Chapter 743A

2011 EDITION

Health Insurance: Required Reimbursements

743A.001 Automatic repeal of certain statutes on individual and group health insurance. (1) Except as provided in subsection (4) of this section, any statute described in subsection (2) of this section that becomes effective on or after July 13, 1985, is repealed on the sixth anniversary of the effective date of the statute, unless the Legislative Assembly specifically provides otherwise.

(2) This section governs any statute that applies to individual or group health insurance policies and does any of the following:

(a) Requires the insurer to include coverage for specific physical or mental conditions or specific hospital, medical, surgical or dental health services.

(b) Requires the insurer to include coverage for specified persons.

(c) Requires the insurer to provide payment or reimbursement to specified providers of services if the services are within the lawful scope of practice of the provider and the insurance policy provides payment or reimbursement for those services.

(d) Requires the insurer to provide any specific coverage on a nondiscriminatory basis.

(e) Forbids the insurer to exclude from payment or reimbursement any covered services.

(f) Forbids the insurer to exclude coverage of a person because of that person's medical history.

(3) A repeal of a statute under subsection (1) of this section does not apply to any insurance policy in effect on the effective date of the repeal. However, the repeal of the statute applies to a renewal or extension of an existing insurance policy on or after the effective date of the repealer as well as to a new policy issued on or after the effective date of the repealer.

(4) This section does not apply to ORS 743A.020, 743A.080, 743A.100, 743A.104 and 743A.108. [Formerly 743.700]

743A.010 Services provided by state hospital or state approved program. No policy of health insurance shall exclude from payment or reimbursement losses incurred by an insured for any covered service because the service was rendered at any hospital owned or operated by the State of Oregon or any state approved community mental health program or community developmental disabilities program. [Formerly 743.701; 2011 c.720 §221]

743A.012 Emergency services. (1) As used in this section:

(a) "Emergency medical condition" means a medical condition:

(A) That manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:

(i) Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;

(ii) Result in serious impairment to bodily functions; or

(iii) Result in serious dysfunction of any bodily organ or part; or

(B) With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.

(b) "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

(c) "Emergency services" means, with respect to an emergency medical condition:

(A) An emergency medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

(d) "Grandfathered health plan" has the meaning given that term in ORS 743.730.

(e) "Health benefit plan" has the meaning given that term in ORS 743.730.

(f) "Prior authorization" has the meaning given that term in ORS 743.801.

(g) "Stabilize" means to provide medical treatment as necessary to:

(A) Ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient from a facility; and

(B) With respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

(2) All insurers offering a health benefit plan shall provide coverage without prior authorization for emergency services.

(3) A health benefit plan, other than a grandfathered health plan, must provide cov-

erage required by subsection (2) of this section:

(a) For the services of participating providers, without regard to any term or condition of coverage other than:

(A) The coordination of benefits;

(B) An affiliation period or waiting period permitted under part 7 of the Employee Retirement Income Security Act, part A of Title XXVII of the Public Health Service Act or chapter 100 of the Internal Revenue Code;

(C) An exclusion other than an exclusion of emergency services; or

(D) Applicable cost-sharing; and

(b) For the services of a nonparticipating provider:

(A) Without imposing any administrative requirement or limitation on coverage that is more restrictive than requirements or limitations that apply to participating providers;

(B) Without imposing a copayment amount or coinsurance rate that exceeds the amount or rate for participating providers;

(C) Without imposing a deductible, unless the deductible applies generally to nonparticipating providers; and

(D) Subject only to an out-of-pocket maximum that applies to all services from nonparticipating providers.

(4) All insurers offering a health benefit plan shall provide information to enrollees in plain language regarding:

(a) What constitutes an emergency medical condition;

(b) The coverage provided for emergency services;

(c) How and where to obtain emergency services; and

(d) The appropriate use of 9-1-1.

(5) An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and may not deny coverage for emergency services solely because 9-1-1 was used.

(6) This section is exempt from ORS 743A.001. [Formerly 743.699; 2011 c.500 §38]

743A.014 Payments for ambulance care and transportation. Any insurance policy issued or issued for delivery in this state that provides coverage for ambulance care and transportation shall provide that payments will be made jointly to the provider of the ambulance care and transportation and to the insured, unless the policy provides for direct payment to the provider. [Formerly 743.718]

Note: See 743A.001.

743A.020 Services provided by acupuncturist. (1) An individual or group health insurance policy that provides coverage for acupuncture services performed by a physician shall provide coverage for acupuncture services performed by an acupuncturist licensed under ORS 677.757 to 677.770.

(2) The coverage required by subsection (1) of this section may be made subject to provisions of the policy that apply to other benefits under the policy, including, but not limited to, provisions related to deductibles and coinsurance and shall be computed in the same manner whether performed by a physician or an acupuncturist.

(3) Subsection (1) of this section does not require group practice health maintenance organizations that are federally qualified pursuant to Title XIII subchapter XI of the Public Health Service Act (42 U.S.C. 300e et seq.) to employ acupuncturists licensed under ORS 677.757 to 677.770.

(4) This section also applies to health care service contractors, as defined in ORS 750.005, and trusts carrying out multiple employer welfare arrangements, as defined in ORS 750.301. [2007 c.313 §2]

Note: 743A.020 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.024 Services provided by clinical social worker. Whenever any individual or group health insurance policy or blanket health insurance policy described in ORS 743.534 (3) provides for payment or reimbursement for any service within the lawful scope of service of a clinical social worker licensed under ORS 675.530:

(1) The insured under the policy shall be entitled to the services of a clinical social worker licensed under ORS 675.530, upon referral by a physician or psychologist.

(2) The insured under the policy shall be entitled to have payment or reimbursement made to the insured or on behalf of the insured for the services performed. The payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be computed in the same manner whether performed by a physician, by a psychologist or by a clinical social worker, according to the customary and usual fee of clinical social workers in the area served. [Formerly 743.714; 2009 c.442 §46]

743A.028 Services provided by denturist. Notwithstanding any provisions of any policy of insurance covering dental health, whenever such policy provides for reimbursement for any service that is within the lawful scope of practice of a denturist, the insured under such policy shall be entitled to reimbursement for such service, whether the service is performed by a licensed dentist or a licensed denturist as defined in ORS 680.500. [Formerly 743.713]

Note: 743A.028 was added to and made a part of the Insurance Code by law but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.032 Surgical services provided by dentist. Notwithstanding any provision of a policy of health insurance, whenever the policy provides for payment of a surgical service, the performance for the insured of such surgical service by any dentist acting within the scope of the dentist's license is compensable if performance of that service by a physician acting within the scope of the physician's license would be compensable. [Formerly 743.719]

743A.034 Services provided by expanded practice dental hygienist. (1) If a policy of insurance covering dental health provides for coverage for services performed by a dentist licensed under ORS chapter 679, the policy must also cover the services when they are performed by an expanded practice dental hygienist, as defined in ORS 679.010, who has entered into a provider contract with the insurer.

(2) The provisions of ORS 743A.001 do not apply to this section. [2011 c.716 §11]

Note: 743A.034 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.036 Services provided by nurse practitioner. (1) Whenever any policy of health insurance provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed and certified nurse practitioner, including prescribing or dispensing drugs, the insured under the policy is entitled to reimbursement for such service whether it is performed by a physician licensed by the Oregon Medical Board or by a duly licensed nurse practitioner.

(2) This section does not apply to group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Health Maintenance Organization Act. [Formerly 743.712]

743A.040 Services provided by optometrist. Notwithstanding any provision of any policy of health insurance, whenever the policy provides for payment or reimbursement for a service that is within the lawful scope of practice of a licensed optometrist, the insurer shall provide payment or reimbursement for the service, whether the service is performed by a physician or a licensed optometrist. Unless the policy provides otherwise, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses or appurtenances thereto. [Formerly 743.703]

743A.044 Services provided by physician assistant. (1) An insurer may not refuse a claim solely on the ground that the claim was submitted by a physician assistant rather than by a supervising physician for the physician assistant.

(2) This section is exempt from ORS 743A.001. [Formerly 743.725; 2010 c.43 §9]

743A.048 Services provided by psychologist. Whenever any provision of any individual or group health insurance policy or contract provides for payment or reimbursement for any service which is within the lawful scope of a psychologist licensed under ORS 675.010 to 675.150:

(1) The insured under such policy or contract shall be free to select, and shall have direct access to, a psychologist licensed under ORS 675.010 to 675.150, without supervision or referral by a physician or another health practitioner, and wherever such psychologist is authorized to practice.

(2) The insured under such policy or contract shall be entitled to have payment or reimbursement made to the insured or on the insured's behalf for the services performed. Such payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be the same whether performed by a physician or a psychologist licensed under ORS 675.010 to 675.150. [Formerly 743.709]

743A.050 Services provided by registered nurse first assistant. (1) An insurer offering a health insurance policy that provides coverage for hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall provide payment or reimbursement for professional services performed by a registered nurse whose certification as a registered nurse first assistant has been recognized by the Oregon State Board of Nursing under ORS 678.366.

(2) This section also applies to health care service contractors, as defined in ORS 750.005, and trusts carrying out multiple employer welfare arrangements, as defined in ORS 750.301. [Formerly 743.798]

Note: See 743A.001.

743A.052 Services provided by professional counselor or marriage and family therapist. (1) If a group health benefit plan, as described in ORS 743.730, provides for coverage for services performed by a clinical social worker or nurse practitioner, the plan also must cover services provided by a professional counselor or marriage and family therapist licensed under ORS 675.715 to 675.835 when the counselor or therapist is acting within the counselor's or therapist's lawful scope of practice.

(2) Health maintenance organizations may limit the receipt of covered services performed by professional counselors and marriage and family therapists to services provided by or upon referral by providers contracting with the health maintenance organization. Health maintenance organizations and health care service contractors may create substantive plan benefit and reimbursement differentials at the same level as, and subject to limitations not more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other medical conditions and apply them to contracting and noncontracting providers.

(3) The provisions of ORS 743A.001 do not apply to this section. [2009 c.549 §2]

Note: 743A.052 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.058 Telemedical services. (1) As used in this section:

(a) "Health benefit plan" has the meaning given that term in ORS 743.730.

(b) "Originating site" means the physical location of the patient receiving a telemedical health service.

(c) "Telemedical" means delivered through a two-way video communication that allows a health professional to interact with a patient who is at an originating site.

(2) A health benefit plan must provide coverage of a telemedical health service if:

(a) The plan provides coverage of the health service when provided in person by the health professional;

(b) The health service is medically necessary; and

(c) The health service does not duplicate or supplant a health service that is available to the patient in person.

(3) An originating site for a telemedical health service subject to subsection (2) of this section includes but is not limited to a:

(a) Hospital;

(b) Rural health clinic;

(c) Federally qualified health center;

(d) Physician's office;

(e) Community mental health center;

(f) Skilled nursing facility;

(g) Renal dialysis center; or

(h) Site where public health services are provided.

(4) A plan may not distinguish between originating sites that are rural and urban in providing coverage under subsection (2) of this section.

(5) A health benefit plan may subject coverage of a telemedical health service under subsection (2) of this section to all terms and conditions of the plan, including but not limited to deductible, copayment or coinsurance requirements that are applicable to coverage of a comparable health service provided in person.

(6) This section does not require a health benefit plan to reimburse a provider for a health service that is not a covered benefit under the plan or to reimburse a health professional who is not a covered provider under the plan. [2009 c.384 §2]

Note: See 743A.001.

Note: 743A.058 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.060 Definition for ORS 743A.062. As used in ORS 743A.062, "peer-reviewed medical literature" means scientific studies printed in journals or other publications that publish original manuscripts only after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity and reliability. "Peer-reviewed medical literature" does not include internal publications of pharmaceutical manufacturers. [Formerly 743.695]

743A.062 Prescription drugs. (1) No insurance policy or contract providing coverage for a prescription drug to a resident of this state shall exclude coverage of that drug for a particular indication solely on the grounds that the indication has not been approved by the United States Food and Drug Administration if the Health Evidence Review Commission established under ORS 414.688 or the Pharmacy and Therapeutics Committee established under ORS 414.353 determines that the drug is recognized as effective for the treatment of that indication:

(a) In publications that the commission or the committee determines to be equivalent to:

(A) The American Hospital Formulary Service drug information;

(B) "Drug Facts and Comparisons" (Lippincott-Raven Publishers);

(C) The United States Pharmacopoeia drug information; or

(D) Other publications that have been identified by the United States Secretary of Health and Human Services as authoritative;

(b) In the majority of relevant peer-reviewed medical literature; or

(c) By the United States Secretary of Health and Human Services.

(2) Required coverage of a prescription drug under this section shall include coverage for medically necessary services associated with the administration of that drug.

(3) Nothing in this section requires coverage for any prescription drug if the United States Food and Drug Administration has determined use of the drug to be contraindicated.

(4) Nothing in this section requires coverage for experimental drugs not approved for any indication by the United States Food and Drug Administration.

(5) This section is exempt from ORS 743A.001. [Formerly 743.697; 2011 c.720 §222]

743A.064 Prescription drugs dispensed at rural health clinics. (1) All health insurance policies that provide a prescription drug benefit, except those policies in which coverage is limited to expenses from accidents or specific diseases that are unrelated to the coverage required by this subsection, must include coverage for prescription drugs dispensed by a licensed practitioner at a rural health clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the clinic or if the prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic.

(2) The coverage required by subsection (1) of this section is subject to the terms and conditions of the prescription drug benefit provided under the policy.

(3) As used in this section, "urgent medical condition" means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems. [Formerly 743.793]

Note: See 743A.001.

743A.065 Early refills of prescription eye drops for treatment of glaucoma. An insurer offering a health benefit plan, as defined in ORS 743.730, that provides coverage of prescription eye drops shall provide coverage for one early refill of a prescription for eye drops to treat glaucoma if all of the following criteria are met:

(1) The refill is requested by an insured less than 30 days after the later of:

(a) The date the original prescription was dispensed to the insured; or

(b) The date that the last refill of the prescription was dispensed to the insured.

(2) The prescriber indicates on the original prescription that a specific number of refills will be needed.

(3) The refill does not exceed the number of refills that the prescriber indicated under subsection (2) of this section.

(4) The prescription has not been refilled more than once during the 30-day period prior to the request for an early refill. [2011 c.660 §25]

Note: See 743A.001.

Note: 743A.065 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.066 Contraceptives. (1) A prescription drug benefit program, or a prescription drug benefit offered under a health benefit plan as defined in ORS 743.730 or under a student health insurance policy, must provide payment, coverage or reimbursement for:

(a) Prescription contraceptives; and

(b) If covered for other drug benefits under the program, plan or policy, outpatient consultations, examinations, procedures and medical services that are necessary to prescribe, dispense, deliver, distribute, administer or remove a prescription contraceptive.

(2) The coverage required by subsection (1) of this section may be subject to provisions of the program, plan or policy that apply equally to other prescription drugs covered by the program, plan or policy, including but not limited to required copayments, deductibles and coinsurance.

(3) As used in this section, "contraceptive" means a drug or device approved by the United States Food and Drug Administration to prevent pregnancy.

(4) A religious employer is exempt from the requirements of this section with respect to a prescription drug benefit program or a health benefit plan it provides to its employees. A "religious employer" is an employer:

(a) Whose purpose is the inculcation of religious values;

(b) That primarily employs persons who share the religious tenets of the employer;

(c) That primarily serves persons who share the religious tenets of the employer; and

(d) That is a nonprofit organization under section 6033(a)(2)(A)(i) or (iii) of the Internal Revenue Code.

(5) This section is exempt from the provisions of ORS 743A.001. [2007 c.182 §3]

Note: 743A.066 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.068 Orally administered anticancer medication. (1) A health benefit plan that provides coverage for cancer chemotherapy treatment must provide coverage for a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits.

(2) As used in this section, "health benefit plan" has the meaning given that term in ORS 743.730.

(3) The provisions of ORS 743A.001 do not apply to this section. [2007 c.566 §2]

Note: 743A.068 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.070 Nonprescription enteral formula for home use. (1) All policies providing health insurance, as defined in ORS 731.162, 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 a nonprescription elemental enteral formula for home use, if the formula is medically necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition.

(2) The coverage required by subsection (1) of this section may be made subject to provisions of the policy that apply to other benefits under the policy including, but not limited to, provisions related to deductibles and coinsurance. Deductibles and coinsurance for elemental enteral formulas shall be no greater than those for any other treatment for the condition under the policy.

(3) This section is exempt from ORS 743A.001. [Formerly 743.729; 2009 c.703 §1]

743A.080 Pregnancy and childbirth expenses. (1) As used in this section, "pregnancy care" means the care necessary to support a healthy pregnancy and care related to labor and delivery.

(2) All health benefit plans as defined in ORS 743.730 must provide payment or reimbursement for expenses associated with pregnancy care and childbirth. Benefits provided under this section shall be extended to all enrollees, enrolled spouses and enrolled dependents. [Formerly 743.693; 2011 c.500 §39]

743A.084 Unmarried women and their children. Each policy of health insurance shall provide:

(1) The same payments for costs of maternity to unmarried women that it provides to married women, including the wives of insured persons choosing family coverage; and

(2) The same coverage for the child of an unmarried woman that the child of an insured married person choosing family coverage receives. [Formerly 743.721]

743A.088 Use by mother of diethylstilbestrol. No policy of health insurance may be denied or canceled by the insurer solely because the mother of the insured used drugs containing diethylstilbestrol prior to the insured's birth. [Formerly 743.710]

743A.090 Natural and adopted children. (1) All individual and group health benefit plans, as defined in ORS 743.730, that include coverage for a family member of the insured shall also provide that the health insurance benefits applicable for children in the family shall be payable with respect to:

(a) A child of the insured from the moment of birth; and

(b) An adopted child effective upon placement for adoption.

(2) The coverage of natural and adopted children required by subsection (1) of this section shall consist of coverage of preventive health services and treatment of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of an additional premium is required to provide coverage for a child, the policy may require that notification of the birth of the child or of the placement for adoption of the child and payment of the premium be furnished to the insurer within 31 days after the date of birth or date of placement in order to effectuate the coverage required by this section and to have the coverage extended beyond the 31-day period.

(4) In any case in which a policy provides coverage for dependent children of participants or beneficiaries, the policy shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, regardless of whether the adoption has become final.

(5) This section does not prohibit an insurer from denying or limiting coverage based on a preexisting condition of a child who is 19 years of age or older.

(6) As used in this section:

(a) "Child" means an individual who is under 26 years of age.

(b) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations.

(6) The provisions of ORS 743A.001 do not apply to this section. [Formerly 743.707; 2011 c.500 §40]

743A.100 Mammogram. (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 women at any time upon referral of the woman's health care provider; and

(b) An annual mammogram for the purpose of early detection for a woman 40 years of age or older, with or without referral from the woman'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 woman is determined by her health care provider to be at high risk for breast cancer. [Formerly 743.727]

743A.104 Pelvic examinations and Pap smear examinations. 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 women 18 to 64 years of age; and

(2) At any time upon referral of the woman's health care provider. [Formerly 743.728]

743A.105 HPV vaccine. (1) All health benefit plans, as defined in ORS 743.730, shall include coverage of the human papillomavirus vaccine for female 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 does not apply to this section. [2009 c.630 §2]

Note: 743A.105 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.108 Physical examination of breast. (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 women 18 years of age and older; and

(b) At any time at the recommendation of the woman's health care provider.

(2) An insurance policy must provide coverage of physical examinations of the breast as described in subsection (1) of this 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, and trusts carrying out a multiple employer welfare arrangement, as defined in ORS 750.301. [Formerly 743.791]

Note: 743A.108 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.110 Mastectomy-related services; expedited external review required. (1) As used in this section, "mastectomy" means the surgical removal of all or part of a breast or a breast tumor suspected to be malignant.

(2) All insurers offering a health benefit plan as defined in ORS 743.730 shall provide payment, coverage or reimbursement for mastectomy and for the following services related to a mastectomy as determined by the attending physician and enrollee to be part of the enrollee's course or plan of treatment:

(a) All stages of reconstruction of the breast on which a mastectomy was performed, including but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) Prostheses;

(d) Treatment of physical complications of the mastectomy, including lymphedemas; and

(e) Inpatient care related to the mastectomy and post-mastectomy services.

(3) An insurer providing coverage under subsection (2) of this section shall provide written notice describing the coverage to the enrollee at the time of enrollment in the health benefit plan and annually thereafter.

(4) A health benefit plan must provide a single determination of prior authorization for all services related to a mastectomy covered under subsection (2) of this section that are part of the enrollee's course or plan of treatment.

(5) When an enrollee requests an external review of an adverse benefit determination as defined in ORS 743.801 by the insurer regarding services described in subsection (2) of this section, the insurer or the Director of the Department of Consumer and Business Services must expedite the enrollee's case pursuant to ORS 743.857 (5).

(6) The coverage required under subsection (2) of this section is subject to the same terms and conditions in the plan that apply to other benefits under the plan.

(7) This section is exempt from ORS 743A.001. [Formerly 743.691; 2011 c.208 §1; 2011 c.500 §41]

743A.120 Prostate screening examinations. (1) An insurer offering 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 prostate cancer screening examinations including a digital rectal examination and a prostate-specific antigen test:

(a) For men who are 50 years of age or older biennially or as determined by the treating physician; and

(b) For men younger than 50 years of age who are at high risk for prostate cancer as determined by the treating physician, including African-American men and men with a family medical history of prostate cancer.

(2) Health care service contractors, as defined in ORS 750.005, and trusts carrying out a multiple employer welfare arrangement, as defined in ORS 750.301, are subject to subsection (1) of this section. [Formerly 743.794]

Note: See 743A.001.

743A.124 Colorectal cancer screenings and laboratory tests. (1) An insurer offering 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 the following colorectal cancer screening examinations and laboratory tests:

(a) For an insured 50 years of age or older:

(A) One fecal occult blood test per year plus one flexible sigmoidoscopy every five years;

(B) One colonoscopy every 10 years; or

(C) One double contrast barium enema every five years.

(b) For an insured who is at high risk for colorectal cancer, colorectal cancer screening examinations and laboratory tests as recommended by the treating physician.

(2) For the purposes of subsection (1)(b) 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.

(3) Health care service contractors, as defined in ORS 750.005, and trusts carrying out a multiple employer welfare arrangement, as defined in ORS 750.301, are also subject to this section. [Formerly 743.799]

Note: See 743A.001.

Note: 743A.124 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.140 Bilateral cochlear implants. (1) Whenever any policy of health insurance provides for reimbursement of a cochlear implant, the insured under the policy is entitled to coverage of bilateral cochlear implants.

(2) For purposes of ORS 746.230, a reasonable investigation of a claim for bilateral cochlear implants must include a request to the treating surgeon for a written recommendation based on peer-reviewed medical literature and for the medical findings that support the recommendation.

(3) The provisions of this section apply to a health benefit plan as defined in ORS 743.730.

(4) The provisions of this section are exempt from ORS 743A.001. [2007 c.504 §2]

Note: 743A.140 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.141 Hearing aids. (1) As used in this section, "hearing aid" means any non-disposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.

(2) A health benefit plan, as defined in ORS 743.730, shall provide payment, coverage or reimbursement for one hearing aid per hearing impaired ear if:

(a) Prescribed, fitted and dispensed by a licensed audiologist with the approval of a licensed physician; and

(b) Necessary for the treatment of hearing loss in an enrollee in the plan who is:

(A) 18 years of age or younger; or

(B) 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution.

(3)(a) The maximum benefit amount required by this section is $4,000 every 48 months, but a health benefit plan may offer a benefit that is more favorable to the enrollee. The benefit amount shall be adjusted on January 1 of each year to reflect the increase since January 1, 2010, in the U.S. City Average Consumer Price Index for All Urban Consumers for medical care as published by the Bureau of Labor Statistics of the United States Department of Labor.

(b) A health benefit plan may not impose any financial or contractual penalty upon an audiologist if an enrollee elects to purchase a hearing aid priced higher than the benefit amount by paying the difference between the benefit amount and the price of the hearing aid.

(4) A health benefit plan may subject the payment, coverage or reimbursement required under this section to provisions of the plan that apply to other durable medical equipment benefits covered by the plan, including but not limited to provisions relating to deductibles, coinsurance and prior authorization.

(5) This section is exempt from ORS 743A.001. [2009 c.553 §2; 2011 c.500 §42a]

Note: 743A.141 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.144 Prosthetic and orthotic devices. (1) All individual and group health insurance policies providing coverage for hospital, medical or surgical expenses shall include coverage for prosthetic and orthotic devices that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. The coverage required by this subsection includes all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device.

(2) As used in this section:

(a) "Orthotic device" means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck.

(b) "Prosthetic device" means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.

(3) The Director of the Department of Consumer and Business Services shall adopt and annually update rules listing the prosthetic and orthotic devices covered under this section. The list shall be no more restrictive than the list of prosthetic and orthotic devices and supplies in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies, but only to the extent consistent with this section.

(4) The coverage required by subsection (1) of this section may be made subject to, and no more restrictive than, the provisions of a health insurance policy that apply to other benefits under the policy.

(5) The coverage required by subsection (1) of this section shall include any repair or replacement of a prosthetic or orthotic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.

(6) If coverage under subsection (1) of this section is provided through a managed care plan, the insured shall have access to medically necessary clinical care and to prosthetic and orthotic devices and technology from not less than two distinct Oregon prosthetic and orthotic providers in the managed care plan's provider network. [2007 c.374 §2]

Note: See 743A.001.

Note: 743A.144 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.148 Maxillofacial prosthetic services. (1) The Legislative Assembly declares that all group health insurance policies providing hospital, medical or surgical expense benefits include coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment.

(2) As used in this section, "maxillofacial prosthetic services considered necessary for adjunctive treatment" means restoration and

management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of:

(a) Controlling or eliminating infection;

(b) Controlling or eliminating pain; or

(c) Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

(3) The coverage required by subsection (1) of this section may be made subject to provisions of the policy that apply to other benefits under the policy including, but not limited to, provisions relating to deductibles and coinsurance.

(4) The services described in this section shall apply to individual health policies entered into or renewed on or after January 1, 1982. [Formerly 743.706]

743A.160 Alcoholism treatment. A health insurance policy providing coverage for hospital or medical expenses not limited to expenses from accidents or specified sicknesses shall provide, at the request of the applicant, coverage for expenses arising from treatment for alcoholism. The following conditions apply to the requirement for such coverage:

(1) The applicant shall be informed of the applicant's option to request this coverage.

(2) The inclusion of the coverage may be made subject to the insurer's usual underwriting requirements.

(3) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance.

(4) The policy may limit hospital expense coverage to treatment provided by the following facilities:

(a) A health care facility licensed as required by ORS 441.015.

(b) A health care facility accredited by the Joint Commission on Accreditation of Hospitals.

(5) Except as permitted by subsection (3) of this section, the policy shall not limit payments thereunder for alcoholism to an amount less than $4,500 in any 24-consecutive month period and the policy shall provide coverage, within the limits of this subsection, of not less than 80 percent of the hospital and medical expenses for treatment for alcoholism. [Formerly 743.412]

Note: See 743.402.

743A.164 Injuries resulting from alcohol and controlled substances. A health insurance policy other than a disability income policy shall provide coverage or reimbursement of expenses for the medical treatment of injuries or illnesses caused in whole or in part by the insured's use of alcohol or a controlled substance to the same extent as and subject to limitations no more restrictive than those imposed on coverage or reimbursement of expenses arising from treatment of injuries or illnesses not caused by an insured's use of alcohol or a controlled substance. [Formerly 743.480]

Note: See 743.402 and 743A.001.

743A.168 Treatment of chemical dependency, including alcoholism, and mental or nervous conditions; rules. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for chemical dependency and for mental or nervous conditions:

(1) As used in this section:

(a) "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with the individual's social, psychological or physical adjustment to common problems. For purposes of this section, "chemical dependency" does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(b) "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

(c) "Group health insurer" means an insurer, a health maintenance organization or a health care service contractor.

(d) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(e) "Provider" means a person that has met the credentialing requirement of a group health insurer, is otherwise eligible to receive reimbursement for coverage under the policy and is:

(A) A health care facility;

(B) A residential program or facility;

(C) A day or partial hospitalization program;

(D) An outpatient service; or

(E) An individual behavioral health or medical professional authorized for reimbursement under Oregon law.

(2) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health care facilities or residential programs or facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

(3) The coverage may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses may be limited to treatment that is medically necessary as determined under the policy for other medical conditions.

(4)(a) Nothing in this section requires coverage for:

(A) Educational or correctional services or sheltered living provided by a school or halfway house;

(B) A long-term residential mental health program that lasts longer than 45 days;

(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;

(D) A court-ordered sex offender treatment program; or

(E) A screening interview or treatment program under ORS 813.021.

(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation.

(5) A provider is eligible for reimbursement under this section if:

(a) The provider is approved by the Department of Human Services;

(b) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;

(c) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or

(d) The provider is providing a covered benefit under the policy.

(6) Payments may not be made under this section for support groups.

(7) If specified in the policy, outpatient coverage may include follow-up in-home service or outpatient services. The policy may limit coverage for in-home service to persons who are homebound under the care of a physician.

(8) Nothing in this section prohibits a group health insurer from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (3) of this section.

(9) The Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(10)(a) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer may provide for review for level of treatment of admissions and continued stays for treatment in health care facilities, residential programs or facilities, day or partial hospitalization programs and outpatient services by either group health insurer staff or personnel under contract to the group health insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

(b) Review shall be made according to criteria made available to providers in advance upon request.

(c) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Oregon Medical Board, a psychologist licensed by the State Board of Psychologist Examiners, a clinical social worker licensed by the State Board of Licensed Social Workers or a professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.

(d) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, group health insurers shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers shall provide a timely response to such inquiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

(11) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers contracting with the health maintenance organization. Health maintenance organizations and health care service contractors may create substantive plan benefit and reimbursement differentials at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other medical conditions and apply them to contracting and noncontracting providers.

(12) Nothing in this section prevents a group health insurer from contracting with providers of health care services to furnish services to policyholders or certificate holders according to ORS 743.531 or 750.005, subject to the following conditions:

(a) A group health insurer is not required to contract with all eligible providers.

(b) An insurer or health care service contractor shall, subject to subsections (2) and (3) of this section, pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions. The insured shall, subject to subsections (2) and (3) of this section, have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(13) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to ensure continuing access to levels of care most appropriate for the insured's condition and progress.

(14) The Director of the Department of Consumer and Business Services, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of these provisions. [Formerly 743.556; 2009 c.442 §47; 2009 c.549 §11]

Note: Section 7, chapter 411, Oregon Laws 1987, provides:

Sec. 7. Application of ORS 743A.001 to ORS 743A.168 and 750.055. ORS 743.145 [renumbered 743A.001] does not apply to section 2 of this Act [743A.168] because section 2 of this Act constitutes a reenactment of ORS 743.557 and 743.558 [both repealed in 1987] or to ORS 750.055 because of its amendment by this Act. [1987 c.411 §7]

743A.170 Tobacco use cessation programs. (1) A health benefit plan as defined in ORS 743.730 must provide payment, coverage or reimbursement of at least $500 for a tobacco use cessation program for a person enrolled in the plan who is 15 years of age or older.

(2) As used in this section, "tobacco use cessation program" means a program recommended by a physician that follows the United States Public Health Service guidelines for tobacco use cessation. "Tobacco use cessation program" includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

(3) This section is exempt from ORS 743A.001. [2009 c.503 §2]

Note: 743A.170 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.175 Traumatic brain injury. (1) A health benefit plan, as defined in ORS 743.730, shall provide coverage of medically necessary therapy and services for the treatment of traumatic brain injury.

(2) This section is exempt from ORS 743A.001. [2009 c.423 §2]

743A.180 Tourette Syndrome. For purpose of coverage by group health insurers, health care service contractors and health maintenance organizations, reimbursement for treatment of Tourette Syndrome shall be made on the basis of the diagnosis and treatment modality employed. [Formerly 743.717]

Note: See 743A.001.

743A.184 Diabetes self-management programs. (1) Subject to other terms, conditions and benefits in the plan, group health benefit plans as described in ORS 743.730 shall provide payment, coverage or reimbursement for supplies, equipment and diabetes self-management programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes prescribed by a health care professional legally authorized to prescribe such items.

(2) As used in this section, "diabetes self-management program" means one program of assessment and training after diagnosis and no more than three hours per year of assessment and training upon a material change of condition, medication or treatment that is provided by:

(a) An education program credentialed or accredited by a state or national entity accrediting such programs; or

(b) A program provided by a physician licensed under ORS chapter 677, a registered nurse, a nurse practitioner, a certified diabetes educator or a licensed dietitian with demonstrated expertise in diabetes. [Formerly 743.694]

Note: See 743A.001.

743A.185 Telemedical health services for treatment of diabetes. (1) As used in this section:

(a) "Health benefit plan" has the meaning given that term in ORS 743.730.

(b) "Originating site" means a location where health services are provided or where the patient is receiving a telemedical health service.

(c) "Telemedical" means delivered through a two-way electronic communication, including but not limited to video, audio, Voice over Internet Protocol or transmission of telemetry, that allows a health professional to interact with a patient, a parent or guardian of a patient or another health professional on a patient's behalf, who is at an originating site.

(2) A health benefit plan must provide coverage of a telemedical health service provided in connection with the treatment of diabetes if:

(a) The plan provides coverage of the health service when provided in person by the health professional;

(b) The health service is medically necessary;

(c) The telemedical health service relates to a specific patient; and

(d) One of the participants in the telemedical health service is a representative of an academic health center.

(3) A health benefit plan may not distinguish between rural and urban originating sites in providing coverage under subsection (2) of this section.

(4) A health benefit plan may subject coverage of a telemedical health service under subsection (2) of this section to all terms and conditions of the plan, including but not limited to deductible, copayment or coinsurance requirements that are applicable to coverage of a comparable health service when provided in person.

(5) This section does not require a health benefit plan to reimburse a provider for a health service that is not a covered benefit under the plan. [2011 c.312 §2]

Note: See 743A.001.

Note: 743A.185 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.188 Inborn errors of metabolism. (1) All individual and group health insurance policies providing coverage for hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall include coverage for treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage shall include expenses of diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

(2) As used in this section, "medical foods" means foods that are formulated to be consumed or administered enterally under the supervision of a physician, as defined in ORS 677.010, that are specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts, that are for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein or have other specific nutrient requirements as established by medical evaluation and that are essential to optimize growth, health and metabolic homeostasis.

(3) This section is exempt from ORS 743A.001. [Formerly 743.726]

743A.190 Children with pervasive developmental disorder. (1) A health benefit plan, as defined in ORS 743.730, must cover for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder all medical services, including rehabilitation services, that are medically necessary and are otherwise covered under the plan.

(2) The coverage required under subsection (1) of this section, including rehabilitation services, may be made subject to other provisions of the health benefit plan that apply to covered services, including but not limited to:

(a) Deductibles, copayments or coinsurance;

(b) Prior authorization or utilization review requirements; or

(c) Treatment limitations regarding the number of visits or the duration of treatment.

(3) As used in this section:

(a) "Medically necessary" means in accordance with the definition of medical necessity that is specified in the policy, certificate or contract for the health benefit plan and that applies uniformly to all covered services under the health benefit plan.

(b) "Pervasive developmental disorder" means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability or mental retardation.

(c) "Rehabilitation services" means physical therapy, occupational therapy or speech therapy services to restore or improve function.

(4) The provisions of ORS 743A.001 do not apply to this section.

(5) The definition of "pervasive developmental disorder" is not intended to apply to coverage required under ORS 743A.168. [2007 c.872 §2]

Note: 743A.190 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743A.192 Clinical trials. (1) A health benefit plan, as defined in ORS 743.730, shall provide coverage for the routine costs of the care of patients enrolled in and participating in qualifying clinical trials.

(2) As used in subsection (1) of this section, "routine costs":

(a) Means medically necessary conventional care, items or services covered by the health benefit plan if typically provided absent a clinical trial.

(b) Does not include:

(A) The drug, device or service being tested in the clinical trial unless the drug, device or service would be covered for that indication by the health benefit plan if provided outside of a clinical trial;

(B) Items or services required solely for the provision of the drug device or service being tested in the clinical trial;

(C) Items or services required solely for the clinically appropriate monitoring of the drug, device or service being tested in the clinical trial;

(D) Items or services required solely for the prevention, diagnosis or treatment of complications arising from the provision of the drug, device or service being tested in the clinical trial;

(E) Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

(F) Items or services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial; or

(G) Items or services that are not covered by the health plan if provided outside of the clinical trial.

(3) As used in subsection (1) of this section, "qualifying clinical trial" means a clinical trial that is:

(a) Funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;

(b) Supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;

(c) Conducted as an investigational new drug application, an investigational device exemption or a biologics license application subject to approval by the United States Food and Drug Administration; or

(d) Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration.

(4) The coverage required by this section may be subject to provisions of the health benefit plan that apply to other benefits within the same category, including but not limited to copayments, deductibles and coinsurance.

(5) An insurer that provides coverage required by this section is not, based upon that coverage, liable for any adverse effects of the clinical trial. [2009 c.274 §2]

Note: See 743A.001.