Preventive Care Services

Policy Number: BIP134.T
Effective Date: January 1, 2025

➲ Instructions for Use

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Federal

Throughout this document the following abbreviation are used:

- USPSTF means the United States Preventive Services Task Force.
- PPACA means the federal Patient Protection and Affordable Care Act of 2010.

Patient Protection and Affordable Care Act

https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf
UnitedHealthcare covers certain medical services under the preventive care services benefit. The federal Patient Protection and Affordable Care Act (PPACA) requires non-grandfathered health plans to cover certain “recommended preventive services” as identified by PPACA under the preventive care services benefit, without cost sharing to members when provided by network providers. This includes:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration Visit legislation.

Legislative Bulletin: FD1203 Religious Exception to Women’s Preventive Care Requirements

HHS also released an amendment to the prevention regulation that allows religious institutions that offer insurance to their employees the choice of whether or not to cover contraception services. Group health plans sponsored by certain religious employers, and group health insurance coverage in connection with such plans, are exempt from the requirement to cover contraceptive services. A religious employer is one that: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a non-profit organization under Internal Revenue Code section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii)."45 C.F.R. §147.130(a)(1)(iv)(B).

Oklahoma

Oklahoma Statute Title 36, Section 6060.5a

Section 6060.5a - [Effective 1/1/2024], Okla. Stat. tit. 36 § 6060.5a | Casetext Search + Citator

A. As used in this section:
   1. "Biomarker" means a biological molecule found in blood, other body fluids, or tissues that is a sign of a normal or abnormal process, or of a condition or disease. A biomarker may be used to see how well the body responds to a treatment for a disease or condition or for other purposes. Biomarkers shall include but are not limited to gene mutation or protein expression;
   2. "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing shall include but not be limited to single-analyte tests, multiplex panel tests, gene or protein expression, and whole exome, whole genome, and whole transcriptome sequencing;
   3. "Clinical utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision;
   4. "Consensus statement" means a statement that:
      a. Is developed by an independent, multidisciplinary panel of experts that use a transparent methodology and reporting structure that includes a conflict of interest policy,
      b. Is based on the best available evidence for the purpose of optimizing clinical care outcomes, and
      c. Is aimed at specific clinical circumstances;
   5. "Health benefit plan" means a plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes; and
   6. "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines that:
      a. Are developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and a conflict of interest policy, and
      b. Establish standards of care that are informed by a systemic review of evidence and an assessment of the benefits and costs of alternative care options that includes recommendations intended to optimize patient care.

B. Any health benefit plan, including the Oklahoma Employees Insurance Plan, that is offered, issued, or renewed in this state on or after the effective date of this act shall provide coverage for biomarker testing. A contract provided with a health benefit plan under this section shall include biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of an insured's disease or condition to guide treatment decisions when the biomarker test provides clinical utility as demonstrated by medical and scientific evidence including, but not limited to:
   1. Labeled indications for tests that are approved or cleared by the United States Food and Drug Administration;
   2. Indicated tests for a drug that is approved by the United States Food and Drug Administration;
   3. Warnings and precautions on United States Food and Drug Administration-approved drug labels;
   4. Centers for Medicare and Medicaid Services national coverage determinations or Medicare administrative contractor local coverage determinations; or
   5. Nationally recognized clinical practice guidelines and consensus statements.

C. A health benefit plan shall ensure that coverage is provided in a manner that limits disruptions in care, including the need for multiple biopsies and biospecimen samples.

D. An insured and a prescribing practitioner shall have access to a clear, readily available, and convenient process to request an exception to a coverage policy of a health benefit plan under this subsection. The process shall be readily accessible on the plan's website. This subsection shall not be construed to require a separate process if the health benefit plan's existing process complies with this subsection.

Okla. Stat. tit. 36, § 6060.5a
Added by Laws 2023, c. 331,s. 1, eff. 01/01/2024.

Oklahoma Statute Title 36, Section 6060.8, Insurance Plans to Include Prostate Screenings

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=438071

A. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 2000, that provides coverage to men forty (40) years of age or older in this state shall offer coverage for annual screening for the early detection of prostate cancer in men over the age of fifty (50) years and in men over the age of forty (40) years who are in high-risk categories. The coverage shall not be subject to policy deductibles. The coverage shall not exceed the actual cost of the prostate cancer screening up to a maximum of Sixty-five Dollars ($65.00) per screening.

B. The benefit required to be provided by subsection A of this section shall in no way diminish or limit diagnostic benefits otherwise allowable under a health benefit plan.

C. The prostate cancer screening coverage shall be offered as follows:
   1. The screening shall be performed by a qualified medical professional including, but not limited to, a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner, or physician assistant;
   2. The screening shall consist, at a minimum, of the following tests:
      a. Prostate-specific antigen blood test, and
      b. A digital rectal examination;
   3. At least one screening per year shall be covered for any man fifty (50) years of age or older; and
   4. At least one screening per year shall be covered for any man from forty (40) to fifty (50) years of age who is at increased risk of developing prostate cancer as determined by a physician.

Oklahoma Statute Title 36, Section 6060.8a, Coverage for Colorectal Cancer Examinations

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=275005

A. Any health benefit plan, including the State and Education Employees Group Health Insurance Plan, that is offered, issued or renewed in this state on or after January 1, 2002, which provides medical and surgical benefits, shall offer coverage for colorectal cancer examinations and laboratory tests for cancer for any nonsymptomatic covered individual, in accordance with standard, accepted published medical practice guidelines for colorectal cancer screening, who is:
   1. At least 50 years of age; or
   2. Less than 50 years of age and at high risk for colorectal cancer according to the standard, accepted published medical practice guidelines.

B. The coverage provided for by this section shall be subject to the same annual deductibles, co-payments or coinsurance limits as established for other covered benefits under the health plan.

C. To minimize costs for nonsymptomatic screening, third-party reimbursement may be at the existing Medicaid rate which shall be payment in full.

D. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this Title; provided, however, the provisions of this section shall not apply to policies or certificates issued to individuals or to groups with fifty (50) or fewer employees, or to plans offered under the state Medicaid program.

Oklahoma Administrative Code Section 365:40-5-20 (#10), Basic Health Care Services

http://okrules.elaws.us/oac/365:40-5-20

(10)Preventive health services, which shall be made available to enrollee's and shall include at least the following:
   (A) Services for children from birth to age 21 as determined by the American Academy of Pediatrics in "Guidelines for Health Supervision";
   (B) Immunizations for adults and children as recommended by the Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control and Prevention, except those required for foreign travel and employment;
   (C) Periodic health evaluations for adults to include voluntary family planning services; and
   (D) Preventive services identified through the HMO quality assurance program designed to contribute to achieving the U.S. Department of Health and Human Services "Healthy People 2010" objectives.

Oklahoma Statute Title 36, Section 6060.4, Coverage for Child Immunization

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=87362

A. A health benefit plan delivered, issued for delivery or renewed in this state on or after January 1, 1998, that provides benefits for the dependents of an insured individual shall provide coverage for each child of the insured, from birth through the date the child is eighteen (18) years of age for:
   1. Immunization against:
      a. Diphtheria
      b. Hepatitis B
      c. Measles
      d. Mumps
      e. Pertussis
      f. Polio
      g. Rubella
      h. Tetanus
      i. Varicella
      j. Haemophilus Influenza Type B, and
      k. Hepatitis A, and
   2. Any other immunization subsequently required for children by the State Board of Health.

B. Benefits required pursuant to subsection A of this section shall not be subject to a deductible, co-payment, or coinsurance requirement.
C. 1. For purposes of this section, "health benefit plan" means group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement or employee self-insured plan as permitted under Employee Retirement Income Security Act of 1974.
2. The term "health benefit plan" shall not include:
a. A plan that provides coverage:
(1) Only for a specified disease or diseases or under an individual limited benefit policy,
(2) Only for accidental death or dismemberment,
(3) Only for dental or vision care,
(4) A hospital- confinement indemnity policy,
(5) Disability income insurance or a combination of accident-only and disability income insurance or,
(6) As a supplement to liability insurance,
b. A Medicare supplemental policy as defined by Section 1882(g)(1) of the Social Security Act (42 U.S.C., Section 1395ss),
c. Worker's compensation insurance coverage,
d. Medical payment insurance issued as part of a motor vehicle insurance policy, or
e. A long-term care policy, including a nursing home fixed indemnity policy, unless a determination is made that the policy provides benefit coverage so comprehensive that the policy meets the definition of a health benefit plan, or
f. Short-term health insurance issued on a nonrenewable basis with a duration of six (6) months or less.

Oklahoma Statutes Section 6060, Coverage for Low-Dose Mammography Screening

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=87358
Amended to read as follows:

Section 6060

Effective 2018 – Oct. 31, 2022

A. For the purposes of this section,
1. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title;
2. “Low-dose mammography” means:
a. The x-ray examination of the breast using equipment specifically dedicated for such purpose, with an average radiation exposure delivery of less than one rad mid-breast and with two views for each breast,
b. Digital mammography, or
c. Breast tomosynthesis;
3. "Breast tomosynthesis" means a radiologic mammography procedure involving the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which breast cancer screening diagnoses may be made.
B. All health benefit plans shall include the coverage specified by this section for a low-dose mammography screening for the presence of occult breast cancer. Such coverage shall not:
1. Be subject to the policy deductible, co-payments and co-insurance limits of the plan; or
2. Require that a female undergo a mammography screening at a specified time as a condition of payment.
C. 1. Any female thirty-five (35) through thirty-nine (39) years of age shall be entitled pursuant to the provisions of this section to coverage for a low-dose mammography screening once every five (5) years.
2. Any female forty (40) years of age or older shall be entitled pursuant to the provisions of this section to coverage for an annual low-dose mammography screening.

Effective Nov. 1, 2022

A. For the purposes of this section:
1. “Breast magnetic resonance imaging” means a diagnostic tool used to produce detailed pictures of the structure of the breast;
2. “Breast ultrasound” means a noninvasive, diagnostic imaging technique that uses high-frequency sound waves to produce detailed images of the breast;
3. “Diagnostic examination for breast cancer” means a medically necessary and clinically appropriate examination, as defined by current guidelines and as determined by a clinician who is evaluating the individual for breast cancer, to evaluate the abnormality in the breast that is:
a. Seen or suspected from a screening examination for breast cancer,

b. Detected by another means of examination, or
c. Suspected based on the medical history or family medical history of the individual.
This examination may include, but is not limited to, a diagnostic mammogram, breast magnetic resonance imaging, or a breast ultrasound;

4. "Diagnostic mammography" means a diagnostic tool that:
   a. Uses X-ray, and
   b. Is designed to evaluate abnormality in a breast;
5. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title;
6. "Low-dose mammography" means:
   a. The X-ray examination of the breast using equipment specifically dedicated for such purpose, with an average radiation exposure delivery of less than one rad mid-breast and with two views for each breast,
   b. Digital mammography, or
   c. Breast tomosynthesis;
7. "Breast tomosynthesis" means a radiologic mammography procedure involving the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which breast cancer screening diagnoses may be made; and
8. "Screening mammography" means a radiologic procedure provided to a woman, who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer, including breast tomosynthesis.

B. All health benefit plans shall include the coverage specified by this section for a low-dose mammography screening for the presence of occult breast cancer and a diagnostic examination for breast cancer. Such coverage shall not:
   1. Be subject to the policy deductible, co-payments and co-insurance limits of the plan; or
   2. Require that a female undergo a mammography screening at a specified time as a condition of payment.

C. 1. Any female thirty-five (35) through thirty-nine (39) years of age shall be entitled pursuant to the provisions of this section to coverage for a low-dose mammography screening once every five (5) years.
   2. Any female forty (40) years of age or older shall be entitled pursuant to the provisions of this section to coverage for an annual low-dose mammography screening.

D. If application of this act would result in health savings account ineligibility under Section 223 of the federal Internal Revenue Code, as amended, the provisions of this section shall only apply to health savings accounts with qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible. Provided, however, the provisions of this section shall apply to items of services that are preventive care pursuant to Section 223(c)(2)(c) of the federal Internal Revenue Code, as amended, regardless of whether the minimum deductible has been satisfied.

Oklahoma Statutes Title 36, Section 6060.1, Coverage for Bone Density Test

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=87359

A. All individual and group health insurance policies providing coverage on an expense incurred basis, and all individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a female forty-five (45) years of age or older in this state, except for policies that provide coverage for specified disease or other limited benefit coverage, shall include the coverage specified by this section for a bone density test to qualified individuals covered by the policy when such test is requested by a primary care or referral physician. The test shall be subject to the policy deductible, copayments and coinsurance limits of the plan; provided, however, no policy or contract shall be required to reimburse more than One Hundred Fifty Dollars ($150.00) for any such test.

B. For purposes of this section:
   1. "Qualified individual" means an individual:
      a. With an estrogen hormone deficiency,
      b. With:
         (1) Vertebral abnormalities,
         (2) Primary hyperparathyroidism, or
         (3) A history of fragility bone fractures,
      c. Who is receiving long-term glucocorticoid, or
      d. Who is currently under treatment for osteoporosis; and
   2. "Bone density test" means a medically accepted measurement of bone mass used to detect low bone mass and to determine a qualified individual's risk for osteoporosis.

Oklahoma Statutes Title 36, Section 6060.3a, Routine Annual Obstetrical/Gynecological Examinations, Large Group 50 Only

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=440867

A. Any health benefit plan, including the State and Education Employees Group Health Insurance plan, that is offered, issued or renewed in this state on or after January 1, 2005, that provides medical and surgical benefits shall provide coverage for routine annual obstetrical/gynecological examinations.
B. The benefit required to be provided by this section shall in no way diminish or limit diagnostic benefits otherwise allowable under a health benefit plan.
C. Nothing in this section shall be construed as requiring such routine annual examination to be performed by an obstetrician, gynecologist, or obstetrician/gynecologist.
D. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title, except that the term "health benefit plan" does not include policies or certificates issued to individuals or groups with fewer than fifty employees.
E. The provisions of this section shall not apply to policies or certificates issued to individuals or groups with fewer than fifty employees.

Oklahoma Statutes Title 36, Section 3202, Definitions and Section 3203 Coverage for Child Health Supervision Services Offer

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=87086
https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=87087

A. All health benefit plans which provide coverage for a family member of the insured or subscriber shall offer coverage for child health supervision services. Such services shall include coverage from the moment of birth through the age of eighteen years. Each such plan or contract shall, at a minimum, provide benefits for child health supervision services at approximately the following age intervals: birth, two months, four months, six months, nine months, twelve months, eighteen months, two years, three years, four years, five years, six years, eight years, ten years, twelve years, fourteen years, sixteen years and eighteen years. A health benefit plan may provide that child health supervision services which are rendered during a periodic review shall only be covered to the extent that services are provided by or under the supervision of a single physician or other primary health care provider during the course of one visit. Benefits for such services shall be subject to the same durational limits, dollar limits, deductibles and coinsurance factors as other covered services in such health insurance policies. All Oklahoma health benefit plans delivered, issued for delivery, modified or renewed on or after January 1, 1995, shall be subject to the provisions of this section.
B. Nothing in the Oklahoma Child Health Insurance Reform Act shall prohibit the health care insurer from including any or all coverage for child health supervision services as standard coverage in their policies or contracts.
    1. "Child health supervision services" means the periodic review of a child's physical and emotional status by a physician or other primary health care provider or pursuant to a physician's supervision;
    2. "Review" shall include but not be limited to a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards;
    3. "Health care insurer" means any entity that provides health insurance in this state. For the purposes of the Oklahoma Child Health Insurance Reform Act, insurer includes but is not limited to a licensed insurance company, not-for-profit hospital service or medical indemnity corporation, a fraternal benefit society, a health maintenance organization, a prepaid health plan, a multiple employer welfare arrangement or any other entity providing a plan of health insurance or health benefits subject to state regulation; and
    4. "Health benefit plan" means any group hospital or medical policy or certificate, contract of insurance provided by a not-for-profit hospital service or medical indemnity plan, prepaid health plan, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, vision, Medicare supplement, long-term care, specified disease, hospital indemnity, or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, any plan, or automobile medical payment insurance.

Oregon

Effective Jan. 1, 2017 New and Renewing

Oregon Revised Statutes (ORS), Section 743A.124, Colorectal Cancer Screenings and Laboratory Tests

https://www.oregonlaws.org/ors/743A.124

(1) A health benefit plan as defined in ORS 743B.005 (Definitions), shall provide coverage for all colorectal cancer screening examinations and laboratory tests assigned either a grade of A or a grade of B by the United States Preventive Services Task Force.
(2) If an insured is 50 years of age or older, an insurer may not impose cost sharing on the coverage required by subsection (1) of this section and the coverage shall include, at a minimum:
  (a) (A) Fecal occult blood tests;
  (B) Colonoscopies, including the removal of polyps during a screening procedure; or
  (C) Double contrast barium enemas, and
  (b) A colonoscopy, including the removal of polyps during the procedure, if the insured has a positive result on any fecal test assigned either a grade of A or a grade of B by the United States Preventive Services Task Force.
(3) If an insured is at high risk for colorectal cancer, the coverage required by subsection (1) of this section shall include colorectal cancer screening examinations and laboratory tests as recommended by the treating physician.
(4) For the purposes of subsection (3) of this section, an individual is at high risk for colorectal cancer if the individual has:
  (a) A family medical history of colorectal cancer;
  (b) A prior occurrence of cancer or precursor neoplastic polyps;
  (c) A prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease or ulcerative colitis; or
  (d) Other predisposing factors.
(5) Subsection (2)(b) of this section does not apply to a high deductible health plan described in (26) U.S.C. 223 are also subject to this section. [Formerly 743.799; 2014 c.9 §1] 2015 c. 206§1
  Note: The amendments to 743A.124 (Colorectal cancer screenings and laboratory tests) by section 1, chapter 206, Oregon Laws 2015, apply to plans issued or renewed on or after January 1, 2017. See section 2, chapter 206, Oregon Laws 2015. The text that applies to plans issued or renewed on or after January 1, 2017, is set forth for the user's convenience.

ORS Section 743A.108, Physical Examination of Breast

https://www.oregonlaws.org/ors/743A.108

(1) A health insurance policy that covers hospital, medical, or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall provide coverage for a complete and thorough physical examination of the breast, including but not limited to, a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows:
  (a) Annually for individuals 18 years of age and older; and
  (b) At any time at the recommendation of an individual's health care provider.
(2) An insurance policy must provide coverage of physical examinations of the breast as described in the subsection (1) of the section regardless of whether a health care provider performs other preventative women's health examinations or makes a referral for other preventative women's health examinations at the same time the health care provider performs the breast examination.
(3) This section applies to health care service contractors, as defined in ORS 750.005 (Definitions), and trusts carrying out a multiple employer welfare arrangement, as defined in ORS 750.301 (Definitions for ORS 750.301 to 750.341). [Formerly 743.791; 2017 c.152 §7]

ORS Section 743A.100, Mammograms

https://www.oregonlaws.org/ors/743A.100

(1) Every health insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall provide coverage of mammograms as follows:
  (a) Mammograms for the purpose of diagnosis in symptomatic or high-risk individual at any time upon referral of the individual's health care provider; and
  (b) An annual mammogram for the purpose of early detection for an individual 40 years of age or older, with or without referral from the individual's health care provider.
(2) An insurance policy described in subsection (1) of this section must not limit coverage of mammograms to the schedule provided in subsection (1) of this section if the individual is determined by her health care provider to be at high risk for breast cancer. [Formerly 743.727]; 2017 c. 152§4

ORS Section 743A.104, Pelvic Examinations and Pap Smears Examinations

https://www.oregonlaws.org/ors/743A.104

All policies providing health insurance, except those policies whose coverage is limited to expenses from accidents or specific diseases that are unrelated to the coverage required by this section, shall include coverage for pelvic examinations and Pap smear examinations as follows:
(1) Annually for individual 18 to 64 years of age; and

(2) At any time upon referral of the individual's health care provider. [Formerly 743.728];2017 c. 152§5

ORS Section 743B.222, Designation of Women's Health Care Provider as Primary Care Provider; Direct Access to Women's Health Care Provider

https://www.oregonlaws.org/ors/743B.222

(1) As used in this section, "women's health care provider" means an obstetrician or gynecologist, physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health or certified nurse midwife, practicing within the applicable lawful scope of practice.
(2) Every health insurance policy that covers hospital, medical or surgical expenses and requires an enrollee to designate a participating primary care provider shall permit a female enrollee to designate a women's health care provider as the enrollee's primary care provider if:
  (a) The women's health care provider meets the standards established by the insurer in collaboration with interested parties, including but not limited to the Oregon section of the American College of Obstetricians and Gynecologists; and
  (b) The women's health care provider requests that the insurer make the provider available for designation as a primary care provider.
(3) If a female enrollee has designated a primary care provider who is not a women's health care provider, an insurance policy as described in subsection (2) of this section shall permit the enrollee to have direct access to a women's health care provider, without a referral or prior authorization, for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.
(4) The standards established by the insurer under subsection (2) of this section shall not prohibit an insurer from establishing the maximum number of participating primary care providers and participating women's health care providers necessary to serve a defined population or geographic service area. [Formerly 743.845] 2017 c.356§96

ORS Section 743A.105, HPV Vaccine

https://www.oregonlaws.org/ors/743A.105

(1) All health benefit plans, as defined in ORS 743B.005 (Definitions), shall include coverage of the human papillomavirus vaccine for beneficiaries under the health benefit plan who are at least 11 years of age but no older than 26 years of age.
(2) ORS 743A.001 (Automatic repeal of certain statutes on individual and group health insurance) does not apply to this section. [2009 c.630 §2] 2017 c. 152§6

Texas

Texas Insurance Code (TIC) Section 1367.053, Coverage Required

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1367.htm#1367.053

(a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide for each covered child from birth through the date of the child's sixth birthday coverage for:
  (1) Immunization against:
    (A) Diphtheria;
    (B) Haemophilus Influenzae Type B;
    (C) Hepatitis B;
    (D) Measles;
    (E) Mumps;
    (F) Pertussis;
    (G) Polio;
    (H) Rubella;
    (I) Tetanus; and
    (J) Varicella; and
  (2) Any other immunization that is required for the child by law.
(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.
(c) In addition to the immunizations required under Subsection (a), a health maintenance organization that issues a health benefit plan shall provide under the plan coverage for immunization against rotavirus and any other immunization required for a child by law.

TIC Section 1271.154, Well Child Care From Birth

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1271.htm#1271.154

(a) In this section, "well-child care from birth" has the meaning used under Section 1302, Public Health Service Act (42 U.S.C. Section 300e-1), and its subsequent amendments. The term includes newborn screening required by the Department of State Health Services and the cost of the newborn screening test kit described by Section 33.019, Health and Safety Code

(b) A health maintenance organization shall ensure that each health care plan provided by the health maintenance organization includes well-child care from birth that complies with:
  (1) Federal requirements adopted under Chapter XI, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments; and
  (2) The rules adopted by the Texas Department of Health to implement those requirements including rules on the cost of the newborn screening test kit described by Section 33.019, Health and Safety Code.

TIC Section 1367.103, Hearing Screening, Coverage Required

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1367.htm#1367.103

(a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide to each covered child coverage for:
  (1) A screening test for hearing loss from birth through the date the child is 30 days of age, as provided by Chapter 47, Health and Safety Code; and
  (2) Necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months of age.

(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

(c) This section does not require a health benefit plan to provide the coverage described by this section to a child of an individual residing in this state if the individual is:
  (1) Employed outside this state; and
  (2) Covered under a health benefit plan maintained for the individual by the individual's employer as an employment benefit.

TIC Section 1362.003, Prostate Cancer Screening

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1362.htm

(a) A health benefit plan that provides coverage for diagnostic medical procedures must provide to each male enrolled in the plan coverage for expenses for an annual medically recognized diagnostic examination for the detection of prostate cancer.

(b) Coverage required under this section includes at a minimum:
  (1) A physical examination for the detection of prostate cancer; and
  (2) A prostate-specific antigen test used for the detection of prostate cancer for each male who:
    (A) Is at least 50 years of age and is asymptomatic; or
    (B) Is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

Texas Administrative Code (TAC) Section 11.1600, OB/GYN Direct Access

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=11&rl=1600

(f) If an HMO does not limit an enrollee's selection of an obstetrician or gynecologist to the limited provider network to which that enrollee's primary care physician or provider belongs, then it must provide a notice in compliance with the Insurance Code Chapter 1451, Subchapter F, (concerning Access to Obstetrical or Gynecological Care) in substantially the following form to current or prospective enrollees: "ATTENTION FEMALE ENROLLEES: You have the right to select and visit an obstetrician-gynecologist (OB-GYN) without first obtaining a referral from your PCP. (Name of HMO) has opted not to limit your selection of an OB-GYN to your PCP's network. You are not required to select an OB-GYN. You may elect to receive your OB-GYN services from your PCP."

TIC Chapter 1363.003 Colorectal Cancer Screening: Minimum Coverage Required

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1363.htm#1363.003

(a) A health benefit plan that provides coverage for screening medical procedures must provide to each individual enrolled in the plan who is 45 years of age or older and at normal risk for developing colon cancer coverage for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer.

(b) The minimum coverage required under this section must include:
  (1) All colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and
  (2) An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.
(c) For an enrollee in a managed care plan as defined by Section 1451.151, the plan may impose a cost-sharing requirement for coverage described by this section only if the enrollee obtains the covered benefit or service outside the plan's network.

TAC Section 11.508, (a)(1)(H) Preventive

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=11&rl=508

(a) Each evidence of coverage providing basic health care services must provide the following basic health care services when they are provided by network physicians or providers, or by non-network physicians and providers as set out in §11.506(9)(b) or §11.506(b)(14) of this title; relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate):
  (1) Outpatient services, including the following:
    (H) Preventive services, including:
      (i) Periodic health examinations for adults as required by Insurance Code §1271.153; (concerning Periodic Health Evaluations);
      (ii) Immunizations for children as required by Insurance Code §1367.053; (concerning Coverage Required);
      (iii) Well-child care from birth as required by Insurance Code §1271.154; (concerning Well-Child Care From Birth);
      (iv) Cancer screenings as required by Insurance Code Chapters 1356(concerning Low-Dose Mammography), 1362 (concerning Certain Tests for Detection of Prostate Cancer), and 1363 (concerning Certain Tests for Detection of Colorectal Cancer
      (v) Eye and ear examinations for children through age 17, to determine the need for vision and hearing correction complying with established medical guidelines; and
      (vi) Immunizations for adults under the United States Department of Health and Human Services Centers for Disease Control Recommended Adult Immunization Schedule by Age Group and Medical Conditions, or its successor;

TIC Section 1271.153, Periodic Health Evaluations

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1271.htm#1271.153

(a) The basic health care services provided under an evidence of coverage must include periodic health evaluations for each adult enrollee.
(b) The services provided under this section must include a health risk assessment at least once every three years and, for a female enrollee, an annual well-woman examination provided in accordance with Subchapter F, Chapter 1451.
(c) This section does not apply to an evidence of coverage for a limited health care service plan or a single health care service plan.

TIC Chapter 1376, Certain Tests for Early Detection of Cardiovascular Disease, Section 1376.003, Minimum Coverage Required

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1376.htm

Preventive Health Services Coverage

(a) A health benefit plan that provides coverage for screening medical procedures must provide the minimum coverage required by this section to each covered individual **(Applies to policies issued or renewed on or after 1/1/10):**
  (1) Who is:
    (A) A male older than 45 years of age and younger than 76 years of age; or
    (B) A female older than 55 years of age and younger than 76 years of age; and
  (2) Who is:
    (A) Is diabetic; or
    (B) Has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher.
(b) The minimum coverage required to be provided under this section is coverage of up to $200 for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years,

performed by a laboratory that is certified by a national organization recognized by the commissioner by rule for the purposes of this section:
(1) Computed tomography (CT) scanning measuring coronary artery calcification; or
(2) Ultrasonography measuring carotid intima-media thickness and plaque.

TIC Mammography Sec. 1356.001

Bill Text: TX HB170 | 2019-2020 | 86th Legislature | Introduced | LegiScan
https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1356&Phrases=1356.001&HighlightType=1&ExactPhrase=False&QueryText=1356.001

Be It Enacted by the Legislature of the State of Texas:

Section 1

Section 1356.001, Insurance Code, is amended by adding Subdivision (1-a) to read as follows:
(1) "Breast tomosynthesis" means a radiologic mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnoses may be determined.
(1-a) "Diagnostic imaging" means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate:
(A) A subjective or objective abnormality detected by a physician or patient in a breast;
(B) An abnormality seen by a physician on a screening mammogram;
(C) An abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician; or
(D) An individual with a personal history of breast cancer or dense breast tissue.
(2) "Low-dose mammography" means:
(A) The x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, and screens, with an average radiation exposure delivery of less than one rad mid-breast and with two views for each breast;
(B) Digital mammography; or
(C) Breast tomosynthesis.

Section 2

Section 1356.002, Insurance Code, is amended by amending Subsection (g) and adding Subsections (i) and (j) to read as follows:
(g) Not withstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:
(1) A basic coverage plan under Chapter 1551;
(2) A basic plan under Chapter 1575;
(3) A primary care coverage plan under Chapter 1579;
and
(4) Basic coverage under Chapter 1601.
(h) Notwithstanding Section 157.008, Local Government Code, or any other law, this chapter applies to a county employee health benefit plan established under Chapter 157, Local Government Code.
(I) To the extent allowed by federal law, this chapter applies to:
(1) The state Medicaid program operated under Chapter 32, Human Resources Code; and
(2) A Medicaid managed care program operated under Chapter 533, Government Code.

Section 3

https://legiscan.com/TX/text/HB170/id/1824448
Section 1356.005, Insurance Code, is amended by adding Subsection (a-1) to read as follows:
(a-1) A health benefit plan that provides coverage for a screening mammogram must provide coverage for diagnostic imaging that is no less favorable than the coverage for a screening mammogram.

Section 4

Section 1356.0021, Insurance Code, is repealed.

Section 5

If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

Section 6
This Act applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2020. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2020, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

Section 7
This Act takes effect September 1, 2019.

TIC Chapter 1361, Detection and Prevention of Osteoporosis, Section 1361.003, Coverage Required
https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1361.htm#1361.003
A group health benefit plan must provide to a qualified enrollee coverage for medically accepted bone mass measurement to detect low bone mass and to determine the enrollee's risk of osteoporosis and fractures associated with osteoporosis.

TIC Section 1271.153, Periodic Health Evaluations
https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1271.htm#1271.153
(a) The basic health care services provided under an evidence of coverage must include periodic health evaluations for each adult enrollee.
(b) The services provided under this section must include a health risk assessment at least once every three years and, for a female enrollee, an annual well-woman examination provided in accordance with Subchapter F, Chapter 1451.
(c) This section does not apply to an evidence of coverage for a limited health care service plan or a single health care service plan.

TIC Section 1370.002-1370.003, Certain Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer
Section 1370.002, Exceptions
https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1370.htm#1370.002
(a) This chapter does not apply to:
  (1) A plan that provides coverage:
    (A) Only for benefits for a specified disease or for another limited benefit, other than a plan that provides benefits for cancer treatment or similar services;
    (B) Only for accidental death or dismemberment;
    (C) For wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
    (D) As a supplement to a liability insurance policy;
    (E) Only for dental or vision care; or
    (F) Only for indemnity for hospital confinement;
  (2) A Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
  (3) A workers' compensation insurance policy;
  (4) Medical payment insurance coverage provided under an automobile insurance policy;
  (5) A credit insurance policy;
  (6) A limited benefit policy that does not provide coverage for physical examinations or wellness exams; or
  (7) A long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1370.001.
(b) To the extent that providing coverage for ovarian cancer screening under this chapter would otherwise require this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit for the ovarian cancer screening under this chapter that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

Section 1370.003, Coverage Required
(a) A health benefit plan that provides coverage for diagnostic medical procedures must provide to each woman 18 years of age or older enrolled in the plan coverage for expenses for an annual medically recognized diagnostic examination for the early detection of ovarian cancer and cervical cancer.
(b) Coverage required under this section includes at a minimum:
  (1) A CA 125 blood test; and

(2) A conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus and
(3) any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer.

(c) A screening test required under this section must be performed in accordance with the guidelines adopted by:
(1) The American College of Obstetricians and Gynecologists; or
(2) Another similar national organization of medical professionals recognized by the commissioner.

Washington

Revised Code of Washington (RCW) Section 48.42.100, Women's Health Care Services-Duties of Health Care Carriers

https://app.leg.wa.gov/rcw/default.aspx?cite=48.42.100

(1) For purposes of this section, health care carriers includes disability insurers regulated under chapter 48.20 or 48.21 RCW, health care services contractors regulated under chapter 48.44 RCW, health maintenance organizations regulated under chapter 48.46 RCW, plans operating under the health care authority under chapter 41.05 RCW, the state health insurance pool operating under chapter 48.41 RCW, and insuring entities regulated under chapter 48.43 RCW.

(2) For purposes of this section and consistent with their lawful scopes of practice, types of health care practitioners that provide women's health care services shall include, but need not be limited by a health care carrier to, the following: Any generally recognized medical specialty of practitioners licensed under chapter 18.57 or 18.71 RCW who provides women's health care services; practitioners licensed under chapters 18.57A and 18.71A RCW when providing women's health care services; midwives licensed under chapter 18.50 RCW; and advanced registered nurse practitioner specialists in women's health and midwifery under chapter 18.79 RCW.

(3) For purposes of this section, women's health care services shall include, but need not be limited by a health care carrier to, the following: Maternity care; reproductive health services; gynecological care; general examination; and preventive care as medically appropriate and medically appropriate follow-up visits for the services listed in this subsection.

(4) Health care carriers shall ensure that enrolled female patients have direct access to timely and appropriate covered women's health care services from the type of health care practitioner of their choice in accordance with subsection (5) of this section.

(5) (a) Health care carrier policies, plans, and programs written, amended, or renewed after July 23, 1995, shall provide women patients with direct access to the type of health care practitioner of their choice for appropriate covered women's health care services without the necessity of prior referral from another type of health care practitioner.
(b) Health care carriers may comply with this section by including all the types of health care practitioners listed in this section for women's health care services for women patients.
(c) Nothing in this section shall prevent health care carriers from restricting women patients to seeing only health care practitioners who have signed participating provider agreements with the health care carrier.

Changes effective 06/11/2020.

Section 35. RCW 48.42.100 and 2000 c 7 s 1

http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/2378-S.SL.pdf

Sec. 35. RCW 48.42.100 and 2000 c 7 s 1 are each amended to read as follows:35 36

(1) For purposes of this section, health care carriers includes 37 disability insurers regulated under chapter 48.20 or 48.21 RCW, 38 health care services contractors regulated under chapter 48.44 RCW, p. 48 SHB 2378.SL 1 health maintenance organizations regulated under chapter 48.46 RCW, 2 plans operating under the health care authority under chapter 41.05 3 RCW, the state health insurance pool operating under chapter 48.41 4 RCW, and insuring entities regulated under chapter 48.43 RCW.

(2) For purposes of this section and consistent with their lawful 6 scopes of practice, types of health care practitioners that provide 7 women's health care services shall include, but need not be limited 8 by a health care carrier to, the following: Any generally recognized 9 medical specialty of practitioners licensed under chapter 18.57 or 10 18.71 RCW who provides women's health care services; practitioners 11 licensed under ((chapters 18.57A and)) chapter 18.71A RCW when 12 providing women's health care services; midwives licensed under 13 chapter 18.50 RCW; and advanced registered nurse practitioner 14 specialists in women's health and midwifery under chapter 18.79 RCW.

(3) For purposes of this section, women's health care services 16 shall include, but need not be limited by a health care carrier to, 17 the following: Maternity care; reproductive health services; 18 gynecological care; general examination; and preventive care as 19 medically appropriate and medically appropriate follow-up visits for the services listed in this subsection.

(4) Health care carriers shall ensure that enrolled female 22 patients have direct access to timely and appropriate covered women's 23 health care services from the type of health care practitioner of 24 their choice in accordance with subsection (5) of this section.
(5) (a) Health care carrier policies, plans, and programs written, 26 amended, or renewed after July 23, 1995, shall provide women patients 27 with direct access to the type of health care practitioner of their 28 choice for appropriate covered women's health care services without 29 the necessity of prior referral from another type of health care practitioner.
(b) Health care carriers may comply with this section by 32 including all the types of health care practitioners listed in this 33 section for women's health care services for women patients.
(c) Nothing in this section shall prevent health care carriers 35 from restricting women patients to seeing only health care 36 practitioners who have signed participating provider agreements with the health care carrier.

RCW Section 48.46.277, Prostate Cancer Screening

SB 6188-Applies to employer group contracts issued or renewed after 12/31/2006
https://app.leg.wa.gov/rcw/default.aspx?cite=48.46.277
(1) Each health maintenance agreement issued or renewed after December 31, 2006, that provides coverage for hospital or medical expenses shall provide coverage for prostate cancer screening, provided that the screening is delivered upon the recommendation of the patient's physician, advanced registered nurse practitioner, or physician assistant.
(2) All services must be provided by the health maintenance organization or rendered upon a referral by the health maintenance organization.
(3) This section shall not be construed to prevent the application of standard policy provisions applicable to other benefits, such as deductible or copayment provisions. This section does not limit the authority of a health maintenance organization to negotiate rates and contract with specific providers for the delivery of prostate cancer screening services. This section shall not apply to medicare supplemental policies or supplemental contracts covering a specified disease or other limited benefits.

RCW Section 48.43.043, Colorectal Cancer Examinations and Laboratory Tests-Required Benefits for Coverage

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.043
(1) Health plans issued or renewed on or after July 1, 2008, must provide benefits or coverage for colorectal cancer examinations and laboratory tests consistent with the guidelines or recommendations of the United States preventive services task force or the federal centers for disease control and prevention. Benefits or coverage must be provided:
(a) For any of the colorectal screening examinations and tests in the selected guidelines or recommendations, at a frequency identified in such guidelines or recommendations, as deemed appropriate by the patient's physician after consultation with the patient; and
(b) To a covered individual who is:
(i) At least fifty years old; or
(ii) Less than fifty years old and at high risk or very high risk for colorectal cancer according to such guidelines or recommendations.
(2) To encourage colorectal cancer screenings, patients and health care providers must not be required to meet burdensome criteria or overcome significant obstacles to secure such coverage. An individual may not be required to pay an additional deductible or coinsurance for testing that is greater than an annual deductible or coinsurance established for similar benefits. If the health plan does not cover a similar benefit, a deductible or coinsurance may not be set at a level that materially diminishes the value of the colorectal cancer benefit required.
(3) (a) A health carrier is not required under this section to provide for a referral to a nonparticipating health care provider, unless the carrier does not have an appropriate health care provider that is available and accessible to administer the screening exam and that is a participating health care provider with respect to such treatment.
(b) If a health carrier refers an individual to a nonparticipating health care provider pursuant to this section, screening exam services or resulting treatment, if any, must be provided at no additional cost to the individual beyond what the individual would otherwise pay for services provided by a participating health care provider.

RCW Section 48.21.225, Mammograms-Insurance Coverage

https://app.leg.wa.gov/rcw/default.aspx?cite=48.21.225
Each group disability insurance policy issued or renewed after January 1, 1990, that provides coverage for hospital or medical expenses shall provide coverage for screening or diagnostic mammography services, provided that such services are delivered upon the recommendation of the patient's physician or advanced registered nurse practitioner as authorized by the nursing care quality assurance commission pursuant to chapter 18.79 RCW or physician assistant pursuant to chapter 18.71A RCW.

This section shall not be construed to prevent the application of standard policy provisions applicable to other benefits such as deductible or copayment provisions. This section does not limit the authority of an insurer to negotiate rates and contract with specific providers for the delivery of mammography services. This section shall not apply to Medicare supplement policies or supplemental contracts covering a specified disease or other limited benefits.

Effective Jul. 23, 2023

https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5396-S.SL.pdf
Each group disability insurance policy issued or renewed after January 1, 1990, that provides coverage for hospital or medical expenses shall provide coverage for screening or diagnostic mammography services, provided that such services are delivered upon the recommendation of the patient's physician or advanced registered nurse practitioner as authorized by the nursing care quality assurance commission pursuant to chapter 18.79 RCW or physician assistant pursuant to chapter 18.71A RCW.

This section shall not be construed to prevent the application of standard policy provisions, **other than the cost-sharing prohibition provided in section 2 of this act, that are** applicable to other benefits This section does not limit the authority of an insurer to negotiate rates and contract with specific providers for the delivery of mammography services. This section shall not apply to Medicare supplement policies or supplemental contracts covering a specified disease or other limited benefits.

RCW Section 48.46.275, Mammograms–Insurance Coverage

https://app.leg.wa.gov/rcw/default.aspx?cite=48.46.275
Each health maintenance agreement issued or renewed after January 1, 1990, that provides benefits for hospital or medical care shall provide benefits for screening or diagnostic mammography services, provided that such services are delivered upon the recommendation of the patient's physician or advanced registered nurse practitioner as authorized by the nursing care quality assurance commission pursuant to chapter 18.79 RCW or physician assistant pursuant to chapter 18.71A RCW.

All services must be provided by the health maintenance organization or rendered upon referral by the health maintenance organization. This section shall not be construed to prevent the application of standard agreement provisions applicable to other benefits such as deductible or copayment provisions. This section does not limit the authority of a health maintenance organization to negotiate rates and contract with specific providers for the delivery of mammography services. This section shall not apply to Medicare supplement policies or supplemental contracts covering a specified disease or other limited benefits.

Effective Jul. 23, 2023

https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5396-S.SL.pdf
Each health maintenance agreement issued or renewed after January 1, 1990, that provides benefits for hospital or medical care shall provide benefits for screening or diagnostic mammography services, provided that such services are delivered upon the recommendation of the patient's physician or advanced registered nurse practitioner as authorized by the nursing care quality assurance commission pursuant to chapter 18.79 RCW or physician assistant pursuant to chapter 18.71A RCW.

All services must be provided by the health maintenance organization or rendered upon referral by the health maintenance organization. This section shall not be construed to prevent the application of standard agreement provisions, **other than the cost-sharing prohibition provided in section 2 of this act**, that are applicable to other benefits. This section does not limit the authority of a health maintenance organization to negotiate rates and contract with specific providers for the delivery of mammography services. This section shall not apply to Medicare supplement policies or supplemental contracts covering a specified disease or other limited benefits.

Washington Administrative Code Section 284-43-5642, Essential Health Benefit Categories

https://apps.leg.wa.gov/wac/default.aspx?cite=284-43-5642
(1) (b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base- benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer should not include the following benefits in establishing actuarial value for the ambulatory category
(vii) Hearing care, routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant

them. However, plans must cover cochlear implants and hearing screening tests that are required under the preventive services category, unless coverage for these services and devices are required as part of and classified to another essential health benefits category; and

(viii)(B) Obesity-related services for which the U.S. Preventive Services Task Force for prevention and chronic care has issued A and B recommendations on or before the applicable plan year, which issuers must cover under subsection (9) of this section.

(9) A health plan must cover "preventive and wellness services, including chronic disease management" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as preventive and wellness services, including chronic disease management, the services that identify or prevent the onset or worsening of disease or disease conditions, illness or injury, often asymptomatic; services that assist in the multidisciplinary management and treatment of chronic diseases; and services of particular preventative or early identification of disease or illness of value to specific populations, such as women, children and seniors.

(a) If a plan does not have in its network a provider who can perform the particular service, then the plan must cover the item or service when performed by an out-of-network provider and must not impose cost-sharing with respect to the item or service. In addition, a health plan must not limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity or recorded gender. If a provider determines that a sex-specific recommended preventive service is medically appropriate for an individual, and the individual otherwise satisfies the coverage requirements, the plan must provide coverage without cost-sharing.

(b) A health benefit plan must include the following services as preventive and wellness services, including chronic disease management:

(i) Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices;

(ii) (A) Screening and tests for which the U.S. Preventive Services Task Force for Prevention and Chronic Care have issued A and B recommendations on or before the applicable plan year.

(B) To the extent not specified in a recommendation or guideline, a plan may rely on the relevant evidence base and reasonable medical management techniques, based on necessity or appropriateness, to determine the frequency, method, treatment, or setting for the provision of a recommended preventive health service;

(iii) Services, tests and screening contained in the U.S. Health Resources and Services Administration ("HRSA") Bright Futures guidelines as set forth by the American Academy of Pediatricians; and

(iv) Services, tests, screening and supplies recommended in the HRSA women's preventive and wellness services guidelines:

(A) If the plan covers children under the age of nineteen, or covers dependent children age nineteen or over who are on the plan pursuant to RCW 48.44.200, 48.44.210, or 48.46.320, the plan must provide the child with the full range of recommended preventive services suggested under HRSA guidelines for the child's age group without cost-sharing. Services provided in this regard may be combined in one visit as medically appropriate or may be spread over more than one visit, without incurring cost-sharing, as medically appropriate; and

(B) A plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a recommended preventive service, including providing multiple prevention and screening services at a single visit or across multiple visits.

(vi) Wellness services.

(c) The base-benchmark plan establishes specific limitations on services classified to the preventive services category that conflict with state or federal law as of January 1, 2017, and should not be included in essential health benefit plans.

Specifically, the base-benchmark plan excludes coverage for obesity or weight control other than covered nutritional counseling. Health plans must cover certain obesity-related services that are listed as A or B recommendations by the U.S. Preventive Services Task Force, consistent with 42 USC 300 gg13(a)(1) and 45 CFR 147.130(a)(1)(i).

(d) The base-benchmark plan does not establish visit limitations on services in this category. In accordance with Section 2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services, the base-benchmark plan does not impose cost-sharing requirements with respect to the preventive services listed under (b)(i) through (iv) of this subsection that are provided in-network.

(e) State benefit requirements classified in this category are:

(i) Colorectal cancer screening as set forth in RCW 48.43.043;

(ii) Mammogram services, both diagnostic and screening (RCW 48.21.225, 48.44.325, and 48.46.275); and

(iii) Prostate cancer screening (RCW 48.20.392, 48.21.227, 48.44.327, and 48.46.277).

State Market Plan Enhancements

Oklahoma

Female members may self-refer to an OB/GYN contracting with their medical group one time annually for a pap smear, pelvic and breast exam.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

Notes:

- Refer to state-specific mandated requirement for preventive health services.
- **If no state-mandated requirement, refer to the Medical Policy titled Preventive Care Services.**

Not Covered

Refer to the Medical Policy titled Preventive Care Services.

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
01/01/2025	All	• Routine review; no change to coverage • Archived previous policy version BIP134.S

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.