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Title 10. Investment

Chapter 5.6. Access for Infants and Mothers Program

Article 1. Definitions

§ 2699.100. Definitions.

(a) “Appellant” means an applicant or subscriber who has filed an appeal with the program.

(b) “Applicant” means a pregnant woman 18 years of age or older who is applying on her own behalf, or a legal guardian or a natural parent, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child. “Applicant” also means a pregnant woman who is applying for coverage on her own behalf who is under 18 years of age, or who is an emancipated minor, or who is a minor not living in the home of a natural or adoptive parent, a legal guardian, foster parent or stepparent.

(c) “Application Date” means the date an application is sent to the program as evidenced by the U.S. postmark date on the application envelope, or documentation from other delivery services including fax delivery.

(d) “Board” means the Managed Risk Medical Insurance Board.

(e) “Coverage” means the payment for benefits provided through the program.

(f) “Disenroll” means to terminate coverage by the program.

(g) “Eligible” means the applicant is qualified to be enrolled in a participating health plan.

(h) “Enroll” means to accept an applicant as a subscriber by notifying a participating health plan to accept the applicant.

(i) “Executive Director” means the executive director for the Board.

(j) “Family member” means the following persons living in the individual's home:

(1) Children under age 21, of married or unmarried parents living in the home.

(2) The married or unmarried parents of the child or sibling children.

(3) The stepparents of the sibling children.

(4) The separate children of either an unmarried parent or a married parent or stepparent.

(5) An unborn child of the pregnant woman who is applying for coverage on her own behalf or on whose behalf an application has been submitted.

(6) Children under the age of 21, of married or unmarried parents, away at school who are claimed as tax dependents.

(7) The spouse of the pregnant woman.

(k) "Federal poverty level" means the level determined by the "Poverty Guidelines for the 48 Contiguous States and the District of Columbia" as contained in the Annual Update of HHS Poverty Guidelines as published in the Federal Register by the U.S. Department of Health and Human Services.

(l) "First trimester" means [begin strikeout]~~the first 13 weeks starting with the first day of a pregnant woman's last menstrual period and ending at the end of the 13th week, or~~[end strikeout] the first 13 weeks of a 40-week, full-term pregnancy[begin strikeout] ~~as documented by a licensed health care professional~~[end strikeout].

(m) "Gross household income" means the total annual gross income of all family members except dependent children. Income includes before tax earnings from a job, including cash, wages, salary, commissions and tips, self-employment net profits, Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability worker's compensation, unemployment benefits, alimony, spousal support, pensions and retirement benefits, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings and interest income. Income excludes child support, public assistance program benefits such as SSI/SSP and CalWORKS payments, foster care payments, general relief, loans, grants or scholarships applied toward college expenses, or earned income of a child aged 13 or under, or a child attending school. Income does not include income exclusions applicable to all federal means tested programs such as, disaster relief payments, per capita payments to Native Americans from proceeds held in trust and/or arising from use of restricted lands, Agent Orange payments, Title IV student assistance, energy assistance payments to low income families, relocation assistance payments, victims of crime assistance program, Spina Bifida payments, earned income tax credit and Japanese reparation payments.

(n) "Healthy Families Program" (HFP) means the Federal/State funded program that is operated pursuant to Title XXI of the Social Security Act and Part 6.2 (commencing with Section 12693) of Division 2 of the California Insurance Code, and that provides low cost health, dental and vision insurance coverage to eligible children.

(o) "Income deduction" means any of the following:

(1) Work expenses of $90 per month for each family member except dependent children working or receiving disability workers' compensation or State Disability Insurance. If a family member earns less than $90, the deduction can only be for the amount earned.

(2) Child care expenses while a family member works or trains for a job of up to $200 per month for each family member under age 2, up to $175 per month for each family member over age 2 and disabled dependent care expenses of up to $175 for a disabled dependent living in the home.

(3) The amount paid by a family member per month for any court ordered alimony or child support.

(4) $50 for alimony payments received by the pregnant woman. If a woman receives less than $50, the deduction can only be for the amount received.

(p) "Infant" means a subscriber's child born to a subscriber while the subscriber is enrolled in the program.

(q) "Living in the home" means using the home as the primary place of residence.

[begin underline](q1) "MAGI" or "Modified Adjusted Gross Income" means, as specified in Section 1397bb(b)(1)(B)(v) of Title 42 of the United States Code, modified adjusted gross income, for an individual, or household income, for a household of more than one person, as those terms are defined in Section 36B(d)(2) of the Internal Revenue Code of 1986, applied in a manner consistent with Section 1902(e)(14) of the Social Security Act (42 U.S.C. 1396a(e)(14)), including but not limited to the five percent (5%) reduction specified at paragraph (14)(I).[end underline]

(r) "Medi-Cal" means the California health care services program under Title XIX of the Social Security Act.

(s) "Medicare" means the Health Insurance for the aged and permanently disabled provided under Title XVIII of the Social Security Act; "Part A" means Hospital Insurance as defined in Title XVIII of the Social Security Act; and "Part B" means Medical Insurance as defined in Title XVIII of the Social Security Act.

(t) "Participating health plan" means any of the following plans which are lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the program to provide coverage to program subscribers:

(1) A private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A nonprofit hospital service plan qualifying under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

(3) A nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code).

(4) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code.

(5) A county or a city and county, in which case no license or approval from the Department of Insurance or the Department of Corporations shall be required to meet the requirements of this part.

(6) A comprehensive primary care licensed community clinic that is an organized outpatient freestanding health facility and is not part of a hospital that delivers comprehensive primary care services, in which case, no license or approval from the Department of Insurance or the Department of Corporations shall be required to meet the requirements of this part.

(u) "Program" means the Access for Infants and Mothers Program.

(v) "Resident" means a person who is present in California with intent to remain present except when absent for transitory or temporary purposes.

(w) "State supported services" mean abortion services provided to the subscribers through the program.

(x) "Subscriber" means an individual who is eligible for and enrolled in the program.

(y) "Subscriber contribution" means the cost to the subscriber to participate in the program.

(z) "Tenses and Number". The present tense includes the past and future, and the future the present; the singular includes the plural and the plural the singular.

(aa) "Time." Whenever in this chapter a time is stated in which an act is to be done, the time is computed by excluding the first day and including the last day. If the last day is a holiday it is also excluded.

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12695, 12695.06, 12695.08, 12695.18, 12695.20, 12695.22, 12695.24, 12696 and 12698, Insurance Code.

Article 2. Eligibility, Application, and Enrollment

2699.200. Basis of Eligibility.

(a) All eligibility requirements contained herein shall be applied without regard to race, creed, color, sexual orientation, health status, national origin, occupation, or occupational history of the individual applying for the program.

(b) To be eligible for the program, an individual shall meet the requirements of either (1) or (2):

(1) Meet all of the following requirements:

(A) Be [begin strikeout]~~certified as~~[end strikeout] pregnant [begin strikeout]~~by a staff person authorized by the Planned Parenthood Organization or a licensed or certified healthcare professional, including, but not limited to a medical doctor, doctor of osteopathy, registered nurse, physician's assistant, nurse midwife, vocational nurse, or medical assistant,~~[end strikeout] and have a reasonable good faith belief that the pregnancy is not beyond the 30th week of gestation as of the application date; and
[begin underline]

1. If the application is not complete a letter will be mailed to the applicant indicating the required information and documentation, if necessary, needed to complete the application. In addition, a telephone call will be placed to the applicant to request the missing information and documentation, if necessary. The applicant must provide all information and documentation, if necessary, needed for the application to be completed within 17 calendar days from the date the application was received by the program and prior to the 30th week of gestation, and the applicant will be so notified.

2. If the application submitted is not complete and it is not completed within seventeen (17) calendar days and prior to the 30th week of gestation, the

application shall be denied. The applicant shall be sent a notice indicating that the application is denied on the basis that the program could not make an eligibility determination because of missing information or documentation.

3. If the application is complete it will be reviewed for an eligibility determination pursuant to Section 2699.203; and[end underline]

(B) Be a resident of the state of California; and

(C) 1. For eligibility that takes effect before January 1, 2014, have a monthly household income after income deductions that is above 200 percent of the federal poverty level but does not exceed 300 percent of the federal poverty level at the time of application; and

2. For eligibility that takes effect on or after January 1, 2014, have a [begin strikeout]~~monthly household income~~[end strikeout][begin underline]MAGI[end underline][begin strikeout]~~, calculated in accordance with the requirements of Section 1397bb(b)(1)(B) of Title 42 of the United States Code as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments,~~[end strikeout] that is above 200 percent of the federal poverty level but does not exceed 300 percent of the federal poverty level at the time of application[begin underline], as those percentages may be adjusted as required by Section 1902(e)(14)(A) of the Social Security Act (42 U.S.C. 1396a(e)(14)(A))[end underline].

(D) Pay the first portion of the subscriber contribution, which shall be fifty dollars ($50), [begin underline]except that this pre-payment requirement shall not apply to applications received on or after January 1, 2014,[end underline] and agree to the payment of the complete subscriber contribution; and

(E) Not be reimbursed by any health care provider or any state or local governmental entity for payment of the subscriber contribution and not have any health care provider or state or local governmental entity pay the subscriber contribution; and

(F) Not be a beneficiary of either no-cost Medi-Cal or Medicare Part A and Part B as of the application date; and

(G) Not be covered for maternity benefits in a private insurance arrangement as of the application date. A pregnant woman in a private insurance arrangement with a separate maternity only deductible or copayment greater than$500

shall be deemed not covered for maternity benefits for purposes of determining eligibility.

(2) Be an infant of less than two (2) years of age born to a program subscriber who was enrolled prior to July 1, 2004, and reside in California.

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05, 12698(b), 12698(c), 12698.05, 12698(c) and 12698.06, Insurance Code; and Maternal and Child Health Access, Petitioner, vs. Managed Risk Medical Insurance Board, et al., Respondents (Superior Court of the State of California, City and County of San Francisco, Case No. CPF-08-508296).

2699.201. Application.

(a) To apply for the program an individual shall submit:

(1) [begin underline]The application described in subsection (d) of this subsection, or alternatively, the Single Streamlined Application as promulgated by the Department of Health Care Services and the California Health Benefit Exchange pursuant to Section 1413(b)(1)(B) of Public Law 111-148 (42 U.S.C. 18083), together with[end underline] [begin strikeout]A[end strikeout][begin underline]a[end underline]ll information, documentation, and declarations necessary to determine program eligibility as set forth in subsection (d) of this section; and

(2) A cashier's check or money order for fifty dollars ($50.00)[begin underline], except that this pre- payment requirement shall not apply to applications received on or after January 1, 2014;[end underline] and

(3) A statement signed by the applicant agreeing that if the pregnant woman is enrolled, the applicant will pay the full subscriber contribution and acknowledging that the program will take aggressive action to collect the full subscriber contribution.

(b) The applicant shall sign and date a declaration stating that the information is true and accurate to the best of his or her knowledge.

(c) The applicant will be notified in writing that the application is incomplete and what documentation is required for completion.

(d)(1) The application, entitled Access for Infants and Mothers (AIM) Application (rev [begin strikeout]12.02.2008[end strikeout][begin underline]01.01.2014[end underline]), which is incorporated by reference, shall contain the following:

(A) The pregnant woman's full name,

(B) The pregnant woman's current living address including house or building number (and unit number if applicable), street, city, county, state, and zip code, and phone number,

(C) The pregnant woman's date of birth,

(D) The pregnant woman's social security number (provision of the Social Security number is not mandatory),

(E) The pregnant woman's ethnicity and primary language (not mandatory),

(F) [begin strikeout]~~Certification by a staff person authorized by the Planned Parenthood Organization or a licensed or certified healthcare professional, including, but not limited to a medical doctor, doctor of osteopathy, registered nurse, physician's assistant, nurse midwife, vocational nurse, or medical assistant,~~[end strikeout][begin underline]A declaration[end underline] that the woman on whose behalf the application is filed is pregnant,

(G) The [begin strikeout]~~first day of the pregnant woman's last menstrual period~~[end strikeout][begin underline]expected delivery date of the pregnant woman's unborn child,[end underline]

(H) A declaration that the pregnant woman is not, to the best of the applicant's knowledge, beyond the 30th week of gestation in a current pregnancy, as of the application date,

(I) Information about whether the applicant or anyone in the household smokes, [begin underline]but providing this information shall not be a condition of eligibility,[end underline]

(J) The address to which the bills for the subscriber's contribution are to be sent, if different from the current living address,

(K) The first and last name, and date of birth of the baby's father if living with the pregnant woman,

(L) Information about whether the father of the baby is married to the pregnant woman,

(M) A list of all family members living in the home, their ages, and relationship to the pregnant woman,

(N) A list of those family members[begin underline] living in the home who had income in the previous or current calendar year[end underline], and their social security numbers [begin underline]or individual taxpayer identification numbers[end underline] [begin strikeout]~~excluding dependent children, living~~

~~in the home who had income in the previous or current calendar year~~[end strikeout], [begin underline]the amount of income and their tax filer or dependent status[end underline](provision of the social security number [begin underline]or individual taxpayer identification number [end underline]is not mandatory[begin underline] but is necessary for electronic verification[end underline]),

(O) [begin underline]As necessary, d[end underline][begin strikeout]D[end strikeout]ocumentation of the total monthly gross household income for either the previous or current calendar year. For each person listed in (N) above, provide documentation for each source of income. Such documentation shall be provided for the previous or current year as indicated below:
[begin underline]
1. [end underline]For the previous calendar year:

a. Federal tax return. If self-employed, a schedule C must be included.

b. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, passbooks, or internal revenue service (IRS) 1099 forms showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income.

[begin underline]
2. [end underline]For the current calendar year:

c. A letter from the person's current employer. The letter shall be dated and written on the employer's letterhead, and shall include the following:

i. The employee's name.

ii. The employer's business name, business address and phone number.

iii. A statement of the person's current gross monthly income for a period ending within 45 days of the date the program receives the document.

iv. A statement that the information presented is true and correct to the best of the signer's knowledge.

v. A signature by someone authorized to sign such letters by the employer. The signer shall include his or her position name or job title and shall not be the person whose income is being disclosed.

d. Paystub or unemployment stub showing gross income for a period ending within 45 days of the date the program receives the document.

e. If self-employed, a profit and loss statement for the most recent three (3) month period prior to the date the program receives the document. A profit and loss statement must include the following:

i. Date.

ii. Name, address and telephone number of the business.

iii. Gross income, gross expenses, and net profit itemized on a monthly basis.

iv. A statement on the profit and loss, signed by the person who earned the income, which states, “the information provided is true and correct.”

f. A letter or Notice of Action from the County Welfare Office issued within the last two (2) months that includes:

i. For each person for whom application is being made, a statement that the person is eligible for share-of-cost Medi-Cal,

ii. A determination of total monthly household income and monthly household income after income deductions [begin underline]or a determination of MAGI, as applicable, pursuant to[end underline] [begin strikeout]as defined in[end strikeout] Section 2699.[end strikeout]100[end strikeout][begin underline]200(b)(C)[end underline], and

iii. A determination of the number of family members living in the household.

g. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, or passbooks showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income,

gifts, lottery/bingo winnings, dividends, or interest income for the previous month.

(P) The name of each family member living in the home who pays court ordered child support or court ordered alimony. The name and age of each person for whom payments are made for child care and/or disabled dependent care by a family member living in the home and the monthly amount paid. [begin underline]As necessary, d[end underline][begin strikeout]D[end strikeout]ocumentation of alimony[begin strikeout] paid[end strikeout], [begin underline]student loan interest,[end underline] child care and/or disabled dependent care expenses paid. Documentation includes copies of court orders, cancelled checks, receipts, statements from the District Attorney's Family Support Division or other equivalent document.

(Q) A declaration that the pregnant woman is not a beneficiary of either no-cost Medi-Cal or Part A and Part B of Medicare,

(R) A declaration that the pregnant woman is a resident of the State of California,

(S) A declaration that the applicant will abide by the rules of participation, utilization review process, and dispute resolution process of any participating health plan in which the pregnant woman is enrolled,

(T) Information about any health coverage that is in effect for the pregnant woman[begin underline], whether directly or through a spouse, the father of the child or otherwise[end underline][begin strikeout] or will be in effect for the infant[end strikeout], including[begin underline], if requested,[end underline] the name, address, and policy number of the current insurance or health plan,

(U) A declaration that the pregnant woman is not, to the best of the applicant's knowledge, covered for maternity benefits in a private insurance arrangement. A pregnant woman with a separate, maternity only deductible or co-payment greater than $500 shall be deemed not covered for maternity benefits for purposes of this declaration,

(V) Name[begin strikeout], address and phone number[end strikeout] of the primary employer of each adult family member who is employed,

(W) [begin strikeout]Information about health coverage available to the applicant, spouse, or father of the baby who is in the household,[end strikeout]

(X) A declaration that the applicant has reviewed the benefits offered by the participating health plans,

(Y) A declaration that the applicant understands and will follow the rules and regulations of the program,

(Z) A declaration that the applicant is giving permission for the program to verify family income, health insurance, residence, and other circumstances,

(AA) A declaration that the subscriber is not being, and will not be, reimbursed by any health care provider or any state and local governmental entity for payment of the subscriber contribution and that no health care provider or state or local governmental entity is paying or will pay the subscriber contribution,

(BB) An indication of the pregnant woman's [begin strikeout]~~first~~ [end strikeout]choice [begin strikeout]~~and second choice~~[end strikeout][begin underline]of[end underline] participating health plan[begin strikeout]~~s~~[end strikeout][begin underline], if there is more than one participating health plan[end underline],

(CC) A declaration that the subscriber agrees to pay the required subscriber contribution, even if the subscriber does not take full advantage of the coverage or services.

(DD) A declaration that the information and documentation submitted is true and correct to the best of the applicant's knowledge.

[begin underline](EE) Notwithstanding the provisions of subparagraphs (O) and (P) of this paragraph (1), for applications received on or after January 1, 2014, the applicant's attestation of income and deductions, subject to verification in a manner consistent with the verification provided for regarding the Single Streamlined Application as promulgated by the Department of Health Care Services and the California Health Benefit Exchange pursuant to Section 1413(b)(1)(B) of Public Law 111-148 (42 U.S.C. 18083).

1. If the income and deductions cannot be verified electronically, as contemplated by subparagraph (EE), the application will be considered incomplete and will be processed as specified in Section 2699.200(b)(1)(A)1, 2 and 3.[end underline]

(2) The Social Security number and other personal information are needed for identification and administrative purposes.

(3) [begin underline]A declaration that the applicant understands that if the pregnant woman is not found eligible for AIM,[end underline] [begin strikeout]~~If applicable, the applicant's signed authorization to forward~~[end strikeout] the application [begin underline]will be forwarded[end underline] to the Medi-Cal Program in the county in which [begin strikeout]~~the applicant~~[end strikeout][begin underline]she[end underline] resides for a determination of eligibility for no-cost Medi-Cal[begin underline] or to Covered California for a determination of eligibility for coverage by a Covered California plan, as applicable based on apparent income[end underline].

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12698(b), 12698(c) and 12698.05, Insurance Code; and Maternal and Child Health

Access, Petitioner, vs. Managed Risk Medical Insurance Board (Superior Court of the State of California, City and County of San Francisco, Case No. CPF-08-508296).

[begin strikeout]~~2699.202. Board Determinations of Program Funding and Initial Review of Applications.~~

~~(a) If the Board makes a finding that sufficient funds are not available to cover the estimated costs of program expenditures and that it is necessary to limit enrollment in the program to ensure that expenditures do not exceed amounts available for the program, the program shall be closed to new enrollment.~~

~~(b)(1) If the Executive Director determines that, in addition to sufficient funds for all eligible subscribers, sufficient funds are available to cover the estimated cost of program expenditures for some new eligible applicants, the program shall be open to new enrollment for the number of eligible applicants for whom the Executive Director determines there are sufficient funds available.~~

~~(2) If the Executive Director determines that sufficient funds are available to cover the estimated costs of program expenditures, the program shall be open to new enrollment.~~

~~(c) If the Board has made a finding pursuant to subsection (a) that sufficient funds are not available, all applications shall be denied due to insufficient funds, unless the program is open to new enrollment for some or all applicants pursuant to subsection (b).~~

~~(d) If, and to the extent that, the program is open to new enrollment, the application shall be reviewed for completeness.~~

~~(1) If it is not complete a telephone call will be placed to the applicant to request the missing information and documentation. If the applicant is reached, the applicant will be asked to provide the necessary information and documentation. If the applicant is not reached by telephone, a letter will be mailed to the applicant indicating the required information and/or documentation needed to complete the application. The applicant must provide all information and/or documentation necessary for the application to be completed within 17 calendar days from the date the application was received by the program and prior to the 30th week of gestation, and the applicant will be so notified.~~

~~(2) If the application submitted is not complete and it is not completed within seventeen (17) calendar days and prior to the 30th week of gestation, the application shall be denied. The applicant shall be sent a notice indicating that their application is denied on the basis that the program could not make an eligibility determination because of missing information or documentation.~~

~~(3) If it is complete it will be reviewed for an eligibility determination pursuant to Section 2699.203.~~

~~**Note:** Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696, 12696.05 and 12696.15, Insurance Code.~~[end strikeout]

. . . [Sections not proposed to be amended have been omitted.]

2699.205. Registration of Infants.

(a) For infants born to subscribers who are enrolled on or after July 1, 2004, the subscriber shall register the infant in the Healthy Families Program as follows:

(1) Upon the birth of the infant, the subscriber shall provide to the Healthy Families Program the following information about the infant:

(A) Name; and

(B) Date of birth; and

(C) Sex; and

(D) For infants born on or after July 1, 2007:

1. Information on whether or not the infant currently is enrolled in employer sponsored health coverage and the date coverage began; and

2. Information on whether or not the infant was previously enrolled in employer sponsored health coverage, the date coverage began, the date in which coverage terminated, and the reason for termination.

(2) The Healthy Families Program shall request the infant's birth weight and primary care provider from the subscriber.

(3) Subject to all requirements specified in the statute and regulations governing the Healthy Families Program, the infant will be enrolled in the Healthy Families Program with coverage effective on the date of the infant's birth.

[begin underline]

(b) This section shall cease to be effective on the date that the Department of Health Care Services commences implementation of the AIM-Linked Infants Program, as described in Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code.[end underline]

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12693.765 and 12696, Insurance Code.

. . . [Section not proposed to be amended has been omitted.]

2699.207. Disenrollment.

(a) A subscriber shall be disenrolled from the program and from the program's participating health plan when any of the following occur:

(1) The subscriber so requests in writing.

(2) The subscriber becomes ineligible because:

(A) The subscriber fails to meet the residency requirement; or

(B) The subscriber has committed an act of fraud to circumvent the statutes or regulations of the program,

(C) The subscriber is no longer pregnant on her effective date of coverage[begin underline], based on her self-attestation before the effective date[end underline]. If notification to the program is received after the effective date, documentation by a licensed or certified healthcare professional must be submitted indicating the date of the miscarriage.

(D) More than 60 days have elapsed since the end of the pregnancy for which the subscriber enrolled in the program. Notwithstanding the previous sentence, beginning January 1, 2014, the program shall provide coverage through the last day of the month in which the 60th day following the end of the pregnancy occurs. As a condition of receiving the premium reduction described in Section 2699.400(a)(5), documentation by a licensed or certified healthcare professional must be submitted to the program indicating the date the pregnancy ended.

(b) When a subscriber is disenrolled pursuant to subsection (a) of this section, the program shall notify the subscriber of the disenrollment. The notice shall be in writing and include the following information:

(1) The reason for the disenrollment.

(2) The effective date of the disenrollment.

(3) An explanation of the appeals process.

(c) Disenrollment pursuant to (a)(1), shall take effect at the end of the calendar month in which the request was received or at the end of a future calendar month as requested by the subscriber.

(d) Disenrollment pursuant to (a)(2)(A), shall take effect as follows:

1. If the program provides notification to the subscriber on or before the 10th of the month, disenrollment shall take effect at the end of the calendar month.

2. If the program provides notification to the subscriber after the 10th of the month, disenrollment shall take effect at the end of the following calendar month.

(e) Disenrollment pursuant to (a)(2)(B), shall take effect as follows:

1. If the program provides notification to the subscriber on or before the 10th of the month, disenrollment shall take effect at the end of the calendar month.

2. If the program provides notification to the subscriber after the 10th of the month, disenrollment shall take effect at the end of the following calendar month.

(f) Disenrollment pursuant to (a)(2)(C), shall take effect upon the date that would have been the effective date of coverage.

(g) Disenrollment pursuant to (a)(2)(D), shall take effect [begin underline]as follows:[end underline]
[begin underline]

1. Disenrollment shall take effect[end underline] on the 61st day following the date the subscriber's pregnancy ended. [begin underline]Notwithstanding the previous sentence, beginning January 1, 2014, the program shall provide coverage through the last day of the month in which the 60th day following the end of the pregnancy occurs.[end underline]

[begin underline]

2. In the event that the program is not notified of the end of the pregnancy as specified in Section 2699.209(b), disenrollment shall take effect pursuant to paragraph 1, based on the expected delivery date.

3. The program shall send the subscriber a reminder notice of the period of coverage on or about 30 days prior to the expected delivery date.[end underline]

(h) Once a subscriber is disenrolled pursuant to Section 2699.207(a), the subscriber cannot be re-enrolled for the same pregnancy.

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698, Insurance Code.

[begin strikeout]~~2699.208. Continuation of Benefits.~~
~~Infants shall be eligible to continue coverage in the program from a participating health plan if the subscriber is deceased or becomes ineligible for reasons other than an act of fraud while the infant is otherwise eligible.~~

~~**Note:** Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696.05, Insurance Code.~~[end strikeout]

2699.209. Coverage.

(a) The date on which the coverage shall begin shall be no later than ten (10) calendar days from the date the applicant is enrolled. Coverage shall not begin if the pregnancy terminates prior to the effective date of coverage.

(b) Unless the subscriber is otherwise disenrolled pursuant to Section 2699.207, coverage in the program for the subscriber shall be for one pregnancy and shall include services following the pregnancy for sixty (60) days. [begin underline]Notwithstanding the previous sentence, beginning January 1, 2014, the program shall provide coverage through the last day of the month in which the 60th day following the end of the pregnancy occurs.[end underline] The subscriber shall notify the program of the date on which the pregnancy for which she enrolled ends. She shall provide this notification by the thirtieth day after the end of the pregnancy.[begin underline] The subscriber's responsibility to provide notification of the end of the pregnancy may be satisfied by a notification provided by the infant's father, the subscriber's health care provider or the subscriber's participating health plan.[end underline]

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698.30, Insurance Code.

2699.210. Transfer of Enrollment.

(a) A subscriber [begin strikeout]~~and/or infant, if any,~~[end strikeout] shall be transferred from one participating health plan to another if any of the following occurs:

[begin strikeout]

~~(1)~~ [end strikeout]A subscriber so requests, in writing, because the subscriber [begin strikeout]~~and/or infant, if any,~~[end strikeout] has moved and no longer resides in an area served by the participating health plan in which the subscriber [begin strikeout]~~and/or infant, if any,~~[end strikeout] is enrolled, and there is at least one participating health plan serving the area in which the subscriber [begin strikeout]~~and/or infant~~[end strikeout] now resides that is accepting new enrollees.

[begin strikeout]

~~(2)~~ [end strikeout]The subscriber or the participating health plan so requests, in writing, because of failure to establish a satisfactory subscriber-plan relationship and the Executive Director determines that the transfer is in the best interests of the program, and there is at least one other participating health plan serving the area in which the subscriber resides that is accepting new enrollees.

[begin strikeout]

~~(3)~~ [end strikeout]The program contract with the participating health plan in which the subscriber is enrolled is canceled or not renewed.

(b) The effective date of transfers pursuant to subsection (a)(1) of this section shall be:

[begin strikeout]

~~(1) On the first day of a month following the transfer request for an infant, if the request is received on or before the 10th of the month. Transfer of enrollment shall take effect on the first day of the second month following the transfer request for an infant, if the request is received after the 10th of the month.~~

~~(2) Within~~[end strikeout] [begin underline]within[end underline] seventeen (17) calendar days of receipt of the transfer request for the subscriber.

(c) The effective date of transfers pursuant to subsection (a)(2) of this section shall be:

[begin strikeout]

~~(1) On the first day of a month following the approval of the transfer request for an infant, if the approval is made on or before the 10th of the month. Transfer of enrollment shall take effect on the first day of the second month following the approval of the transfer request for an infant, if the approval is made after the 10th of the month.~~

~~(2) W~~[end strikeout][begin underline]w[end underline]ithin fifteen (15) calendar days from approval of the transfer request for the subscriber.

(d) The effective date of transfers pursuant to subsection (a)(3) of this section shall be prior to the end of the contract.

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696 and 12697.10, Insurance Code.

[begin strikeout]~~2699.211. Payment for Application Assistance.~~

~~(a) The program shall pay an insurance agent as defined in Section 31 of the Insurance Code, or broker as defined in Section 33 of the Insurance Code, or a licensed general acute care hospital, or a licensed medical doctor, or a licensed doctor of osteopathy, or a registered nurse, or a county health department, or a county welfare department, or a licensed day care operator, or a licensed primary care community clinic, or a direct state maternal and child health contractor, or a participating health plan, or a licensed chiropractor for assisting an individual in completing the application form, if the following conditions are met:~~

~~(1) The individual is enrolled as a result of the application; and~~

~~(2) The request for payment is made in writing and specifies to whom the payment shall be made; and~~

~~(3) Such request accompanies the application and includes the name, position/title and address and, if applicable, the license number of the person who assists in the completion of the application and the tax identification number of the person/entity to be paid. An incomplete request will be rejected; information missing from the application cannot be submitted at a later date.~~

~~(b) The amount of such payment shall be fifty dollars ($50.00).~~

~~**Note:** Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696, Insurance Code.~~[end strikeout]

Article 4. Subscriber Contributions and Payment for Services

2699.400. Subscriber Contributions.

(a) Subscriber contributions shall be:

(1) An initial fifty dollars ($50.00) to be submitted with the application, [begin underline]except that this pre-payment requirement shall not apply to applications received on or after January 1, 2014,[end underline] and

(2) For subscribers who are enrolled prior to July 1, 2004, the difference between two per cent (2%) of the subscriber's gross household income, less deductions, as documented with the application and fifty dollars ($50.00), which amount shall be due in twelve (12) equal monthly installments beginning with the first month following enrollment; and

(3) For infants born to subscribers who are enrolled prior to July 1, 2004, one hundred dollars ($100.00) which shall be due on the infant's first birthday unless either of following apply:

(A) The infant is disenrolled from the program prior to the infant's first birthday, or

(B) The subscriber provides written proof that the infant is current for the infant's first year immunizations. Such immunizations shall be consistent with the most current version of the Recommended Childhood Immunization Schedule jointly adopted by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians. The written proof of completed current first year immunizations shall be signed by a licensed medical doctor, licensed doctor of osteopathy, registered nurse, or licensed physician's assistant. When such written notice is provided the amount shall be fifty dollars ($50.00).

(4) For subscribers who are enrolled on or after July 1, 2004, the difference between one and one-half percent (1.5%) of the subscriber's gross household income, less deductions, as documented with the application and fifty dollars ($50.00), [begin underline]or one and one-half percent (1.5%) of the subscriber's annual MAGI, as applicable, pursuant to Section 2699.200(b)(1)(C),[end underline] which amount [begin strikeout]~~shall be due~~[end strikeout][begin underline]may be paid[end underline] in twelve (12) equal monthly installments beginning with the first month following enrollment.

(5)(A) For subscribers who are enrolled on or after July 1, 2008, and no longer pregnant by the end of their first trimester, the subscriber contribution shall be reduced and shall be one-third (1/3) of the subscriber contribution calculated pursuant to subsections (a)(1) and (a)(4) of this section.

(B) As a condition of receiving this reduction, documentation by a licensed or certified healthcare professional must be submitted to the program indicating the date the pregnancy ended.

(b) There shall be no penalty for early payment of any portion of the subscriber contribution.

(c) In cases of multiple births to a subscriber, the $100 payment shall apply to each infant born to a subscriber who is enrolled prior to July 1, 2004.

(d) Subscribers shall not be reimbursed by any health care provider or state or local governmental entity for payment of the subscriber contribution and shall not have any health care provider or state or local governmental entity pay the subscriber contribution.

(e) No portion of the subscriber contribution is refundable except as provided in Sections 2699.202 and 2699.203, unless the subscriber is disenrolled pursuant to Subsection 2699.207(a)(2)(C), or unless the subscriber contribution is reduced pursuant to Section 2699.400(a)(5).

(f) A federally recognized California Indian Tribal Government may make required subscriber [begin strikeout]~~and infant~~[end strikeout] contributions on behalf of a member of the tribe.

(g) An applicant in arrears of subscriber contributions shall be sent a reminder notice. Applicants who become ninety (90) days in arrears on subscriber contributions will be reported to a credit reporting agency. If accounts are paid in full at a later date, the credit reporting agency's records shall be updated.

Note: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696, 12696.05 and 12698, Insurance Code.

. . . [Sections not proposed to be amended have been omitted.]