California Health and Safety Code
Sec. 1367.71
(a)
Every health care service plan contract, other than a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2000, shall be deemed to cover general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting. The health care service plan may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.
(b)
This section shall apply only to general anesthesia and associated facility charges for only the following enrollees, and only if the enrollees meet the criteria in subdivision (a):
(1)
Enrollees who are under seven years of age.
(2)
Enrollees who are developmentally disabled, regardless of age.
(3)
Enrollees whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.
(c)
Nothing in this section shall require the health care service plan to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section shall be subject to all other terms and conditions of the plan that apply generally to other benefits.
(d)
Nothing in this section shall be construed to allow a health care service plan to deny coverage for basic health care services, as defined in Section 1345.
(e)
A health care service plan may include coverage specified in subdivision (a) at any time prior to January 1, 2000.