits obtained from a provider not included in the vision plan's panel of approved providers will be reimbursed in accordance with what the participating vision plan would pay a provider included in the vision plan's panel of approved providers for this benefit.

### **Child Health and Disability Prevention**

*CHDP Coverage.* The Child Health & Disability Prevention Program (CHDP) provides preventive health screens and immunizations to children. CHDP providers will be screening children for potential eligibility for either Medicaid or Healthy Families. The providers will refer children's families to the appropriate program and will be authorized to provide initial treatment for conditions identified in health screens for a period of 30 days. Healthy Families will reimburse CHDP providers for the screen and initial treatment to the extent that these services were provided to a child who becomes enrolled in the Healthy Families program, were provided within 30 days of enrollment and were initial treatment of a condition identified in the screen. These services will not be subject to copayment. CHDP program scope of services includes all of the following:

- History and Physical Examination by Comprehensive Care Provider
  - New Patient - child who has not previously received a health assessment from the examiner, and there is no health assessment record for the child established with the provider.

- Extended Visit - a visit in which the patient requires as much or more time to be given a health assessment as does a new patient.
- Routine Visit - a visit in which the patient requires less time than ordinarily needed with a new patient or an extended visit.
- Health and developmental history
- Assessment of nutritional status
- Unclothed physical examination including assessment of physical growth
- Pelvic Exam
- Vision Screening:  
Snellen eye test or equivalent visual acuity test
- Hearing Screening:  
Pure Tone Audiometry
- Tuberculin Testing:  
Mantoux
- Laboratory Tests:  
Hematocrit or Hemoglobin  
Sickle Cell Status (Electrophoresis)  
Blood Lead Screening  
Urinalysis, routine, complete or Urine "Dipstick"  
Culture for Neisseria Gonorrhoea  
Papanicolaou (Pap) Smear  
Ova and Parasites, direct smears, concentration and identification  
Venereal disease research laboratories (VDRL), rapid plasma reagin (RPR), and automated reagin test (ART)  
Chlamydia Test
- Immunizations:  
DTP (diphtheria and tetanus toxoid with pertussis vaccine)  
DT (combined tetanus and diphtheria toxoid, pediatric type)

Td (combined tetanus and diphtheria toxoid, adult type)  
Hib (Haemophilus Influenza Type b) vaccine  
Polio: IPV (inactivated trivalent poliovirus vaccine)  
TOPV (trivalent oral poliovirus vaccine)  
Measles vaccine  
Rubella vaccine  
MMR (measles, mumps, rubella) vaccine  
HBIG (hepatitis B immune globulin) for post-exposure  
Hepatitis B vaccine  
Varicella vaccine  
Hepatitis B/Haemophilus Influenza Type b vaccine  
DTaP (diphtheria and tetanus toxoid with acellular pertussis vaccine)  
DTaP/Haemophilus Influenza Type b vaccine  
DTP/Haemophilus Influenza Type b vaccine  
Pneumococcal vaccine  
Influenza vaccine

## **Specialized Services**

### *Mental Health Coverage for Emotionally Disturbed Youth*

Health plans will develop memoranda of understanding with county mental health departments for treatment of serious emotional disturbances. “Seriously emotionally disturbed children or adolescents” are minors who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child’s age according to expected developmental norms. Members of this target population meet one or more of the following criteria:

- As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
  - The child is at risk of removal from home or has already been removed from the home.
  - The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

- The child meets special education eligibility requirements under California law.

Seriously emotionally disturbed children or adolescents will have access to the following scope of benefits:

- *Acute Psychiatric Inpatient Hospital Services.* Services are provided by a hospital to beneficiaries who need facilities, services and equipment for diagnosis or treatment of a mental disorder. The determination of the need for acute care shall be made in accordance with existing law. An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.
- *Administrative Day Service.* Psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a lack of residential placement options at appropriate, non-acute treatment facilities.
- *Adult Residential Treatment Service.* Rehabilitative services, provided in a non-institutional residential setting, which provide a therapeutic community including a range of activities and services for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service is available 24 hours a day, seven days a week. Service activities may include assessment, plan development, therapy, rehabilitation and collateral.
- *Crisis Residential Treatment Service.* Therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program for beneficiaries as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care. The service supports beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.
- *Crisis Intervention.* A service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who are not eligible to deliver crisis stabilization or who are eligible, but deliver the service at a site other than a provider site that has been certified by the Department or a Mental Health Plan to provide crisis stabilization.

- *Crisis Stabilization.* A service lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis stabilization must be provided on site at a 24 hour health facility or hospital-based outpatient program or at other provider sites which have been certified by the Department or a Mental Health Plan to provide crisis stabilization services.
- *Day Rehabilitation.* A structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning consistent with requirements for learning and development which provides services to a distinct group of beneficiaries and is available at least three hours and less than twenty-four hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.
- *Day Treatment Intensive.* A structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting, with services available at least three hours and less than twenty-four hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.
- *Medication Support Services.* Those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.
- *Mental Health Services.* Those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the requirements for learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.
- *Psychiatric Health Facility Services.* Therapeutic and/or rehabilitative services provided in a non-hospital psychiatric health facility on an inpatient basis to beneficiaries who need acute care and whose physical health needs can be met in an affiliated hospital or in outpatient settings. The determination of the need for acute care shall be made in accordance with Section 1820.205. An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the psychiatric health facility.

- *Targeted Case Management.* Services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure a beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

### *California Children's Services*

The CCS benefit package provides those services that are medically necessary for the diagnosis or treatment of a CCS-eligible illness, injury or medical condition. Medically necessary services also include those services, in accord with accepted medical standards of practice, which promote optimum health and improve, maintain or prevent deterioration of function. The program does not provide long-term institutional care (e.g., nursing home facility, pediatric subacute facility) or long-term hourly nursing services in the home.

It requires children with long-term conditions to receive ongoing medical care at special care centers and reimburses those centers for the additional case coordination and staffing management required by CCS. CCS also pays for assisting a family in accessing medical care (transportation costs, meals and lodging). Scope of services includes all medically necessary diagnostic assessments, treatment, rehabilitation, and follow up care in addition to those case management and other services that are necessary for the treatment of the CCS eligible condition. The California Children Services Program provides the following services for children enrolled in the program:

- *Physician services.*
- *Inpatient/Outpatient hospital services.* Inpatient and outpatient hospital services are covered for the treatment of the condition including medical and surgical procedures and rehabilitative services.
- *Home health agency service provided by a licensed and certified Health Agency.* At a minimum, the following home and community services shall be provided:
  - *Licensed nursing care in the home.* Licensed nursing services provided at the child's place of residence shall be a benefit if there is a need, in the provision of services to the child, for a licensed nurse to:
    - Perform medical/nursing interventions which require the ability to interpret, evaluate, assess and monitor the child's response to interventions.
    - Identify and evaluate clinical changes which would result in significant ramifications for the child's medical condition, and initiate appropriate

- medical and/or nursing interventions.
- Analyze and respond to physiological changes found through monitoring various physiological parameters.
- Assess parent or other caregiver's ability to manage the child's medical needs in the home and develop a training plan for the caregivers.

These services are authorized on an intermittent basis, with visits lasting two hours or less when prescribed by the CCS authorized providers

- *Certified home health aide visits.* Services by a home health aide, provided through a home health agency under the supervision of a RN are a benefit when such services are clinically indicated to assist children enrolled in the Pilot Project with the following activities: personal hygiene, such as skin, mouth, hair care and bathing; ambulation; prescribed exercises; the use of the bathroom, commodes or bedpans; preparation of meals and the performance of household services which will facilitate the care in the home; and/or performance of other activities as outlined in the plan of care and taught by a health professional for a specific child or adolescent. Such services are required when they can not reasonably be expected to be performed by the child's caretaker because of the caretaker's illness, medical condition and/or recovery from injury.
- *Physical and occupational therapy.* Physical and occupational therapy services are a benefit in the home when clinically indicated and the instability of the child's medical condition prohibits the child from accessing those services through an outpatient medical facility, private practitioner's office or a CCS medical therapy unit.
- *Other licensed and non-licensed services.* Other licensed and nonlicensed services provided by a home health agency, including medical social services and home infusion therapy, are a benefit when the requested service(s) is to treat a child's medical condition, is requested by the CCS approved physician authorized to provide care, and can be provided safely in the child's place of residence.
- *Medical transportation.* The CCS Program provides emergency transportation by ground ambulance when it is needed to access medically necessary care in an emergency situation. CCS also provides emergency transportation by air ambulance when the enrolled child's condition requires rapid transport, when it is a reasonable alternative to ground transport (due to distance and/or time required) or when air transport is less costly.

CCS will provide non-emergency transport by ambulance or wheelchair van and litter van when there is documentation that the child's medical condition warrants the use of one of these types of transport rather than private car or public transportation. CCS will also

provide this method of transportation when an enrolled child is to be transferred from a tertiary care facility for inpatient care in a lower level facility in his/her own community or nearer to his/her community.

- *Second opinions.* CCS provides access to second opinions from CCS paneled specialty or sub-specialty providers.
- *Pediatric specialist services.* CCS provides pediatric specialist and sub-specialist services as required for the appropriate diagnosis and/or treatment of medical conditions.
- *Special care center (SCC) services.* CCS provides SCC services for those children whose medical condition and/or complicating conditions require referral to and treatment by a CCS approved SCC.

A CCS approved SCC provides a coordinated multi-disciplinary, multi-specialty team approach to the assessment and management of children with chronic, complex medical conditions. A center's core team includes a medical director (a specialist in treatment of medical conditions seen at the center), a nurse specialist, and a social worker. A team also frequently involves the consultation of a dietitian, as well as other appropriate pediatric medical and surgical specialists and sub-specialists.

The services provided by the centers include:

- Initial and periodic comprehensive outpatient evaluations by health care professionals on the center team.
- Diagnostic services when there is a need to establish the presence of a CCS eligible condition or the status of the eligible condition.
- Treatment services provided or requested by CCS-paneled physician team members to manage a child's CCS eligible condition. These can include pharmaceuticals, durable medical equipment, and medical supplies.
- Initial and periodic team conferences to coordinate decision making and health care services identified by team members as needed by the child.
- Outpatient laboratory and/or radiology services as ordered by the CCS-paneled physician team members.
- *Organ transplantation services.*
  - Heart, Lung, Heart/Lung, Liver, Small Bowel or Bone Marrow Transplants.

CCS refers children thought to require heart, lung, heart/lung, liver, small bowel, or bone marrow transplants to a Medi-Cal approved organ transplant center for the comprehensive evaluation of the need for the transplant. CCS will be responsible for the costs of this evaluation.

- DHS (CMS Branch) reviews and determine the medical eligibility for the ransplant;
- Coordinate pre and post transplant services; and
- Assists the family with necessary support services during the entire process.
- Renal and Corneal Transplants
  - Children requiring renal transplants will be referred to a CCS approved renal center for care and evaluation of the need for a transplant.
  - Children requiring corneal transplants will have that care provided under the direction of a CCS paneled ophthalmologist.
- *Pharmacy services.*
  - Licensed pharmaceuticals

CCS provides all drugs licensed by the Federal Food and Drug Administration that are necessary as part of the child's plan of treatment.
  - Investigational Drugs

CCS provides for providing for investigational new drugs on an inpatient/outpatient basis when there is documentation that the drug has the approval of the Federal Food and Drug Administration as a treatment investigational new drug.
  - Unlabeled Use of Drugs

CCS will authorize the un-labeled use of drugs when the requested unlabeled use represents reasonable and current prescribing practice, as determined by reference to current medical literature and consultation with provider organizations, academic and professional specialists and sub-specialists.
  - Over-the-counter medications

CCS provides over-the-counter medications when the dosage required to treat the CCS eligible condition exceeds normal dosages and/or length of use for the over-the-counter medication.

- Enteral/parenteral nutrition

CCS provides parenteral solutions, replacement formulas, calorie dense formulas and additives when they are required in the medical management of a CCS eligible condition or would otherwise be a Medi-Cal benefit, e.g., a child of normal height and weight with no increased caloric needs who is nourished by tube feeds only. (Also see Section 7.3. AC)

- Medical foods

CCS provides medical foods which are specifically formulated to be consumed or administered internally, purchasable only through a pharmacy, intended for the specific dietary management of a CCS eligible condition for which specific nutritional requirements exist, and where medical/health problems can occur by consuming regular foods available in the grocery store.

- *Dialysis.* CCS provides either hemodialysis or peritoneal dialysis, when it is medically necessary.
- *Durable medical equipment (Rehabilitative).* CCS provides standard and custom durable medical equipment required for mobility, community access and independence in the home environment. This equipment may include, but will not be limited to, tilt wheelchairs, power chairs, walkers, commodes, positioning equipment, custom wheelchairs, custom wheel chair seating, custom motorized wheelchair bases and batteries. All repairs, replacements due to growth and/or new technology, maintenance, family training and follow up on the use of the equipment are also covered by CCS.
- *Durable medical equipment (Medical).* CCS provides medical, including respiratory, equipment required for the treatment of the child's medical conditions in the home. Such equipment may include, but is not limited to, apnea monitors, glucometers, infusion pumps, kangaroo pumps, ventilators, suction machines, gaseous and/or liquid oxygen, specialty beds and mattresses. CCS provides emergency back up equipment, maintenance of the equipment and family training in the use of the equipment.
- *Medical supplies.* CCS will provide those supplies that are necessary for treatment of medical conditions within the home, including those supplies that are necessary for the administration of prescribed pharmaceuticals. The supplies shall include, but are not limited to, gauze pads, syringes, infusion sets, and catheters.

- *Incontinence supplies.* CCS will provide diapers when a child is under five years of age and the use of diapers is medically necessary and exceeds the normal use by a child of the same age; or, a child is five years of age and older and the diapers are medically necessary.
- *Prosthetics and orthotics.* CCS provides prosthetics and orthotics. Orthotics are those devices required to correct or prevent deformity, to replace a body function and/or for positioning. Prosthetics are those devices utilized to replace or enhance a body part or function. These items shall include, but are not limited to, dynamic splints, shoes, braces, artificial arms and legs.

CCS arranges for orthotics repairs, adjustments and/or replacements necessary for growth or new technology; usage training, as well as routine clinical check ups by appropriate clinicians.

- *Augmentative and alternative communication devices.* CCS is responsible for providing electronic or non-electronic aids, devices, or systems (in a form most appropriate for the child) that correct an expressive communication disability that precludes effective communication and precludes meaningful participation in daily activities. CCS provides an assessment by a CCS-paneled speech/language pathologist, in conjunction with either an occupational or physical therapist, to determine the necessity and appropriateness of a device. In addition, speech therapy is provided after delivery of the device.

CCS provides the necessary components, including computer software programs, symbol sets, overlays, mounting devices, switches, cables, connectors and output devices, supplies, training in the use of the device and device repair, and modification.

- *Vision services.* CCS provides eye examinations when required for a CCS-eligible, medical condition including refraction, eyeglasses, contact lenses, low vision aids, prosthetic eyes and other eye appliances. Shatter resistant eyewear will be provided when there is absence of vision in one eye or one eye is absent.

- *Therapies*

- *Speech and language*

CCS provides speech therapy services for those children in whom a difficulty in speech accompanies and/or complicates the treatment of a CCS eligible condition. Such conditions include, but are not limited to orofacial anomalies, including cleft palate; speech defects; significant dysarthria or communication disorders associated with hearing impairment; loss of acquired voice speech or language due to head trauma; or loss of acquired voice, speech or language due to

physiologically based disease process.

CCS provides speech and language therapy services for school-aged children when the medically necessary services are not available through the local special education agency or when the level of the intensity of services and/or the expertise required for the services is inappropriate for school therapists to administer.

- Physical and Occupational Therapy

CCS provides outpatient physical and occupational therapy when:

- Short-term physical and/or occupational therapy, with defined time-limited goals, is necessary to improve functional skills, eliminate the need for the extension of a patient stay and/or to prevent rehospitalization or
- Long-term physical and/or occupational therapy, with time-limited and frequently monitored goals, is necessary to maintain or prevent deterioration of functional skills.

- Oral motor feeding training

CCS provides oral motor feeding training when the oral motor feeding difficulty is related to the CCS eligible condition and the training is anticipated to result in adequate nutrition being provided only through oral feeding efforts.

- *Audiology.*

- CCS is responsible for providing audiology services for enrolled children with hearing loss, including examination by a paneled otolaryngologist, audiological assessment by an approved hearing and speech center, and a speech/language evaluation by a paneled speech/language pathologist.

- If the child is a candidate for amplification, CCS provides:

- Hearing aids
- Hearing aid accessories, including cords, receivers, ear molds and batteries
- Assistive listening systems including FM systems
- Repairs and replacements of authorized equipment
- Aural rehabilitation services

- Periodic evaluation by approved hearing and speech center.
- *Cochlear implants.*
  - Cochlear implants will be provided to children 18 months through 20 years of age (infants with acquired deafness secondary to meningitis are an exception to this age limit) with:
    - Diagnosis of bilateral sensorineural deafness with a loss of 90dB or greater in the speech range frequencies
    - An accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the CNS, as demonstrated by CT scan or other appropriate radiologic evaluation
    - No infection or other active disease of the middle ear
    - No contraindications to anesthesia and surgery
    - Cognitive ability to use auditory clues, as based on speech perception tests, communication skills assessment, language evaluation, reports from educational specialists, and educational/psychological assessments
    - Motivation of candidate and/or commitment of family and/or care givers, including a realistic expectation by the child and/family of the outcomes
    - A reasonable expectation by treating providers that the implant will confer awareness of speech at conversational levels
    - A recommendation from an approved cochlear implant facility.
  - CCS provides:
    - The pre-cochlear implant evaluation, to include audiology testing, speech pathology assessments, psychological assessments, otolaryngological evaluation and team conferences.
    - Cochlear implant surgery for an enrolled child who meets the criteria above, that includes the physician services, the hospital stay, intraoperative nerve monitoring, electromyography and the cost of the device.

- The post-cochlear implant services, that include implant orientation, implant mapping and processor programming, speech perception tests, audiological sound field tests, test assistant, speech and language evaluations at intervals following the implant and aural/oral rehabilitation services.
- *Laboratory services.* CCS provides all laboratory services necessary for the diagnosis and ongoing monitoring of care and treatment
- *Radiology services.* CCS provides all diagnostic, interventional and therapeutic radiological procedures necessary for the diagnosis, ongoing monitoring of care and treatment in x-ray, ultrasound and magnetic resonance imaging.
- *Medical nutrition therapy.* CCS provides medical nutrition therapy by a registered dietitian that includes nutritional assessment and the development and implementation of a therapy plan.
- *Mental health.* CCS provides mental health services to include:
  - A psychological evaluation, which may include the parents and/or legal guardian, provided as part of a child's treatment services, when the possible psychological symptoms are considered by the CCS approved physician to be complicating the management of the CCS eligible condition and the psychological evaluation has been determined to be medically necessary.
  - Out-patient psychotherapy for a child when, after review of the medical records, it is found necessary to treat an intercurrent mental disorder complicating the treatment of an eligible medical condition, requested by the child or parents, and determined to be medically necessary by a CCS approved physician.
  - Referral to the county mental health plan for all other mental health services.
- *Other services and equipment.* Any other medically necessary services or equipment which promote optimum health and improve, maintain or prevent deterioration of function.
- *Out-of-state care.* CCS provides care out-of-state when the medically-necessary care is not available within the State of California.
- *Investigational services.* CCS provides those drugs, equipment, procedures or services for which laboratory and animal studies have been completed and for which human studies are in progress when it is documented that the following conditions have been met:

- Conventional therapy will not adequately treat the child's condition.
  - Conventional therapy will not prevent progressive disability or premature death
  - The provider of the proposed service has a record of safety and success with the service or procedure equal to that of other providers of the investigational services.
  - The investigational service is the lowest cost item that meets the client's medical needs and is less costly than all conventional alternatives.
  - There is reasonable expectation that the investigational service will significantly prolong the patient's life or will maintain or restore a range of physical and social function suited to activities of daily living.
  - The service is not being performed as part of a research study protocol.
- *Dental services.* Dental care for those children whose CCS eligible condition makes dental care difficult, directly causes a dental problem and/or the nature or severity of the eligible condition makes the care a necessary part of the management of the condition. These conditions include, but are not limited to:
    - Complex congenital heart disease;
    - Seizure disorders;
    - Immune deficiencies;
    - Cerebral palsy;
    - Hemophilia;
    - Malignant neoplasms, including leukemia;
    - Status post organ transplant.

### **AIM Benefit Package**

*AIM coverage.* Health coverage under the AIM program is virtually identical to that available through the state employees benchmark health plan. AIM does not cover dental or vision benefits. However, AIM has more restrictive mental health coverage (10 inpatient days), because the state views this benefit as not germane to a child of 0-1.

### **Medi-Cal Benefit Package**

*Medi-Cal coverage.* Coverage under Medi-Cal will be consistent with that provided under California's Title XIX state plan.