10133.65, 10133.66, 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, 10144.57, 10175.5, 10176, 10176.9 and 10180, Insurance Code.

Adopt: Section 2562.07. Coverage Disclosures and Policy Form Filings.

(a) A coverage document shall state the following:

(1) Coverage is provided for medically necessary health care benefits to prevent, diagnose, and treat mental health conditions and substance use disorders under the same terms and conditions that are applied to other medical conditions and in accordance with the federal Mental Health Parity and Addiction Equity Act.

(2) Coverage is provided for the full range of levels of care and may not be limited to short-term treatment or alleviation of only acute symptoms.

(3) All utilization review coverage determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge of a covered person diagnosed with a mental health condition or substance use disorder must be made using the most recent versions of the following instruments:

(A) For a primary substance use disorder diagnosis in adolescents and adults, *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* by the American Society of Addiction Medicine.

(B) For a primary mental health diagnosis in adults nineteen (19) years of age and older, *Level of Care Utilization System* (LOCUS) by the American Association for Community Psychiatry.

(C) For a primary mental health diagnosis in children six (6) to eighteen (18) years of age, *Child and Adolescent Level of Care/Service Intensity Utilization System* (merged CALOCUS-CASII) by the American Association for Community Psychiatry and the American Academy of Child and Adolescent Psychiatry.

(D) For a primary mental health diagnosis in children five (5) years of age and younger*, Early Child Service Intensity Instrument* (ECSII) by the American Academy of Child and Adolescent Psychiatry.

(4) The requirements in subdivisions (d)(2) and (d)(3) of Section 2562.06.

(5) The notice required by subdivision (b) of Section 2562.08.

(b) A coverage document shall include the following definitions, as set forth in Insurance Code sections 10144.5 and 10144.52 and this article:

(1) Emergency health care services.

(2) Emergency medical condition.

(3) Generally accepted standards of mental health and substance use disorder care.

(4) Health care benefit.

(5) Health care facility.

(6) Health care provider.

(7) Iatrogenic infertility.

(8) Intermittent.

(9) Medically necessary or medical necessity.

(10) Mental health condition or substance use disorder.

(11) Standard fertility preservation services.

(12) Urgent care services.

(13) Utilization review.

(14) Utilization review criteria.

(c) A coverage document shall disclose coverage of the following health care benefits:

(1) The health care benefits described in Section 2562.05.

(2) Any other health care benefits that are generally recognized as medically necessary to prevent, diagnose, or treat a mental health condition or substance use disorder by health care providers practicing in relevant clinical specialties.

(d) A coverage document shall list covered health care benefits for mental health conditions and substance use disorders under the following Mental Health Parity and Addiction Equity Act benefit classifications to specify the applicable cost sharing:

(1) Inpatient.

(2) Outpatient, or if outpatient benefits are subclassified, office visits and all other outpatient items and services.

(3) Emergency health care services.

(4) Prescription drugs.

(e) A coverage document shall include the following network disclosures:

(1) Medically necessary health care benefits for preventing, diagnosing, and treating mental health conditions and substance use disorders must be accessible from in-network health care providers and facilities within network standards for geographic and timely access. If a medically necessary health care benefit for a mental health condition or substance use disorder is unavailable in-network within applicable geographic or timely access standards, an insurer must arrange for an available and accessible out-of-network provider or facility to provide care. Cost sharing for out-of-network care that is arranged by an insurer due network inaccessibility is limited to the amount that would have been due to an in-network provider or facility. Cost sharing paid for arranged out-of-network care will accrue to any applicable in-network deductible and to the in-network out-of-pocket maximum.

(2) The geographic and timely access standards set forth in Insurance Code section 10133.54, Article 6 of Subchapter 2 of this chapter (commencing with Section 2240), and Section 2562.06.

(3) A complete and accurate description of the process for requesting assistance, providing in-network referrals, and arranging out-of-network coverage as set forth in subdivisions (b)(3) and (c) of Section 2562.06.

(4) A complete and accurate description of the requirements in subdivisions (e) through (h) of Section 2562.06.

(f) Cost sharing that applies to health care benefits for mental health and substance use disorders shall comply with Insurance Code section 10144.4, and such compliance shall be continuously maintained and demonstrated in a quantitative analysis submitted with policy forms for authorization, or upon request by the Department.

(g) Nonquantitative treatment limitations that are imposed on health care benefits for mental health conditions or substance use disorders shall comply with Insurance Code section 10144.4, and such compliance shall be continuously maintained and demonstrated in a comparative analysis submitted with policy forms for authorization, or upon request by the Department.

NOTE: Authority cited: Sections 10144.4, 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 10270.6, 10270.9, 10290, 10291, 10291.5, 10144.4, 10144.51, 10144.52, 10144.53 and 10144.57, Insurance Code.

Adopt: Section 2562.08. Training and Provision of Utilization Review Criteria.

(a) To ensure proper application and implementation of the utilization review criteria required by Insurance Code section 10144.52 and this article, an insurer shall adopt a formal education program consistent with subdivision (e) of Insurance Code section 10144.52 that meets the following requirements:

(1) Within six (6) months of the effective date of this section, and at least every three (3) years thereafter, an insurer shall sponsor formal education programs offered by the nonprofit professional associations identified in subdivision (a) of Section 2562.03, and the World Professional Association for Transgender Health, regarding the association's clinical criteria, to educate all its utilization review staff, including supervisors, and the staff and supervisors of any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf, on proper application of the criteria in utilization review. For purposes of this subdivision (a)(1), sponsoring includes arranging and paying for the formal education program, provided that the education program is offered by the respective nonprofit professional association, or a third party designated or licensed by the association to conduct such a program.

(2) An insurer shall ensure that all utilization review staff and supervisors subject to subdivision (a)(1) of this section have been trained in the use and application of the most recent edition of the nonprofit professional association criteria required pursuant to Section 2562.03 before making any coverage determinations concerning service intensity, level of care placement, continued stay, or transfer or discharge, or before making coverage determinations with respect to health care benefits that are within the scope of clinical criteria developed by the World Professional Association for Transgender Health.

(3) In accordance with Insurance Code section 10144.52(e)(2), an insurer shall provide the following stakeholders with access to the formal education program, without limitation on frequency of access:

(A) Network providers.

(B) Group policyholders.

(C) Insureds and their health care providers and authorized representatives.

(D) Out-of-network providers delivering health care benefits to an insured pursuant to Section 2562.06 or a coverage document's out-of-network benefits.

(b) (1) An insurer shall notify an insured or an insured's authorized representative, and the insured's health care provider, that all utilization review criteria, and training materials and resources that are part of the formal education program described in subdivision (a) of this section, are available upon request at no cost. This notice shall be published on an insurer's website; disclosed in an insurer's coverage documents; and no less frequently than semi-annually, included in its relevant updates and communications with network and out-of-network providers.

(2) Method of Delivery. Upon request, an insurer shall provide all utilization review criteria, and all training materials and resources that are part of the formal education program described in subdivision (a), to an insured, the insured's authorized representative, and the insured's health care provider at no cost. An

insurer shall provide the utilization review criteria and the training materials and resources described in subdivision (b)(1) in one or more of the following ways:

(A) In paper form delivered to the requestor's mailing address. Elements of a formal education program that cannot be provided in paper form shall instead be made available as provided in subdivision (b)(2)(C).

(B) Electronically by email. An insurer shall notify the requestor in its response that a paper copy is available at no cost and describe the process for obtaining a paper copy. Elements of a formal education program that cannot be provided by email shall instead be made available as provided in subdivision (b)(2)(C).

(C) Electronically on an insurer's website, or alternatively with respect to a formal education program's training materials and resources, on a host website directly linked from an insurer's website. In making the content available online, an insurer shall do the following:

1. Ensure the utilization review criteria and training materials and resources allow for electronic retention, such as saving and printing.

2. Make the content accessible to individuals living with disabilities in accordance with applicable federal and state law.

3. Include notice that a paper copy is available at no cost and describe the process for obtaining a paper copy.

(3) Timeframe for Delivery. The utilization review criteria and formal education program training materials and resources described in subdivision (b)(1) shall be sent to the requesting party within thirty (30) calendar days of a request.

NOTE: Authority cited: Sections 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 10123.135, 10144.5, 10144.52 and 10144.57, Insurance Code.

Adopt: Section 2562.09. Interrater Reliability Requirements.

[Reserved.]

NOTE: Authority cited: Sections 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 10144.5, 10144.52 and 10144.57, Insurance Code.

Adopt: Section 2562.10. Utilization Review Coverage Determinations and Notices of Adverse Coverage Determinations.

(a) An adverse utilization review coverage determination shall be made only by a licensed physician or other licensed health care provider who is competent to evaluate the specific

clinical issues involved in the health care services under review. "Competent to evaluate the specific clinical issues involved in the health care services under review" means, at a minimum, that the provider has appropriate training and experience in the field of medicine involved in the coverage determination, and the provider was trained if required by Section 2562.08.

(b) Pursuant to subdivision (h)(2) of Insurance Code section 10123.135, for utilization review coverage determinations involving urgent care services, including pursuant to a request by an insured, or an insured's authorized representative or provider, to extend an approved, ongoing course of treatment beyond the period of time or number of treatments that was previously approved, an insurer shall comply with the expedited review process that is required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent regulations issued or incorporated thereunder, including Section 147.136 of Title 45 of the Code of Federal Regulations.

(1) Any determination made by an insurer of whether medical care or treatment constitutes urgent care services shall defer to the opinion of an insured's attending health care provider. An insurer's negligence or fault in not requesting or reviewing records documenting such an opinion, or when an emergency medical condition or urgent care services were documented in an insured's medical record or in or supporting a submitted claim, shall not constitute the absence of an attending provider's opinion.

(2) Subject to subdivision (i) of Section 2562.05, Insurance Code section 10123.191 and the regulations promulgated thereunder shall govern a request for coverage of a prescription drug that is based on exigent circumstances as defined in that section or involves urgent care services as defined and used in this article.

(c) An insurer shall include all the following content in written notices of adverse utilization review coverage determinations provided to an insured, or an insured's authorized representative or provider, including the notices required by subdivision (h)(4) of Insurance Code section 10123.135 and notices of final adverse utilization review coverage determinations on appeal:

(1) Information sufficient to identify the health care benefits and claim involved, including the health care benefits at issue, date of service, health care provider or facility, claim amount (if applicable), and a statement disclosing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

(2) Reference to the location, and a description, of the applicable terms of the insured's coverage document.

(3) A description of the specific clinical criteria that will be, or was, used to make the coverage determination, including a reference to the location of the criteria in the enclosure required by subdivision (d)(9) of this section.

(4) The specific reasons for the adverse utilization review coverage determination.

(A) If an adverse coverage determination was made due to insufficient information to make the determination, a description of the additional information that is reasonably necessary to make the coverage determination, and an explanation of why such information is necessary.

(B) If an adverse coverage determination was made for a reason or reasons other than or in addition to insufficient information, a clear and concise explanation of the reasons for the adverse coverage determination, including explanation of how applying the relevant clinical criteria and terms of the insured's coverage document to the insured's specific medical circumstances supports the decision.

(C) If an adverse coverage determination was made using one of the instruments required by Section 2562.03, the dimension component and combined scores on which the coverage determination was based.

(5) A description of available internal and external appeals processes, including information regarding how to initiate an appeal. If an initial adverse utilization review coverage determination involved urgent care services, a description of the expedited review process for appeals involving urgent care services.

(6) Notice of the availability of independent medical review and an enclosure (or attachment) of the Department's application for independent medical review.

(7) Contact information for the Department's consumer assistance hotline and online consumer and provider complaint center, as provided at www.insurance.ca.gov.

(8) In a written notice to an insured's health care provider, the name, title, direct phone number, email address, and professional qualifications of the health care provider who made the adverse coverage determination.

(9) An enclosure or attachment of the complete clinical criteria or guidelines used to make the coverage determination. If the complete clinical criteria are available and accessible on an insurer's website, an insurer may instead provide the title of the applicable clinical policy and instructions for locating and accessing the clinical policy on the insurer's website and describe the process for obtaining a paper or electronic copy by email.

(10) If an adverse coverage determination was made using the instruments required by Section 2562.03, or by applying clinical criteria developed by the World Professional Association for Transgender Health, notice of the availability of the formal education programs sponsored pursuant to Section 2562.08 and instructions for obtaining access to the training materials and resources as set forth in subdivision (b) of that section.

(11) The nondiscrimination notice and taglines required by Insurance Code section 10133.11.

(d) Upon request of an insured or an insured's authorized representative for language assistance services in relation to a written notice of an adverse utilization review coverage determination, an insurer shall do the following:

(1) Provide a written translation in an indicated language, as defined by Insurance Code section 10133.8 and Article 12.1 of Subchapter 3 of this chapter (commencing with Section 2538.1), or an applicable non-English language, within 21 calendar days of receiving a request therefor. With respect to an address in any county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language.

(2) For a request involving urgent care services, provide oral interpretation in an applicable non-English language during the same phone call, or for any other language, arrange for the insured or the insured's authorized representative to receive oral interpretation services in such person's preferred language free of charge within 24 hours of receiving the request.

(e) In the provision of written notices of adverse utilization review coverage determinations, an insurer shall comply with all laws governing the confidentiality and disclosure of personal information, including with respect to sensitive services under Insurance Code section 791.29.

(f) An insurer that authorizes a health care benefit for a health condition, including but not limited to a mental health condition or substance use disorder, shall not rescind or modify the authorization after a health care provider or facility renders the health care benefit in good faith pursuant to that authorization for any reason, including, but not limited to, a subsequent rescission, cancellation, or modification of the insured's contract, a subsequent determination that the insurer did not make an accurate determination of the insured's eligibility for benefits or coverage, or pursuant to a concurrent or retrospective utilization review.

NOTE: Authority cited: Sections 10123.135, 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 791.02, 796.04, 791.29, 10123.135, 10123.191, 10123.193, 10123.195, 10123.197, 10123.201, 10133.8, 10133.11, 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, 10144.57, 10145.3 and 10169, Insurance Code.

Adopt: Section 2562.11. Utilization Review and the Mental Health Parity and Addiction Equity Act.

(a) (1) Utilization review and utilization review criteria are a nonquantitative treatment limitation as defined by the Mental Health Parity and Addiction Equity Act. An insurer that applies and conducts utilization review of health care benefits for mental health conditions or substance use disorders shall comply with the rule on nonquantitative treatment limitations, both as written and in operation, set forth in subdivision (a)(2) of this section.

(2) The processes, strategies, evidentiary standards, or other factors used to manage the health care benefits required under Insurance Code sections 10144.5, 10144.51, 10144.52, 10144.53, and 10144.57, and this article, or any other health care benefits that an insurer covers for a mental health condition or substance use disorder, shall be comparable as written and in operation to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to manage benefits for diagnoses that do not constitute a mental health or substance use disorder.

(b) An insurer shall not impose a nonquantitative treatment limitation on a health care benefit for a mental health condition or substance use disorder, including utilization review or a utilization review criterion, that is not compliant with, or for which the insurer has not performed and documented in advance, and updated as necessary, a comparative analysis of the design and application of the nonquantitative treatment limitation that in good faith satisfies the requirements of the Mental Health Parity and Addiction Equity Act.

(c) An insurer shall not conduct utilization review more frequently than is reasonably necessary to assess whether the health care benefits under review are medically necessary, recommended by nonprofit professional association clinical practice guidelines or the instruments required by Section 2562.03, or is permissible under Insurance Code section 10144.4.

(d) An insurer that conducts utilization review of health care benefits for mental health conditions or substance use disorders shall do so in a manner that is comparable to, and not more stringently than, the manner in which it conducts utilization review of health care benefits for diagnoses that do not constitute a mental health condition or substance use disorder.

(e) An insurer shall not impose a quantitative treatment limitation on a health care benefit for a mental health condition or substance use disorder or apply a quantitative treatment limitation to a health care benefit that was medically necessary for a for a mental health condition or substance use disorder.

(f) For purposes of this section, “health care benefit” includes the set of benefits described in Section 2562.01(g) of this article, for either:

(1) A mental health condition or substance use disorder.

(2) A diagnosis that is not a mental health condition or substance use disorder.

NOTE: Authority cited: Sections 10123.135, 10144.4, 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Section 10123.135, 10144.4, 10144.5, 10144.51, 10144.52, and 10144.53, Insurance Code.

Adopt: Section 2562.12. Record Keeping and Compliance.

(a) An insurer shall maintain, procure, and provide documentation, including contracts and written policies and procedures, and any other information requested by the Department, to demonstrate that the insurer, and any specialized behavioral health insurer, third-party administrator, contracting provider, or other entity that performs utilization review or utilization management functions on its behalf, is applying the most recent version of treatment criteria developed by a relevant nonprofit professional association pursuant to Insurance Code sections 10144.5 and 10144.52, and this article.

(b) An insurer shall preserve the books and records required under this article for the current year and the four preceding years in an easily accessible location at the headquarters office of the insurer and as required under Insurance Code sections 733 and 734, and Section 2695.3 of Title 10 of the California Code of Regulations.

NOTE: Authority cited: Sections 733-734, 790.04, 790.10, 10144.5, 10144.52, 10144.57, 12340-12417, 12921 and 12926, Insurance Code. Reference: Sections 733-734, subdivision (h) of Section 790.03, 10123.191, 10123.193, 10123.195, 10123.197, 10123.201, 10123.135, 10144.5, 10144.52 and 10144.57, Insurance Code.

Adopt: Section 2562.13. Enforcement Actions.

(a) In addition to applicable provisions of the Insurance Code, the general and formal administrative adjudication procedures of the Administrative Procedure Act (Chapters 4.5 and 5 of Part 1 of Division 3 of Title 2 of the Government Code) apply to enforcement actions that are brought under this article as provided in this section.

    (1) An adjudicative proceeding that is brought under this article may be conducted before a presiding officer who is an administrative law judge of the Administrative Hearing Bureau of the Department, except as otherwise required by the Insurance Code or Administrative Procedure Act.

    (2) The Department may serve notice of an investigation or enforcement action by electronic means to an insurer's attorney. The insurer's responses or portions thereof may be included in the record of a proceeding under this article, except as prohibited by Government Code Section 11415.60 or any applicable provision of the Insurance Code.

(b) If a civil penalty is sought in an adjudicative proceeding under this article, such proceeding shall be conducted in accordance with Chapter 5 of the Administrative Procedure Act (commencing with Section 11500 of the Government Code).

(c) The Department may elect the Administrative Procedure Act's informal hearing procedure (Article 10 of Chapter 4.5 (commencing with Section 11445.10 of the Government Code)) to seek a decision to compel an insurer to comply with, or cease and desist from violating, Insurance Code section 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, or this article.

(1) If interpretation of law or material facts are in dispute, the Department and insurer shall submit a pleading on the law, facts, and application of law to such facts to the presiding officer at least 15 days in advance of the proceeding, or at least 5 days in advance if the Department considers the matter urgent. In a proceeding under this subdivision, the Department deems cross-examination unnecessary for the determination of material facts unless stated otherwise in its pleading.

(2) The Department or presiding officer may convert the proceeding to a formal hearing that is subject to Chapter 5 of the Administrative Procedure Act (commencing with Section 11500 of the Government Code) at any time.

(3) A proposed decision, or portion thereof, that is adopted by the Commissioner constitutes a final order. This subdivision (c)(3) does not limit the Commissioner's or Department's authority under Government Code section 11440.10 or 11517.

(4) A decision that is sought pursuant to an informal hearing under this subdivision, and any other remedy that is available to the Commissioner, may be pursued while the Department is investigating or otherwise pursuing any other available remedies that may relate to an insurer's alleged conduct without prejudicing, to the full extent permitted by law, such other available remedies.

(d) The Department may elect to issue an emergency decision for temporary, interim relief under the procedure set forth in Article 13 of Chapter 4.5 (commencing with Section 11460.10 of the Government Code) when it has a reasonable basis to believe that an ongoing violation of Insurance Code section 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, or this article, or a pattern or practice of past ongoing incompliance therewith, may exist. An emergency decision may be issued to compel an insurer to comply at the time and in the manner prescribed therein. The Department shall demand of the insurer in advance that it comply and may, if practicable, afford the insurer an informal opportunity to be heard before issuing an emergency decision.

(e) If the Commissioner determines that an insurer has violated Insurance Code section 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, or this article, the Commissioner may, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code), by order, assess a civil penalty not to exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation.

(1) A single act may constitute violations of both Sections 10144.5 and 10144.52, in which case penalties shall accrue for each such violation.

(2) An ongoing violation shall be subject to civil penalties for each day that the violation continues.

(3) If a violation affected one or more insureds, penalties shall accrue for each insured who was affected by each such violation.

(f) If the Department notifies an insurer in writing that a gap-filling clinical policy or the documentation maintained pursuant to section 2562.04 is not compliant with Insurance Code sections 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, or this article, failing to discontinue use of the clinical policy in utilization review shall constitute a violation of Section 10144.52 for each day that the clinical policy remains in effect, following a 15-day grace period beginning on the date the insurer was notified. This subdivision does not preclude the Commissioner from assessing civil penalties for other violations of Section 10144.52.

(g) In assessing a civil penalty, the Commissioner shall consider, to the extent applicable or practicable, but shall not be limited to considering, the following factors:

(1) The nature, scope, and gravity of the violation.

(2) The degree of actual or potential harm to insureds, and detriment to the public, that resulted or could have resulted from the violation.

(3) Whether, under the totality of the circumstances, the insurer made a good faith attempt to comply with Insurance Code sections 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, 10144.57, and this article.

(4) The extent to which the insurer cooperated with the Department's investigation, and the nature of such cooperation.

(5) The extent to which the insurer aggravated or mitigated any damage caused by the violation, and the nature of the damage.

(6) The extent to which the insurer voluntarily took remedial action for past noncompliance and corrective action to assure prospective compliance, and the nature of such remedial or corrective action.

(7) The insurer's history of noncompliance with the Insurance Code and regulations promulgated thereunder.

(8) The amount of penalty that is necessary to deter similar violations in the future.

(h) An insurer shall be responsible for ensuring compliance with this article regardless of contracting or delegation arrangements and shall be subject to the assessment of civil penalties for violations of Insurance Code sections 10144.4, 10144.5, 10144.51, 10144.52, and 10144.53, or 10144.57, and this article, that are committed by any specialized behavioral health insurer, third-party administrator, contracting provider, or other entity that was acting on its behalf.

(i) A civil penalty under Insurance Code section 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, or this article, shall not constitute an exclusive remedy. This section does not preclude the Department from pursuing any other remedies that are available by law or limit the Department's procedural or substantive authority under the Insurance Code or the Administrative Procedure Act. Omission from this section of any procedures that may

be elected pursuant to Chapter 4.5 of the Administrative Procedure Act does not indicate that such procedures are unavailable, or that the Department will not elect such procedures.

NOTE: Authority cited: Sections 10144.5, 10144.52 and 10144.57, Insurance Code; Sections 11400.20, 11425.50, 11445.20, 11445.50 and 11460.20, Government Code. Reference: Sections 790.035, 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, 10144.57, 12919, 12921, 12921.1, 129121.2, 12921.3, 12921.4, 12921.5, and 12926, Insurance Code; Sections 11400 et seq. and 11500 et seq., Government Code.

Amend: Section 2562.4. Behavioral Health Treatment for Pervasive Developmental Disorder or Autism Spectrum Disorder.

(a) Scope of Section. ~~In addition to the limitations on scope set forth in section 2562.1 of this article, the scope of this section 2562.4 shall be further limited by the following sentence: This section does not apply to a policy or plan described in subdivision (d) of Insurance Code section 10144.51.~~ This section applies only to coverage for services or treatments rendered for pervasive developmental disorder or autism spectrum disorder. The requirements in this section are in addition to, and do not replace, any requirements and limitations set forth in this article, in Insurance Code sections 10144.4, 10144.5, and 10144.52, or in any other applicable law.

(b) An insurer shall not impose the following on medically necessary treatment or services rendered to an individual for the treatment or diagnosis of pervasive developmental disorder or autism:

(1) An annual visit limit, or

(2) An annual dollar limit, a copayment, a deductible, or any other financial term that does not comply with Insurance Code section 10112.1, 10144.4 and 10144.5.

(c) In cases where behavioral health treatment is medically necessary, an insurer shall not modify, delay, or deny ~~or unreasonably delay~~ coverage for behavioral health treatment based on any of the following:

(1) Based on an-asserted need for cognitive, developmental or intelligence quotient (IQ) testing,

(2) On the grounds that behavioral health treatment is deemed experimental, investigational, or educational,

(3) On the grounds that-behavioral health treatment is not being, will not be, or was not, provided or supervised by a licensed person, entity or group when the provider or supervisor in question is ~~certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies,~~ a qualified autism service provider,

qualified autism service professional, or qualified autism service paraprofessional as defined in Insurance Code section 10144.51,

(4) On the grounds that behavioral health treatment has been, is being, should be or will be provided by a Regional Center contracting with the Department of Developmental Services,

(5) On the grounds that an annual visit limit has been reached or exceeded, assuming such a limit is otherwise permissible, or

(6) For any other reason, provided, however, that the insurer may apply a deductible or other financial term or limit when the same term or limit is equally applicable to all benefits under the policy, and complies with the requirements of Insurance Code sections 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, and 10144.57.

(d) The following definitions apply for purposes of this section:

(1) "Behavioral health treatment" has the meaning set forth in subdivision (c)(1) of Insurance Code section 10144.51.

(2) "Treatment or services" includes, but is not limited to, speech therapy, occupational therapy, and behavioral health treatment, in addition to any other medically necessary treatment, as described in subdivision (c)(3), for pervasive developmental disorder or autism spectrum disorder.

Note: Authority cited: Sections ~~790.10,~~ 10144.5, 10144.51, ~~12921 and 12926~~ 10144.52 and 10144.57, Insurance Code~~; *CalFarm Ins. Co. v. Deukmejian*, 48 Ca1.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal.4th 216 (1994)~~. Reference: Sections 790.03, 10144.5~~(a)~~, ~~10144.5(c) and~~ 10144.51, 10144.52 and 10144.57, Insurance Code.