California Insurance Code

10123.7. (a) On or after January 1, 1986, every insurer issuing group health **insurance** shall offer coverage for orthotic and **prosthetic** devices and services under the terms and conditions that may be agreed upon between the group policyholder and the insurer. Every insurer shall communicate the availability of that coverage to all group policyholders and to all prospective group policyholders with whom they are negotiating. Any coverage for **prosthetic** devices shall include original and replacement devices, as prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license. Any coverage for orthotic devices shall provide for coverage when the device, including original and replacement devices, is prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license, or is ordered by a licensed health care provider acting within the scope of his or her license. Every insurer shall have the right to conduct a utilization review to determine medical necessity prior to authorizing these services.

(b) Notwithstanding subdivision (a), on and after July 1, 2007, the amount of the benefit for orthotic and **prosthetic** devices and services shall be no less than the annual and lifetime benefit maximums applicable to all benefits in the policy. Any copayment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for orthotic and **prosthetic** devices and services shall be no more than the most common amounts contained in the policy.

(c) This section shall not apply to Medicare supplement, short-term limited duration health **insurance**, vision-only, dental-only, or CHAMPUS supplement **insurance**, or to hospital indemnity, hospital-only, accident-only, or specified disease **insurance** that does not pay benefits on a fixed benefit, cash payment only basis.