MANDATED BENEFITS: OTHER

Over the past several years there has been increasing interest in a topic generally known as "mandated benefits." This term actually covers three subtopics:

(1) Statutes and rules requiring that certain persons be covered by health insurance policies.

(2) Statutes and rules mandating certain illnesses or procedures be covered by health insurance policies.

(3) Statutes and rules mandating that care by certain providers must be reimbursed if it is a covered expense. For example, in some states a statute provides that insurers must cover treatments provided by chiropractors if they would cover those same treatments provided by a medical doctor, and the chiropractor is acting within the scope of his license.

In addition to the types of mandates listed above, statutes vary in whether the coverage specified is *required* to be included in the policy or certificate, or whether it must be *offered* to the subscribers, usually with an increased cost. This chart will focus on the second classification enumerated. State statutes or regulations providing that certain coverage must be included or offered are summarized on the following pages. A number of different coverages are required in numerous states, while a few are unique to only one or two states. This chart only includes states that currently have a mandated benefit provision in place.

CATEGORIES

CRANIOFACIAL ABNORMALITIES
DIABETES
HEARING IMPAIRED
METABOLIC DISEASE FORMULAS
OFF-LABEL DRUG USE
PEDIATRIC – WELL-BABY CARE
TELEMEDICINE
TEMPOROMANDIBULAR JOINT DISORDERS (TMJ)
THERAPY
TRANSPLANTS

MISCELLANEOUS

AIDS VACCINE
CHIROPRACTIC CARE
FOOTWEAR
HEMOPHILIA
HOSPICE SERVICE
LYME DISEASE
OBESITY
OSTOMY SUPPLIES
PORT-WINE STAINS
PROSTHESIS
SCREENING FOR SEXUALLY TRANSMITTED DISEASES
SICKLE CELL ANEMIA
ULCERATIVE COLITIS

CRANIOFACIAL ABNORMALITIES

The date following each state indicates the last time information for the state was reviewed/changed.

STATE	CITATION	SUMMARY
AR (12/23)	§ 23-79-1502; Ark. Admin. Code 003.22.111-3	A health benefit plan that is offered, issued, provided, or renewed in this state shall include coverage and benefits for reconstructive surgery and related medical care for a person of any age who is diagnosed as having a craniofacial anomaly if the surgery and treatment are medically necessary to improve a functional impairment that results from the craniofacial anomaly as determined by a nationally approved cleft-craniofacial team, approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina.
CA (12/23)	§§ 1367.63; 10123.88	"Reconstructive surgery" shall include medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.
CO (12/23)	§ 10-16-104	There shall be no age limit on benefits for cleft lip and cleft palate. Care and treatment shall include medically necessary procedures.
CT (12/23)	§§ 38a-490c; 38a-516c	Cover medically necessary orthodontic processes and appliances for the treatment of craniofacial abnormalities of individuals 18 years of age and younger, if the processes are recognized by the American Cleft Palate-Craniofacial Association; covers group and individual policies. No coverage shall be required for cosmetic surgery.
FL (12/23)	§§ 627.64193; 627.66911; 641.31	A health insurance policy that covers a child under the age of 18 must provide coverage for treatment of cleft lip and cleft palate for the child, including medical, dental, speech therapy, etc., prescribed by a physician.
HI (12/23)	§§ 431:10A-132; 432:1-613	Each individual and group accident and health or sickness insurance policy, contract, plan, or agreement issued or renewed in this state after 12/31/2015, shall provide to the policyholder and individuals under 26 years of age covered under the policy, contract, plan, or agreement, coverage of medically necessary orthodontic services for the treatment of orofacial anomalies resulting from birth defects or birth defect syndromes. Coverage required by this section shall be paid for by medical insurance.
ID (12/23)	IDAPA 18.04.02 § 010; 18.04.02 § 011; §§ 41-2140; 41-3437; 41-3923	A health policy that covers newborns or individuals 18 years of age or younger shall cover congenital anomalies, including cleft lip and cleft palate.
IL (12/23)	215 ILCS 105/8	Required for correction of cleft lip and palate and other craniofacial and maxillofacial birth defects.
IN (12/23)	§ 27-8-5.6-2	Plans for newly born children must include benefits for inpatient and outpatient expenses arising from medical and dental treatment of cleft palate and cleft lip.

CRANIOFACIAL ABNORMALITIES

STATE	CITATION	SUMMARY
LA (12/23)	§ 22:1026	Cleft lip and cleft palate covered, including related needs such as orthodontics, speech therapy, etc.
MD (12/23)	Ins. § 15-818	Cleft palate and cleft lip inpatient and outpatient benefits arising from orthodontics, oral surgery, etc., shall be covered.
MA (12/23)	M.G.L.A. 175 § 47BB; 176A § 8EE; 176B § 4EE[1]; 176G § 4W; 176I § 12; MA Bulletin No. B-2012-12 (December 31, 2012)	Health plans that cover a child under the age of 18 shall provide coverage for cleft lip and cleft palate of the child.
MN (12/23)	§ 62A.042	Cleft palate and cleft lip coverage required for expenses arising from medical and dental expenses up to limiting age for coverage of dependents.
NJ (12/23)	N.J.A.C. §§ 11:4-16.5; 11:24-6.3	HMO shall include policy assuring access to specialty outpatient centers for craniofacial and congenital anomalies. No health policies shall limit or exclude coverage of congenital anomalies of a covered dependent child.
NC (12/23)	§ 58-51-30	Must cover all necessary treatment and care for individuals with cleft lip and cleft palate.
OK (12/23)	Okla. Admin. Code 365:40-5-20	HMO basic health care services shall include inpatient and outpatient care for treatment of the birth defect known as cleft lip or cleft palate or both including medically necessary oral surgery, orthodontics, otological, audiological, and speech/language treatment.
OR (12/23)	§ 743A.150	All health benefit plans shall provide coverage for the treatment of craniofacial anomalies if the services are medically necessary to restore function.
SC (12/23)	§ 38-71-240	Must provide medically necessary care and treatment for cleft lip and cleft palate.
TX (12/23)	I.C. § 1367.153	Must cover reconstructive surgery for craniofacial abnormalities caused by congenital defect, trauma, disease, etc. Applies to children under the age of 18.
VT (12/23)	8 V.S.A. § 4089g	Must cover surgical and nonsurgical treatments for musculoskeletal disorders affecting the face and neck caused by congenital defect, trauma, disease, etc.
VA (12/23)	§ 38.2-3411	Must cover inpatient and outpatient dental, oral surgical, and orthodontic services that are medically necessary for cleft lip, cleft palate, and ectodermal dysplasia.

DIABETES

STATE	CITATION	SUMMARY
AK (12/23)	§ 21.42.390	A contract covering pharmacy services must include coverage for diabetes treatment, including medication, equipment and supplies. If diabetes treatment is prescribed by a health provider, the plan shall include coverage for outpatient self-management training or education, and medical nutrition therapy.
AZ (12/23)	§§ 20-826; 20-1057; 20-1342; 20-1402; 20-1404; 20-2325	Any contract covering diabetes must include coverage for equipment and supplies that are medically necessary, including blood glucose monitors, test strips, syringes, etc.
AR (12/23)	§§ 23-79-601 to 23-79-607; Ark. Admin Code 054.00.70-1 to 054.00.70-10	Every policy or subscriber contract must include one per lifetime training program per insured for diabetes self-management training where medically necessary. Must include coverage for equipment, supplies and services for treatment of diabetes.
CA (12/23)	Ins. §§ 10176.61; 10176.6; 10177.7; Health & Safety §§ 1367.51; 1367.005 Ins. § 10123.141	Every policy shall offer diabetic self-management education programs. Insurance, self-insured employee welfare benefit plans, disability insurance policies and health care service plans shall include equipment and supplies, including blood glucose monitors and test strips, insulin pumps, lancets, syringes, insulin, etc. Coverage for special footwear for persons suffering from foot disfigurement from diabetes.
CO (12/23)	§ 10-16-104	Provide coverage for equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy.
CT (12/23)	§§ 38a-492d; 38a-518d §§ 38a-492e; 38a-518e	Provides medically necessary equipment, laboratory, and diagnostic tests for individual policies. Shall provide coverage for self management training.
DE (12/23)	18 Del.C. §§ 3344; 3560	Every policy shall provide benefits for the following equipment and supplies for the treatment of diabetes, if recommended in writing or prescribed by a physician: insulin pumps, blood glucose meters and strips, urine testing strips, insulin, syringes, and pharmacological agents for controlling blood sugar.
DC (12/23)	§§ 31-3001 to 31-3004	Provide coverage for equipment, supplies, self-management training and education for treatment of diabetes. May not require higher deductible or co-payment.
FL (12/23)	§§ 627.6408; 627.65745; 641.31	Covers medically appropriate and necessary equipment, supplies, and training in the treatment of diabetes.

DIABETES

STATE	CITATION	SUMMARY
GA (12/23)	§ 33-24-59.2 § 49-5-273	All policies and plans must offer coverage for medically necessary equipment, supplies, pharmacological agents, medical nutrition therapy and outpatient self-therapy as prescribed by a physician. PeachCare for Kids Program – children in families with income below 235% of the federal poverty level. No copayment shall be charged for preventive services and no copayments or premiums shall be charged for any child under six years of age. Preventive services include but are not limited to medically necessary maintenance medication and monitoring for chronic conditions such as asthma and diabetes.
HI (12/23)	§§ 431:10A-121; 432:1-612	Must cover self-management training, education, equipment and supplies.
IL (12/23)	215 ILCS 5/356w 215 ILCS 5/356z.49	Group policy shall provide coverage for training and education on diabetes self-management, equipment, and supplies. Group or individual policy of accident and health insurance shall provide coverage for A1C testing for prediabetes, type1 diabetes, and type 2 diabetes in accordance with identified risk factors.
IN (12/23)	§§ 27-8-14.5-0.1 to 27-8-14.5-7	Must provide medically necessary supplies and equipment. Must provide coverage for self-management training.
IA (12/23)	§ 514C.18	Policies providing for third party payment or prepayment of health or medical expenses shall provide coverage benefits for the treatment of all types of diabetes mellitus when prescribed by a physician. Shall cover equipment, supplies, and self-management training and education.
KS (1/24)	§ 40-2,163	Must provide coverage for equipment, supplies, and self-management training and education.
KY (1/24)	KRS §§ 304.17A-096; 304.17A-148	All health benefit plans must cover equipment, supplies and necessary training for the treatment of insulin dependent diabetes, subject to the same deductibles and coinsurance.
LA (1/24)	§ 22:1034	Provide coverage for equipment, supplies and outpatient self-management training for diabetes. Does not apply to individually underwritten policy.
ME (1/24)	24 M.R.S.A. §§ 2332-F; 2754; 2847-E; 4240	Covers medically appropriate and necessary equipment as certified by the treating physician, insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets and outpatient self-management training and educational services. Educational services shall be authorized by the State's Diabetes Control Project.

DIABETES

STATE	CITATION	SUMMARY
MD (1/24)	Ins. § 15-822 Ins. § 15-706	Must provide coverage for medically necessary equipment, supplies and outpatient self-management training and education. Must provide reimbursement for services rendered by a dietitian or nutritionist, up to 6 visits with a dietitian or nutritionist per 12-month period, if a licensed physician determines the services are medically necessary for the treatment of diabetes.
MA (1/24)	M.G.L.A. 32A § 17G; 175 § 47N; 176G § 4H; 176A § 8P	Must provide medically necessary coverage for the diagnosis or treatment of diabetes, including blood glucose monitoring strips, insulin, syringes, etc.
MI (1/24)	§§ 500.3406p; 550.1416b	Program to prevent onset of diabetes, including diet, lifestyle, fitness, etc. Cover supplies needed for diabetes treatment at same deductible and coinsurance provisions as medical equipment or prescriptions. Cover outpatient self-management training and education, and medications used in foot ailments, infections and other associated conditions.
MN (1/24)	M.S.A. §§ 62A.3093; 62A.316	Must cover supplies needed for diabetes treatment at same deductible and coinsurance provisions as medical equipment or prescriptions. Cover outpatient self-management training and education, including medical nutrition therapy.
MS (1/24)	§ 83-9-46	Must offer coverage for equipment and supplies used in connection with diabetes management, including supplies for monitoring blood glucose and insulin self-administration.
MO (1/24)	§ 376.385	Must offer coverage for equipment, supplies, support, and self-management training used in the management and treatment of diabetes.
MT (1/24)	MCA 2-18-704; 33-22-129	State employee group coverage must include coverage for medically necessary and prescribed outpatient self-management training for treatment of diabetes. At minimum, must cover at least: 20 visits of training and education in diabetes self-management provided in either an individual or group setting if the person has not received the training and education previously; 12 visits of followup diabetes self-management training and education services in subsequent years for an insured who has previously received and exhausted the initial 20 visits of education. Also, must provide coverage for equipment and supplies: insulin, syringes, injection aids, devices for self-monitoring glucose levels, insulin pump and oral prescriptions. Annual co-payment and deductibles same as other covered benefits.
NE (1/24)	§ 44-790	All health benefit plans must cover equipment, supplies and necessary training for the treatment of insulin dependent diabetes, subject to the same deductibles and coinsurance.
NV (1/24)	§§ 689A.0427; 689B.0357; 695B.1927; 695C.1727	Cover training and education for self-management of diabetes, subject to same coinsurance and deductibles as for other covered conditions.

DIABETES

STATE	CITATION	SUMMARY
NH (1/214)	§§ 415:6-e; 415:18-f; 420-A:17-a; 420-B:8-k	Provides residents with coverage for medically appropriate and necessary outpatient self-management training, including medical nutrition therapy.
NJ (1/24)	N.J.S.A. 17:48-6n; 17:48A-7L; 17:48E-35.11; 17B:26-2.1L; 17B:27-46.1m; 26:2J-4.11	Must provide coverage for equipment, supplies, and self-management education/training needed for treatment of diabetes.
NM (1/24)	§§ 59A-22-41; 59A-46-43	Covers medically appropriate and necessary equipment as certified by the treating physician, insulin, oral hypoglycemic agents, monitors, test strips, syringes, injection aids, lancets and outpatient self-management training and educational services, subject to coinsurance and deductibles consistent with other benefits. The amount an individual with diabetes is required to pay for a preferred formulary prescription insulin drug or a medically necessary alternative is an amount not to exceed a total of twenty-five dollars per thirty-day supply.
NY (1/24)	Ins. Law §§ 3216; 3221; 4303; 4322	Covers equipment and supplies for non-insulin dependent and insulin dependent persons. Includes blood glucose monitors and other supplies. Education for self-management of diabetes shall also be covered. Includes materials for the visually impaired.
NC (1/24)	§§ 58-51-61; 58-65-91; 58-67-74	Must provide coverage for diabetes self-management training, supplies and equipment and laboratory procedures.
ND (1/24)	§ 54-52.1-04.18	Must provide health insurance benefits coverage that provides for insulin drug and medical supplies for insulin dosing and administration. Coverage must limit out-of-pockets costs for a thirty-day supply of covered insulin drugs to not exceed $25 per pharmacy or distributor.
OK (1/24)	36 Okl.St.Ann. § 6060.2; 74 Okl.St.Ann. § 1307.2	Provides coverage for equipment and supplies to treat Type I or Type II and gestational diabetes.
OR (1/24)	§ 743A.082 § 743A.185	A health benefit plan may not require copayment or impose a coinsurance requirement or a deductible on covered health services, medications, and supplies that are medically necessary for a woman to manage her diabetes during the period of each pregnancy through 6 weeks postpartum. A health benefit plan must provide coverage of a telemedical health service provided in connection with treatment of diabetes if the plan provides coverage of the health service when provided in person, the service is medically necessary, the telemedicine health service relates to a specific patient and one of the participants in the telemedical health is a representative of an academic health center.
PA (1/24)	40 P.S. § 764e	Shall provide coverage of the equipment, supplies and outpatient self-management training and education.

DIABETES

STATE	CITATION	SUMMARY
RI (1/24)	§§ 27-18-38; 27-19-35; 27-20-30; 27-41-44	Provide coverage for equipment and supplies to treat insulin treated diabetes, non-insulin treated diabetes and gestational diabetes. Includes medically necessary visits to medical nutrition therapy.
SC (1/24)	§ 38-71-46	Provide coverage for medical treatment, equipment, supplies and self-management training for treatment of diabetes.
SD (1/24)	§§ 58-17-1.2; 58-18-83; 58-18B-56; 58-38-43; 58-40-39; 58-41-117; 58-38-42	Covers equipment and supplies for non-insulin dependent and insulin dependent persons. Includes blood glucose monitors and other supplies. Education for self-management of diabetes shall also be covered but subject to limitations.
TN (1/24)	§ 56-7-2605	Covers medically appropriate and necessary equipment as certified by the treating physician, insulin, oral hypoglycemic agents, monitors, test strips, syringes, injection aids, and lancets and outpatient self-management training and educational services, subject to coinsurance and deductibles consistent with other benefits.
TX (1/24)	I.C. §§ 1358.002 to 1358.057; 28 TAC §§ 21.2601 to 21.2606	Health benefit plan that covers diabetes must also cover diabetes equipment (including noninvasive glucose monitors), supplies and self-management training programs. May be subject to deductible and coinsurance no greater than that for other conditions.
UT (1/24)	§ 31A-22-626; U.A.C. R590-200	Coverage for diabetes subject to same deductibles and coinsurance as other services. Covers diabetes self-management training, supplies and insulin.
VT (1/24)	8 V.S.A. § 4089c	Insurer shall provide coverage for equipment, supplies and self-management training for diabetes.
VA (1/24)	§§ 2.2-2818; 38.2-3418.10	Covers equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy.
WA (1/24)	§§ 48.20.391; 48.21.143; 48.44.315; 48.46.272 § 41.05.185	Plans or contracts that include pharmacy services shall provide appropriate and medically necessary equipment and supplies, as prescribed. All plans or contracts shall provide outpatient self-management training and education, including medical nutrition therapy. All state purchased health care shall provide benefits for services and supplies for persons with diabetes.
WV (1/24)	§§ 33-59-1; 33-25E-3	Health insurance policies shall cover equipment and supplies for non-insulin dependent and insulin dependent persons. Includes blood glucose monitors and other supplies. Education for self-management of diabetes shall also be covered. Any health benefits policy that includes eye care benefits, including diabetic retinal examination, shall provide each covered person diagnosed with diabetes direct access to an eye care provider for one annual diabetic retinal examination.

DIABETES

STATE	CITATION	SUMMARY
WI (1/24)	§ 40.52 § 632.895	Must cover equipment, supplies, medication, and self-management education programs. Disability insurance must include coverage for equipment and supplies for diabetes treatment.
WY (1/24)	§§ 26-20-201; 26-18-103	Covers equipment and supplies for non-insulin dependent and insulin dependent persons. Includes blood glucose monitors and other supplies. Includes self-management training and education.

HEARING IMPAIRED

STATE	CITATION	SUMMARY
AK (1/24)	§§ 21.42.385; 21.42.349	Insurers who have written at least $300,000 in premiums in the last calendar year are required to offer minimum hearing coverage. If a policy provides coverage for pregnancy and childbirth, it must also provide coverage for newborn and infant hearing screenings and confirmatory hearing diagnostic evaluations.
AZ (1/24)	A.A.C. R9-31-213	Coverage required for children for diagnosis and treatment for defects in hearing, for testing to determine hearing impairment, and for provision of hearing aids.
AR (1/24)	§ 23-79-130	Policies must include coverage for necessary treatment of impairment of speech or hearing, subject to the same coinsurance and deductible as other covered services.
CA (1/24)	10 CCR § 2699.6700	Hearing services, including those for preventative measures, must be offered by participating health plans under the requirements of the Knox-Keene Health Care Service Plan Act of 1975.
CO (1/24)	§ 10-16-104	Any health benefit plan that provides hospital, surgical, or medical expense insurance, except supplemental policies covering a specified disease or other limited benefit, shall provide coverage for hearing aids for minor children who have a hearing loss.
CT (1/24)	§§ 19a-59; 38a-490b	Institutions required to provide screening for newborn hearing loss. Policies required to provide coverage for hearing aids for children 12 years of age or younger.
DE (1/24)	18 Del.C. §§ 3352; 3568 16 Del.C. § 804A	All policies must cover infant hearing screenings with similar coinsurance, deductible, etc., as for other medical expenses. Hospitals shall establish a Universal Newborn Hearing Screening program and provide a hearing screening test for every newborn.
DC (1/24)	DC ST § 7-858.02	Each hospital, birthing facility, and nurse-midwife shall inform and educate the parent of a newborn of the purpose and availability of newborn screening for hearing impairment, and screen all newborns delivered or cared for at the hospital, home, or birthing facility for hearing impairment, unless the newborn's parent withholds consent for the screening procedure.
FL (1/24)	§§ 383.145; 409.815	Each licensed hospital or other state-licensed birthing facility that provides maternity and newborn care services shall provide that all newborns are, prior to discharge, screened for the detection of hearing loss. This includes screening, identification, and follow-up care for newborns. Hearing aids shall be covered only when medically indicated to assist in the treatment of a medical condition.

HEARING IMPAIRED

STATE	CITATION	SUMMARY
GA (1/24)	§ 33-24-59.21	Coverage shall provide one hearing aid per hearing impaired ear not to exceed $3,000 per hearing aid for covered individuals 18 years or younger. Coverage shall include one replacement for one hearing aid every 48 months.
HI (1/24)	§ 321-101	Department of health established a program to screen for hearing loss in children. Within available resources, the program shall include consultation with and education of students, parents, and health and education personnel about hearing screening, treatment, and services.
ID (1/24)	ID ADC 16.03.09.742	The Department will cover the purchase of non-implantable or implantable hearing aids for participants under the age of twenty-one.
IL (1/24)	410 ILCS 205/3	Hearing screening services shall be administered to all children as early as possible, but no later than their first year in any public or private education program, licensed day care center or residential facility for children with disabilities; and periodically thereafter, to identify those children with hearing impairments so that such condition can be managed or treated.
IN (1/24)	§§ 16-35-8-1 to 16-35-8-14	The hearing aid fund is established for the purpose of providing hearing aid assistance to eligible children through the hearing aid assistance program.
IA (1/24)	IAC 191-80.4(505, 514H)	Pediatric preventative services shall include hearing screenings.
KS (1/24)	K.S.A. 65-1,157a	(b) Every child born in the state of Kansas, within five days of birth, unless a different time period is medically indicated, shall be given a screening examination for detection of hearing loss.
KY (1/24)	§§ 304.17A-131; 304.17A-132; 806 KAR 17:150	Provide coverage for cochlear implants for persons with profound hearing impairment. Provide one hearing aid per affected ear every 36 months for insured individuals under 18 years old.
LA (1/24)	§§ 22:1027; 22:1038; 22:245; 40:2208 § 22:1038	Coverage for expenses incurred by any hearing impaired enrollee for services performed by a qualified interpreter/translator. Insurers shall provide coverage for hearing aids for children under the age of 18 if a qualified audiologist dispenses the hearing aids or hearing specialist. Limited to $1,400 per hearing aid every 36 months.
ME (1/24)	24-A M.R.S.A. §§ 2847-O; 4255; 2762	All HMOs, individual, and group health insurance policies, contracts and certificates must provide coverage for the purchase of a hearing aid for each hearing-impaired ear for an individual covered under the policy, contract or certificate who is 18 years of age or under.

HEARING IMPAIRED

STATE	CITATION	SUMMARY
MD (1/24)	Ins. § 15-838	Provide coverage for hearing aids for minor child if hearing aid is prescribed, fitted and dispensed by a licensed audiologist.
MA (1/24)	M.G.L.A. 32A § 23; 176G § 4N; 175 § 47X; 176A § 8Y	Coverage provided to any active or retired employee of the commonwealth who is insured under the commission for expenses incurred in the medically necessary diagnosis and treatment of hearing disorders. For dependents 21 years or younger the commission shall provide coverage for the cost of one hearing aid per hearing impaired ear up to $2,000 for each hearing aid.
MI (1/24)	M.C.L.A. 333.5432	If a health professional in charge of the care of a newborn infant or, if none, the health professional in charge at the birth of an infant, the hospital, the health department, or other facility administers or causes to be administered to the infant a hearing test and screening, then that person or facility shall report to the department, on a form as prescribed by the department, the results of all hearing tests and screens conducted on infants who are less than 12 months of age and on children who have been diagnosed with hearing loss and are less than 3 years of age.
MN (1/24)	§ 62Q.675	Must cover hearing aids for all individuals for hearing loss due to congenital malformation of the ears. Once per 3-year period; same deductibles and coinsurance as for other services.
MS (1/24)	§ 41-90-1	Benefits and services to be provided include hearing screenings and hearing aids for newborn children.
MO (1/24)	V.A.M.S. 376.1220; 376.781 V.A.M.S. 376.1220; 191.925	Policies which provide for hospital treatment shall offer coverage for the necessary care and treatment of loss or impairment of hearing subject to the same durational limits, dollar limits, deductibles and coinsurance factors as other covered services in such policies or contracts. Every infant shall be screened for hearing loss.
MT (1/24)	§ 53-19-402	Hospitals shall provide screening for newborn hearing impairments.
NE (1/24)	§ 71-4742	Hospitals and birthing facilities required to include a hearing screening test as part of its standard of care for newborns.
NH (1/24)	§ 415:6-p	Insurers shall provide coverage for the professional services associated with the practice of fitting, dispensing, servicing, or sale of hearing instruments or hearing aids. The benefits included shall not be subject to any greater deductible or coinsurance or copay than any other benefits provided by the insurer. Insurers are required to cover the cost of a hearing aid for each ear, as needed, as well as related services necessary to assess, select, and fit the hearing aid with a maximum for the hearing aid and related services of no less than $1,500 per hearing aid every 60 months.

HEARING IMPAIRED

STATE	CITATION	SUMMARY
NJ (1/24)	N.J.S.A. 17:48E-35.10; 17:48-6m; 17B:27-46.1L; 17B:27A-7; 17B:27A-19; 26:2J-4.10	Provide screening for newborn hearing loss.
	N.J.S.A. 17B:27-46.1gg; 17B:27A-19.18; 17:48E-35.31; 17B:27A-7.14; 17B:26-2.1aa; 17:48A-7dd; 17:48-6gg; 26:2J-4.32	Shall provide coverage for medically necessary expenses incurred in the purchase of a hearing aid for a covered person 15 years of age or younger.
NM (1/24)	§§ 59A-22-34.5; 59A-23-7.8; 59A-46-38.5; 59A-47-37.1	Shall provide coverage for a hearing aid and any related service for the full cost of one hearing aid per hearing-impaired ear for insured children under 18 years of age or under 21 years of age if still attending high school.
NY (1/24)	NY Pub. Health § 2500-g	Newborn infants shall be screened for hearing problems.
NC (1/24)	§§ 58-3-260; 58-3-285	Each health benefit plan shall provide coverage for newborn hearing screening ordered by the attending physician. Every health benefit plan shall provide coverage for one hearing aid per hearing-impaired up to $2,500 every 36 months for covered individuals under 22 years old.
OH (1/24)	§§ 3701.504 to 3701.508	Each hospital and freestanding birthing center required to conduct a hearing screening on each newborn or infant born in the hospital or center unless the newborn or infant is transferred to another hospital, promptly notify the newborn's or infant's attending physician of the screening results, and notify the department of health of the screening results for each newborn or infant screened. The department of health shall prepare and distribute information describing factors or conditions of hearing loss and the effect, each facility will provide the parent, guardian, or custodian with the information. No newborn or infant shall be required to undergo hearing screening if the parent, guardian, or custodian objects.
OK (1/24)	36 Okl.St.Ann. § 6060.7	Group plans must cover audiological services and hearing aids for children up to 18 years of age. May limit to one hearing aid benefit every 4 years.
OR (1/24)	§ 743A.141	Shall provide payment, coverage or reimbursement for one hearing aid per hearing impaired ear if necessary for the treatment of hearing loss in an enrollee in the plan who is under 18 years of age; or 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution.

HEARING IMPAIRED

STATE	CITATION	SUMMARY
PA (1/24)	40 P.S. § 764f	Any insurer that underwrites Medicare or Medicaid insurance shall provide coverage in such insurance for a hearing aid.
RI (1/24)	§§ 27-18-60; 27-19-51; 27-20-46; 27-41-63	For every policy issued after 1/1/06, provide an optional rider for group policies with additional coverage for hearing aids; cover hearing aids for children under age 18 in every group and individual policy up to $1,500 per year every 3 years. For individuals 19 years or older the plan shall provide coverage for $700 per individual hearing aid per ear, every 3 years.
SC (1/24)	1976 § 44-37-40	Newborn hearing screenings must be conducted during birth admission on all newborns born in hospitals in this State using procedures recommended or approved by the department. However, when a newborn is delivered in a hospital with an average of less than one hundred deliveries a year, the screening is not required, but the parents must be given the information required pursuant to subsection (C)(3). Parents are then given information to assist them in having a hearing screening performed.
SD (1/24)	§§ 58-18-95; 58-18B-60; 58-17-153; 58-41-127	Any qualified health plan shall include coverage for medically necessary physician services for the treatment of hearing impairment to a person under the age of 19, including services rendered by an audiologist.
TN (1/24)	§ 56-7-2603 § 56-7-2368	Any policy which provides hospital expense, and surgical or medical expense insurance must offer to provide benefits for conditions or disorders of hearing so long as such conditions or disorders receive treatment from duly licensed audiologists or speech pathologists. Every policy shall provide coverage of up to $1,000 per individual hearing aid per ear, every 3 years, for every child covered by such a policy.
TX (1/24)	I.C. § 1365.003 I.C. § 1367.253	Group plans shall offer and make available under the plan coverage for the necessary care and treatment of loss of impairment of speech or hearing. A health benefit plan must provide coverage for the cost of a medically necessary hearing aid or cochlear implant and related services and supplies for a covered individual who is 18 year of age or younger. Applies only to a health benefit delivered, issued for delivery, or renewed on or after 1/1/18. (Effective 9/1/17)
UT (1/24)	U.A.C. R414-71-5	Screening services, including a hearing assessment, are to be conducted. When a screening indicates the need for further evaluation, diagnostic services must be provided.
VT (1/24)	Vt. Admin. Code 12-5-1:4.0	Health care providers should perform a hearing loss screening test on newborn infants unless the parent, guardian or custodian of the newborn refuses screening.
VA (1/24)	§ 38.2-3411.4	Provide coverage for infant hearing screening and audiological examinations.

HEARING IMPAIRED

STATE	CITATION	SUMMARY
VI (1/24)	22 V.I.C. § 1802	An individual or group health insurance policy, health care plan, or certificate of health insurance must provide coverage for a hearing aid and any related services for the full cost of one hearing aid per hearing impaired ear up to $2,200 per ear, every 36 months for hearing aids for insured children.
WA (1/24)	WAC 284-43-5642	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: 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 preventative services category, unless coverage for these services and devices are required as part of and classified to another essential health benefits category.
WV (1/24)	§§ 16-22A-1; 16-22A-3	The physician present immediately after a live birth shall perform, or cause to be performed, a test for hearing loss in the infant.
WI (1/24)	§ 632.895	Every disability insurance policy and every self-insured health plan shall provide coverage of the cost of hearing aids and cochlear implants that are prescribed by a physician or audiologist for a covered child under 18 years of age who is certified as deaf or hearing impaired.
WY (1/24)	WY ADC 048.0037.51 § 7 WY ADC 048.0035.2 § 4	The covered services provided to CHIP clients, at a minimum, shall include hearing services. Wyoming Newborn Hearing Screening test must be performed on all newborns.

METABOLIC DISEASE FORMULAS

STATE	CITATION	SUMMARY
AK (1/24)	§ 21.42.380	Shall provide coverage for formulas for treatment of PKU, with same co-payment and deductible as for other illness.
AZ (1/24)	§§ 20-2327; 20-826; 20-1057; 20-1342; 20-1402; 20-1404	Coverage that contains a prescription drug benefit shall provide coverage for medical foods to treat inherited metabolic disorders. Cover at least 50% of the cost of medical foods.
AR (1/24)	§§ 23-79-701 to 23-79-703	A tax credit up to $2,400 per year per covered person for medical food, low protein food for persons afflicted with PKU and other listed metabolic diseases is allowed against the Arkansas income tax. All health plans shall provide coverage for PKU, galactosemia, organic acidemias and disorders of amino acid metabolism, subject to same co-pay and deductible as required by health plan, for amounts paid exceeding the tax credit.
	§ 23-79-129	Every accident and health insurance policy or health care plan shall cover newborn children and shall include tests for PKU.
CA (1/24)	Ins. § 10123.89; Health & Safety § 1374.56	Policies issued by a health care service plan or an insurer must cover testing and treatment of PKU, including special food products.
CO (1/24)	§ 10-16-104	Coverage for inherited enzymatic disorders, including PKU, etc. Maximum age for PKU treatment is 21; no limit for other metabolic diseases. Cover medical foods used to treat metabolic disease. May impose coinsurance and deductibles. The maximum age to receive benefits for phenylketonuria is 21 years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is 35 years of age.
CT (1/24)	§§ 38a-492c; 38a-518c	Individual and group health insurance policies must cover low protein modified food products intended for the dietary treatment of inherited metabolic disease and cystic fibrosis if administered under the direction of a physician. Covered same as prescriptions.
DE (1/24)	18 Del.C. §§ 3355; 3571	A health insurance contract shall, under the family member coverage, include coverage for medical formulas and foods and low protein modified formulas and modified food products for the treatment of inherited metabolic diseases, if such medical formulas and foods or low protein modified formulas and food products are: (1) prescribed as medically necessary for the therapeutic treatment of inherited metabolic diseases, and (2) administered under the direction of a physician.
DC (1/24)	§ 31-3802.01	All group and individual health policies providing maternity and newborn care shall include metabolic newborn screening.
FL (1/24)	§ 627.42395	Any health insurance policy must offer prescription and nonprescription enteral formulas for treatment of inherited diseases as specified. Coverage shall not exceed $2,500 annually for any insured individual, through the age of 24.

METABOLIC DISEASE FORMULAS

STATE	CITATION	SUMMARY
GA (1/24)	Ga. Code Ann., § 31-12-7	If such child has a metabolic disorder, counseling regarding the nature of the disease, its effects, and its treatment is available without cost from the department and the county board of health or county department of health.
HI (1/24)	§§ 431:10A-120; 432:1-609	Must cover medical foods and low-protein modified food products for the treatment of an inborn error of metabolism.
ID (1/24)	IDAPA 18.04.12.081	A health benefit plan will not limit or exclude coverage by type of illness, accident, treatment, or medical condition, except as follows: k. [F]or metabolic or peripheral vascular disease.
IN (1/24)	§ 27-8-24.1	Must cover medical food intended for the dietary treatment of an inherited metabolic disease or condition. Same deductibles, coinsurance amounts as apply to other coverages.
IA (1/24)	IA ADC 191-71.14(513B)	Except as specifically provided for, no benefits will be provided for services, supplies or charges: 23. [F]or metabolic or peripheral vascular disease.
KY (1/24)	§§ 304.17A-139; 304.17A-258	A health benefit plan that provides prescription drug coverage shall provide that coverage for 100% human diet, if the 100% human diet and supplemented milk fortifier products are prescribed for the prevention of necrotizing enterocolitis and associated comorbidities, and are administered under the direction of a physician. Coverage under this subsection may be subject to a cap of $15,000 per infant, for each plan year, subject to annual inflation adjustments. Health benefit plans that provide prescription drug coverage shall include therapeutic food, formulas, supplements, and low-protein modified food products necessary for the treatment of inborn errors of metabolism or genetic conditions; coverage may be subject to a cap of $25,000 for therapeutic food, formulas, and supplements and $4,000 on low-protein modified foods.
LA (1/24)	§§ 22:1035; 22:246; 22:469	Must provide coverage for low-protein foods for treatment of inherited metabolic disorders. Benefit limited to $200 a month.
ME (1/24)	24 M.R.S.A. § 2320-D; 24-A M.R.S.A. §§ 2745-D; 2837-D; 4238	Must include coverage for metabolic formula and special modified low-protein foods for inborn error of metabolism. Benefit limited to $3,000 per year.
MD (1/24)	Ins. §§ 15-807; 19-705.5 Ins. § 15-817	Group policy shall cover medical foods prescribed by doctor for therapeutic treatment of inherited metabolic disease. Child wellness services shall include a visit for the collection of adequate samples for hereditary and metabolic newborn screening.

METABOLIC DISEASE FORMULAS

STATE	CITATION	SUMMARY
MA (1/24)	M.G.L.A. 175 § 47C; 176A § 8B; 176B § 4C	Coverage of newborns shall include special medical formulas necessary for treatment of PKU.
	M.G.L.A. 175 § 47I; 176A § 8L; 176B § 4k; 176G § 4D	Shall provide coverage for nonprescription enteral formulas for home use. Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low-protein. Benefit limit not to exceed $5,000 annually.
MN (1/24)	§§ 62A.26; 62E.06	Must provide dietary treatment for PKU.
MO (1/24)	§ 376.1219	Shall provide coverage for formula and low-protein modified food products for PKU or any inherited disease of amino and organic acids. Insured must be less than 6 years of age.
MT (1/24)	§ 33-22-131	Mandated coverage for dietary formulas for PKU sufferers. Covers treatment of inborn errors of metabolism. Coverage must include expenses of diagnosing, monitoring and controlling the disorder.
NE (1/24)	§§ 71-519; 71-520	Mandated coverage for screening tests and treatment for PKU sufferers. Fees for formula may not exceed $2,000 per year.
NV (1/24)	§§ 689A.0423; 689B.0353; 695B.1923; 695C.1723	Mandated coverage for enteral formulas medically necessary for treatment of inherited metabolic diseases and up to at least $2,500 per year for special food products prescribed by physician.
NH (1/24)	§§ 415:6-c; 415:18-e; 420-A:17; 420-B:8-ff	Provide nonprescription enteral formula for treatment of inherited metabolic disease. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein in an amount not to exceed $1,800 annually for any insured individual.
NJ (1/24)	N.J.S.A. 17:48-6s; 17:48A-7q; 17:48E-35.16; 17B:26-2.1o; 17B:27-46.1r; 17B:27A-7.4; 17B:27A-19.6; 26:2J-4.17	Cover expense of treatment of metabolic disease, including purchase of medical foods.
	N.J.S.A 17:48-6z; 17:48A-7y; 17:48E-35.24; 17B:27-46.1z; 17B:26-2.1v; 17B:27A-7; 17B:27A-19; 26:2J-4.25	Specialized non-standard infant formulas for babies with multiple food protein intolerance.
NM (1/24)	§§ 59A-22-41.1; 59A-46-43.2; 59A-47-38	Every individual and group policy must provide coverage for genetic inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard treatments exist.

METABOLIC DISEASE FORMULAS

STATE	CITATION	SUMMARY
NY (1/24)	NY INS §§ 3216; 3221; 4303; 4322	Every policy which provides coverage for prescription drugs, must include cost of enteral formulas when prescribed as medically necessary for disorders that will cause the individual to become malnourished. Includes modified solid food products that are medically necessary. Benefit limit is $2,500 per 12-month period.
ND (1/24)	§§ 26.1-36-09.7	Cover medical foods and low-protein modified food products for therapeutic treatment of inherited metabolic disease.
OR (1/24)	§ 743A.188	Must include coverage for inborn errors of metabolism. Coverage includes diagnosis, monitoring and controlling disorders, including medical foods.
PA (1/24)	40 P.S. § 3904	Shall provide that the health insurance benefits applicable under the policy include coverage for the cost of nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a physician. Any health care insurer shall provide that the health insurance benefits should include coverage for infants and children for amino acid-based elemental medical formula ordered by a physician as medically necessary and administered orally.
RI (1/24)	§ 23-13-14	All newborns shall be subject to metabolic screening tests and the cost shall be covered by health insurance plans.
SC (1/24)	§ 44-37-30	Any child born in South Carolina shall have neonatal testing to detect inborn metabolic errors and hemoglobinopathies.
SD (1/24)	§§ 58-17-62; 58-18-41; 58-38-23; 58-40-21; 58-41-98	Mandated offer of coverage for testing and treatment, including dietary management and formulas.
TN (1/24)	§ 56-7-2505	Mandated coverage for dietary formulas for treatment of PKU.
TX (1/24)	I.C. § 1359.003	Mandated coverage for formulas necessary for treatment of PKU, same as prescription drugs.
UT (1/24)	§ 31A-22-623; UAC R590-76-7; R590-194	Must include coverage for special dietary products for those suffering from hereditary metabolic disease.

METABOLIC DISEASE FORMULAS

STATE	CITATION	SUMMARY
VT (1/24)	8 V.S.A. § 4089e	Must include coverage for medical foods prescribed for medically necessary treatment for an inherited metabolic disease. Coverage for low-protein modified food products must be at least $2,500 per 12-month period.
VA (1/24)	§ 38.2-3418.18	Mandated coverage for dietary formulas for treatment of metabolic disorders.
WA (1/24)	§§ 48.21.300; 48.46.510; 48.44.440; 48.20.520	Shall provide coverage for formulas for treatment of PKU.
WY (1/24)	W.S.§ 35-4-801 W.S. § 26-20-401	Must provide coverage for treatment of inherited enzymatic disorders, including medical nutrition therapy. Tax credit for insurer for coverage under the inherited enzymatic disorder coverage requirement.

OFF-LABEL DRUG USE

STATE	CITATION	SUMMARY
AL (1/24)	§ 27-1-10.1	Insurance policy may not exclude coverage on the grounds that the drug is being used for other purposes than approved by the FDA if the drug treatment is recognized in at least one standard reference compendium. Does not require insurers to provide coverage for any experimental or investigational drug that the FDA has found to be contraindicated for treatment of a condition.
AZ (1/24)	§ 20-2326	Shall not limit or exclude coverage of prescription drugs, prescribed as a cancer treatment, because the FDA approval is limited to treatment of a different type of cancer, if the off-label use is recognized as safe and effective in at least one standard medical reference compendia listed.
AR (1/24)	§ 23-79-147	Shall not limit or exclude coverage of prescription drugs, prescribed as a cancer treatment, because the FDA approval is limited to treatment of a different type of cancer, if the off-label use is recognized as safe and effective in at least one standard medical reference compendia listed. Shall not limit or exclude coverage under the health benefit plan for a drug approved by the United States Food and Drug Administration that is on the prescription drug formulary of the insurance policy by mandating that a covered person with metastatic cancer undergo step therapy unless the preferred drug is consistent with best practices that: (1) use for the treatment of metastatic cancer or associated conditions listed; (2) FDA approved indication; or (3) National Comprehensive Cancer Network Drugs and Biologics Compendium indication; or (4) evidence-based, peer-reviewed, recognized medical literature.
CA (1/24)	Ins. § 10123.195; Health & Safety § 1367.21	Shall not limit or exclude prescription coverage because a drug is prescribed for a different use than approved by the FDA if it meets all of the following conditions: 1) the drug is approved by the FDA; 2) the drug is prescribed for a life-threatening condition; 3) the drug is medically necessary to treat a chronic and seriously debilitating condition and the drug is on the insurer's formulary; and 4) the drug usage is recognized by one of the listed standard medical reference compendia.
CO (1/24)	§ 10-16-104.6	Shall not limit or exclude coverage for any drug approved by the FDA for use in the treatment of cancer on the basis that the drug has not been approved by the FDA for the treatment of the specific type of cancer for which the drug is prescribed if: (a) the drug is recognized for treatment of that cancer in the authoritative reference compendia as identified by the Secretary of the United States Department of Health and Human Services; and (b) the treatment is for a covered condition.
CT (1/24)	§§ 38a-518b; 38a-492b	Shall not limit or exclude coverage of prescription drugs, prescribed as a cancer treatment, because the FDA approval is limited to treatment of a different type of cancer, if the off-label use is recognized as safe and effective in at least one standard medical reference compendia listed.
FL (1/24)	§ 627.4239	Shall not limit or exclude coverage of prescription drugs, prescribed as a cancer treatment, because the FDA approval is limited to treatment of a different type of cancer, if the off-label use is recognized as safe and effective in standard medical reference compendia or its use is recommended in medical literature.

OFF-LABEL DRUG USE

STATE	CITATION	SUMMARY
GA (1/24)	§§ 3.3-24-59.11; 33-53-2	Shall not limit or exclude prescription coverage because a drug is prescribed for a different use than approved by the FDA, if it meets all of the following conditions: 1) the drug has been approved by the FDA; 2) the drug is prescribed for a life-threatening condition; 3) the drug is medically necessary to treat the condition and the drug is on the insurer's formulary; and 4) the drug usage is recognized by one of the listed standard medical reference compendia.
IL (1/24)	215 ILCS 5/356z.7; 215 ILCS 125/4-6.3; 5 ILCS 375/6.4	Shall not limit or exclude coverage of prescription drugs, prescribed as a cancer treatment, because the FDA approval is limited to treatment of a different type of cancer, if the off-label use is recognized as safe and effective in at least one standard medical reference compendia listed.
IN (1/24)	§§ 27-8-20-1 to 27-8-20-9	Insurance policy that includes prescription coverage may not exclude coverage on the grounds that the drug is being used for other purposes than approved by the FDA if the drug treatment is recognized in at least one standard reference compendium or the use is found to be safe and effective in formal clinical studies and the results are published in a peer-reviewed medical journal.
KS (1/24)	§ 40-2,168	Shall not limit or exclude coverage of prescription drugs, prescribed as a cancer treatment, because the FDA approval is limited to treatment of a different type of cancer, if the off-label use is recognized as safe and effective in at least one standard medical reference compendia listed or in substantially accepted peer-review medical publication.
LA (1/24)	§ 22:999	Any plan which covers the treatment of cancer shall not exclude coverage of prescription drugs used to treat cancers of a different type than approved by FDA, if recommended in medical literature or standard medical reference compendia, except for limited benefit health insurance policies or contracts.
ME (1/24)	24 M.R.S.A. §§ 2320-F; 2745-E; 2837-F; 4234-D	Shall not limit or exclude coverage of prescription drugs, prescribed as a cancer treatment, because the FDA approval is limited to treatment of a different type of cancer, as long as use of that drug is a medically accepted indication for the treatment of cancer.
	24 M.R.S.A. §§ 2320-G; 2745-F; 2837-G; 4234-E	Policies that cover prescription drugs may not exclude coverage for any drugs prescribed for the treatment of HIV or AIDS because the drug has not been FDA approved for that indication, if it is a recognized use by standard medical reference compendia or peer-reviewed medical journals.
MD (1/24)	MD Insurance § 15-804	A policy or contract that provides coverage for prescription drugs may not exclude coverage of a drug for an off-label use of the drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature.

OFF-LABEL DRUG USE

STATE	CITATION	SUMMARY
MA (1/24)	M.G.L.A. 175 §§ 47K to 47L; 176B § 4N; 176G § 4E	Policies that cover prescription drugs may not exclude coverage for any drugs prescribed for the treatment of cancer because the drug has not been FDA approved for that indication, if it is a recognized use by standard medical reference compendia or a peer-reviewed medical journal or by the commissioner.
	M.G.L.A. 175 §§ 47O to 47P; 176B § 4P; 176G §4G	Policies that cover prescription drugs may not exclude coverage for any drugs prescribed for the treatment of HIV or AIDS because the drug has not been FDA approved for that indication, if it is a recognized use by standard medical reference compendia or peer-reviewed medical journals or by the commissioner.
MI (1/24)	§§ 500.3406q; 550.1416c	If provide coverage for prescription drugs, shall provide coverage for off-label use of a federal FDA approved drug when the drug is prescribed for a life-threatening condition or a chronic and seriously debilitating condition, if the use is recognized in one of the listed sources.
MN (1/24)	§ 62Q.525	Shall not limit or exclude coverage of prescription drugs, prescribed as a cancer treatment, because the FDA approval is limited to treatment of a different type of cancer, if the off-label use is recognized as safe and effective in at least one standard medical reference compendia listed or a medically recognized peer-reviewed journal.
MS (1/24)	§ 83-9-8	Shall not limit or exclude coverage of prescription drugs, prescribed as a cancer treatment, because the FDA approval is limited to treatment of a different type of cancer, if the off-label use is recognized as safe and effective in at least one standard medical reference compendia listed or a medically recognized peer-reviewed journal.
NE (1/24)	§ 44-788	No policy that provides prescription drug coverage shall exclude coverage of a drug prescribed to treat cancer, AIDS, HIV or immunodeficiency syndrome because the FDA approval is limited to a different use, if the off-label use is recognized by medical literature.
NV (1/24)	§§ 689A.0404; 689B.0365; 695B.1908; 695C.1733	If the policy includes prescription coverage for an FDA approved drug, must include coverage for any other use of the drug for cancer treatment, if it is recognized in the United States Pharmacopeia Drug Information, the American Hospital Formulary Service Drug Information, or supported by at least two articles reporting the results of scientific studies that are published in scientific or medical journals.
NH (1/24)	§§ 415:6-g; 415:18-j	If provide coverage for prescription drugs, shall not exclude drug for other indication than approved by FDA if recommended in medical literature or impose use of an alternative drug not approved by the FDA for the indication being treated unless the alternative drug is recognized for treatment in medical literature. An override of such condition of coverage shall be granted if the provider can demonstrate the ineffectiveness or adverse reactions of the alternative drug listed.

OFF-LABEL DRUG USE

STATE	CITATION	SUMMARY
NJ (1/24)	N.J.S.A. 17:48-6h; 17B:26-2.1g; 17B:27-46.1g; 17:48E-35.5; 17:48A-7g; 26:2J-4.5 N.J.S.A. 26:1A-36.9; N.J.A.C. 11:24-5.7	Must provide benefits for expenses incurred in prescribing drugs for treatment for which they have not been approved by the FDA, if the drug is recognized as being medically appropriate for the specific treatment in a listed reference compendia. Off-label drug use is legal when prescribed in a medically appropriate way.
NC (1/24)	§§ 58-51-59; 58-65-94; 58-67-78	Shall not limit or exclude coverage of prescription drugs, prescribed as a cancer treatment, because the FDA approval is limited to treatment of a different type of cancer, if the off-label use is recognized as safe and effective in at least one standard medical reference compendia listed or a medically recognized peer-reviewed journal.
ND (1/24)	§ 26.1-36-06.1	Contracts that cover prescription drugs shall provide benefits for expenses incurred in prescribing drugs for treatment for which they have not been approved by the FDA if the drug is recognized as being medically appropriate for the specific treatment in a listed reference compendium.
OH (1/24)	§ 1751.66 § 3923.60	Shall not limit or exclude coverage of prescription drugs, prescribed as a cancer treatment, because the FDA approval is limited to treatment of a different type of cancer, if the off-label use is recognized as safe and effective in at least one standard medical reference compendia listed. No group or individual policy of sickness and accident insurance that provides coverage for prescription drugs shall limit or exclude coverage for any drug approved by the FDA on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia listed.
OK (1/24)	63 Okl.St.Ann. § 1-2604	No individual policy of accident and health insurance issued which provides coverage for prescription drugs, nor any group blanket policy of accident and health insurance issued which provides coverage for prescription drugs shall exclude coverage of drugs for cancer treatment or the study of oncology because the off-label use of such drug has not been approved by FDA for that indication in one of the standard reference compendia listed.
OR (1/24)	§ 743A.062	No insurance policy or contract providing coverage for a prescription drug shall exclude coverage of that drug for a particular indication solely on the grounds that the indication has not been approved by the FDA if the Health Resources Commission determines that the drug is recognized as effective for the treatment of that indication.
RI (1/24)	§§ 27-55-1 to 27-55-3	No policy that covers prescription drugs shall exclude coverage of drugs for cancer treatment or the study of oncology because the off-label use of such drug has not been approved by FDA for that indication in one of the standard reference compendia listed or medical literature.

OFF-LABEL DRUG USE

STATE	CITATION	SUMMARY
SC (1/24)	§ 38-71-275	No policy which covers prescription drugs shall exclude coverage of any such drug used for the treatment of cancer on the grounds that the drug has not been approved by FDA for the treatment of the specific type of cancer for which the drug has been prescribed; provided, that such drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature.
SD (1/24)	§§ 58-17-100 to 58-17-106	If cover prescription drugs shall cover drugs used to treat cancer or other life-threatening illness even if they have not been approved by the FDA for that indication if the drug is recognized in medical literature or one of the standard reference compendia.
TN (1/24)	§ 56-7-2352	If cover prescription drugs, shall cover off-label drug use when it is prescribed in a medically appropriate way, and medical literature or standard reference compendia recognize the use.
TX (1/24)	I.C. § 1369.004	If cover prescription drugs, shall cover off-label drugs used to treat a patient for a covered chronic, disabling, or life-threatening illness if recognized for treatment of the illness in a reference compendium or peer-received literature.
	28 TAC § 21.3011	A health benefit plan must provide coverage for any drug prescribed to treat, including any services to administer the drug, a covered chronic, disabling, or life-threatening illness if the drug has been approved by the FDA for at least one reason and is recognized for treatment for which the drug is prescribed in a standard drug reference compendium or peer-reviewed literature.
VT (1/24)	8 V.S.A. § 4100e	A health insurance plan that provides coverage for prescription drugs shall provide coverage for off-label use in cancer treatment.
VA (1/24)	§ 38.2-3407.5	If cover prescription drugs, may not exclude coverage on the grounds that the drug is being used for purposes other than approved by the FDA if the drug treatment is recognized as safe and effective treatment of that specific type of cancer in at least one standard reference compendia.
	§ 2.2-2818	No policy which covers prescription drugs shall exclude coverage of any such drug used for the treatment of cancer on the grounds that the drug has not been approved by FDA for the treatment of the specific type of cancer for which the drug has been prescribed; provided, that such drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature.
WA (1/24)	WAC 284-30-450	Insurance policy may not exclude coverage on the grounds that the drug is being used for other purposes than approved by the FDA if the drug treatment is recognized in at least one standard reference compendium.

PEDIATRIC – WELL-BABY CARE

STATE	CITATION	SUMMARY
AL (1/24)	AL ADC 420-5-6-.04	HMOs must provide at least pediatric care from birth including pediatric maintenance visits, treatment visits, and immunizations according to written schedules.
AK (1/24)	§§ 21.42.351; 21.42.349	A health care insurer that offers health care insurance that covers a dependent of a covered individual shall, initially and at each renewal, offer coverage for the cost of well-baby exams. The coverage required to be offered by this section is subject to standard policy provisions applicable to other benefits, including deductible or copayment provisions.
AR (1/24)	§ 23-79-141; Ins. Reg. 45	Mandated offering of coverage for routine periodic physical examination to age 18, co-payments and deductibles shall not exceed those established for the same services under the Medicaid program in this state.
CA (1/24)	Ins. § 10123.5; Health & Safety § 1367.5 Ins. § 10123.55; Health & Safety § 1367.3	Mandated coverage consistent with recommendation of American Academy of Pediatrics for physical examinations through age 16. Mandated offering of comprehensive preventative care for ages 17-18 for group plans, including periodic health evaluations, immunizations and laboratory services for the health evaluations.
CO (1/24)	§ 10-16-104	Child health supervision services, childhood immunizations, influenza vaccinations and pneumococcal vaccinations pursuant to the schedule established by the ACIP.
CT (1/24)	§ 38a-535	Mandated coverage of preventive pediatric care consistent with coverage provided for other services, including immunizations, through age 6.
DE (1/24)	18 Del.C. § 3335 18 Del.C. § 3558 18 Del.C. §§ 3360; 3571D	Mandated benefit for injury or sickness, including medically diagnosed congenital defects and birth abnormalities as well as routine care furnished any infant from the moment of birth. Immunizations for routine use in children, adolescents and adults. Every health insurance policy covered by this section shall entitle children covered by the policy to receive developmental screenings at ages 9 months, 18 months, and 30 months.
DC (1/24)	§ 31-3801	Mandated benefit from moment of birth and for preventive care services.

PEDIATRIC – WELL-BABY CARE

STATE	CITATION	SUMMARY
FL (1/24)	§§ 627.6416; 627.6579; Bulletin 87-205	Mandated coverage for health supervision services, exempt from deductibles to age 16.
	§ 641.31098	HMO shall provide well-baby and well-child screening for diagnosing the presence of autism spectrum disorder.
GA (1/24)	§§ 33-29-3.4; 33-30-4.5; GA ADC 120-2-68-.04 to 120-2-68-.06; 290-5-37-.03	Mandated benefit for periodic review of child's physical and emotional status, including immunizations, from birth through age 5. No deductibles, commissioner may provide exclusions or coinsurance amounts.
HI (1/24)	§§ 431:10A-115.5; 431:10A-206.5; 432:1-602.5	Mandated health supervision services benefit for all policies that cover children from birth to age 5. Exempt from deductibles, and immunizations are exempt from co-payments.
IL (1/24)	215 ILCS 170/40	There shall be no co-payment required for well-baby or well-child health care, including, but not limited to, age-appropriate immunizations as required under state or federal law.
	215 ILCS 125/4-17; 215 ILCS 106/30	HMO required provisions shall include routine physical examinations and immunizations, sick visits, diagnostic x-rays and laboratory services, and emergency outpatient services.
IN (1/24)	§§ 12-17.6-4-3; 12-17.6-4-2	Deductibles, coinsurance, or other cost sharing is not permitted with respect to well-baby and well-child care.
IA (1/24)	I.C.A. § 514I.5	Shall include physician services, including surgical and medical, office visits, newborn care, well-baby and well-child care, immunizations, urgent care, specialist care, allergy testing and treatment, mental health visits, and substance abuse visits.
	IAC 191-80.1 to 191-80.5	Preventive services from birth through age 7 are mandated for group policies. No deductibles.
KS (1/24)	§ 40-2,102	Mandated coverage for immunizations to age 6.
LA (1/24)	§ 22:1030	Mandated coverage for immunizations to age 6.

PEDIATRIC – WELL-BABY CARE

STATE	CITATION	SUMMARY
ME (1/24)	24-A M.R.S.A. §§ 2768; 2847-S; 4258 24-A M.R.S.A. §§ 2743; 2834; 4234-C	All HMO, group and individual health insurance policies, contracts and certificates must provide coverage for children's early intervention services. The coverage for newly born children must consist of coverage of injury, sickness or other benefits provided by the policy, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
MD (1/24)	Ins. § 15-817	Requires coverage of specified list of service, including all childhood and adolescent immunizations as recommended by the CDC and all age appropriate screening as determined by the AAP. Exempt from deductibles.
MA (1/24)	M.G.L.A. 175 § 47C	Mandated benefit for preventative care services to age 6.
MN (1/24)	§ 62A.047	Must provide coverage for child health supervision services which includes preventive services and appropriate immunizations.
MS (1/24)	§§ 83-9-33; 83-9-34	A health benefit plan that provides benefits for a family member of the insured shall provide an option for the insured to elect coverage for each newly born child of the insured, from birth through the date the child is 24 months of age, for: immunizations listed and any other immunization the commissioner of insurance determines to be required by law for the child.
MO (1/24)	§§ 376.1215; 376.801	All individual and group health insurance policies shall provide coverage for immunizations from birth to 5 years.
MT (1/24)	§§ 33-22-303; 33-30-1014	Each group disability insurance plan must provide well-child care for children from birth through 7 years of age. Coverage for well-child care includes routine immunizations.
NE (1/24)	§ 44-784	Any insurance company that provides insurance coverage for dependent under 6 years shall provide immunizations from birth to the age of 6.
NJ (1/24)	N.J.S.A. 26:2J-4.10; 17:48E-35.10; 17B:27-46.1l	Shall cover all childhood immunizations.

PEDIATRIC – WELL-BABY CARE

STATE	CITATION	SUMMARY
NM (1/24)	§§ 59A-22-34.3; 59A-46-38.2	Childhood immunizations, including booster doses, as recommended by American Academy of Pediatrics, shall be covered subject to deductibles and coinsurance under the policy.
	§§ 59A-22-34.4; 59A-23-7.4; 59A-46-38.4; 59A-47-27.1	Must cover circumcision of newborn males.
NY (1/24)	Ins. Law §§ 3216 (i)(17); 3221	Mandated coverage of preventive and primary care services to age 19, not subject to deductibles and coinsurance.
	Cir. Letter 2001-16	Lists requirements of well child visits and adds a newborn hearing screening requirement.
	Cir. Letter 2006-13	HMO's child coverage must comply with AAP recommendations.
OH (1/24)	§§ 3923.55 to 3923.56	Mandated benefit for health supervision services to age 9. Subject to reasonable coinsurance and deductibles. Benefits limited to $500 first year of child's life, $150 per year thereafter. Includes required coverage for hearing screening with maximum coverage of $75.
OK (1/24)	36 Okl.St.Ann. §§ 3201 to 3203	Must offer coverage for health supervision services through age 18.
	36 Okl.St.Ann. § 6060.4	Lists immunizations health plans must cover form birth through age 18.
PA (1/24)	40 P.S. §§ 3501 to 3508	Shall provide that the health insurance benefits applicable under the policy include coverage for child immunizations. A health insurance policy shall provide for coverage for medically necessary booster doses of all immunizing agents used in child immunizations.
	31 Pa. Code § 89.806	A health insurance policy shall provide coverage for the cost of the immunization of a child.
PR (1/24)	24 L.P.R.A. § 7032	Health insurance plans must cover preventive services, including immunizations from birth to age 18 and one exam per year.
RI (1/24)	§§ 27-38.1-1 to 27-38.1-3	Mandated benefit for pediatric preventative care to age 19, co-payments no larger than other covered services.
SD (1/24)	ARSD 20:06:56:03	The essential health benefits package consists of pediatric services, including oral and vision care.

PEDIATRIC – WELL-BABY CARE

STATE	CITATION	SUMMARY
TX (1/24)	I.C. § 1271.154	Child immunizations from birth to age 6; not subject to deductible and coinsurance. Screening test for hearing loss covered birth through age 30 days; diagnostic follow-up to age 24 months.
	I.C. § 1367.053	Health benefit plans must cover listed immunizations from birth to age 6.
	I.C. § 1507.003	Mandates coverage of childhood immunizations and hearing screening.
	28 TAC § 11.506	HMOs may not charge a deductible or co-payment for immunizations from birth through age 6, unless they are a small employer.
VT (1/24)	VT ADC 4-3-24:7; 4-3-19:5	Newborn coverage for 31 days to include well-baby care.
VA (1/24)	§ 38.2-3411.1	Mandated offer of health supervision coverage through age 6. Not subject to coinsurance and deductibles. Well-child care is a part of basic health care services required to be provided by HMO.
	§ 38.2-3411.3	Shall provide coverage for all routine and necessary immunizations from birth to 36 months.
	§ 38.2-3442	A health carrier shall provide immunizations for routine use in children.
WA (1/24)	WAC 284-43-5602; 284-43-5780	Health policies must include coverage for pediatric care, including oral and vision care.
WV (1/24)	§§ 33-15-17; 33-16-12; 33-16D-14; 33-16A-15; 33-25-8c; 33-25A-8c	Child immunizations covered without coinsurance or deductible.
WI (1/24)	§ 632.895(14); Bulletin 6-23-2000	Mandated coverage for necessary and appropriate immunizations from birth to age 6 for a dependent who is a child of an insured.
WY (1/24)	WY ADC 044.0002.13 § 7	HMOs must include immunizations for children in accordance with the recommendations of the AAP.

TELEMEDICINE

STATE	CITATION	SUMMARY
AK (1/24)	§ 21.42.422	A health care insurer that offers, issues for delivery, or renews in the state a health care insurance plan in the group or individual market that provides mental health benefits shall provide coverage for mental health benefits provided through telehealth by a health care provider licensed in this state and may not require that prior in-person contact occur between a health care provider and a patient before payment is made for covered services.
AZ (1/24)	§§ 20-841.09; 20-1406.05; 20-1057.13; 20-1376.05	Must provide coverage for health care services that are provided through telehealth if the health care service would be covered were it provided through in-person consultation between the subscriber and a health care provider and provided to a subscriber receiving the service in a rural region of the state.
AR (1/24)	§ 23-79-1602	All health benefit plans delivered, issued for delivery, reissued, or extended in Arkansas on or after 1/1/2016, or at any time when any term of the health benefit plan is changed or any premium adjustment is made thereafter shall cover the services of a physician who is licensed by the Arkansas State Medical Board for healthcare services through telemedicine on the same basis as the health benefit plan provides coverage for the same healthcare services provided by the physician in person.
CA (1/24)	Ins. § 10123.85; Health & Safety § 1374.13	Recognize the practice of telehealth as a legitimate means by which an individual may receive health care services provided from a health care provider without an in-person contact with the health care provider. No health insurer shall require that in-person contact occur between a health care provider and a patient before payment is made for the services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into. No health insurer shall limit the type of setting where services are provided for the patient provided by telehealth.
CO (1/24)	§§ 10-16-123; 25.5-5-414	A health benefit plan shall not require in-person contact between a provider and a covered person for services appropriately provided through telehealth, subject to all terms and conditions of the health benefit plan.
CT (1/24)	§§ 38a-499a; 38a-526a	Individual and group health insurance policies shall provide coverage for medical advice, diagnosis, care or treatment provided through telehealth, to the extent coverage is provided for such advice, diagnosis, care or treatment when provided through in-person consultation between the insured and a health care provider. Such coverage shall be subject to the same terms and conditions applicable to all other benefits under such policy.
DE (1/24)	18 Del.C. §§ 3370; 3571R	A health insurer offering a health benefits plan shall provide coverage for the cost of healthcare through telemedicine services. No insurer shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than those that apply to all items and services covered under the policy.
DC (1/24)	§ 31-3862	A health insurer offering a health benefits plan in DC may not deny coverage for a healthcare service on the basis that the service is provided through telehealth if the same service would be covered when delivered in person. A health insurer shall reimburse the provider when the service is delivered through telehealth.

TELEMEDICINE

STATE	CITATION	SUMMARY
GA (1/24)	§ 33-24-56.4	Application of and payment for covered medical care allowed by means of telemedicine if services are provided by a physician or other health care practitioner acting within the scope of practice.
HI (1/24)	§§ 431:10A-116.3; 432D-23.5; 432:1-601.5	Shall not require a face-to-face contact between health care provider and patient as prerequisite for payment for individual policies.
IL (1/24)	215 ILCS 5/356z.22	An individual or group policy of accident or health insurance providing telehealth services shall not: require that in-person contact occur between a health care provider and a patient before the provision of a telehealth service. Services through telehealth shall not exceed the deductibles, copayments, coinsurance, or any other cost-sharing required by the individual or group policy of accident or health insurance for the same services provided through in-person consultation.
IN (1/24)	§§ 27-13-7-22; 27-8-34-6	An individual contract or a group contract must provide coverage for telehealth services in accordance with the same clinical criteria as the individual contract or the group contract provides coverage for the same health care services delivered to an enrollee in person. Telehealth services may not be subject to a dollar limit, copayment, or coinsurance requirement that is less favorable to an enrollee that applies to the same health care services delivered in person.
IA (1/24)	I.C.A. § 514C.34	A policy, contract, or plan providing for third-party payment or prepayment of health or medical expenses shall not discriminate between coverage benefits for health care services that are provided in person and the same health care services that are delivered through telehealth.
KS (1/24)	K.S.A. 40-2,210 to 2,216	No individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society, health maintenance organization or the Kansas medical assistance program shall exclude an otherwise covered healthcare service from coverage solely because such service is provided through telemedicine, rather than in-person contact, or based upon the lack of a commercial office for the practice of medicine, when such service is delivered by a healthcare provider.
KY (1/24)	§ 304.17A-138	Shall not require face-to-face contact for services provided through a telehealth network.
LA (1/24)	§ 22:1821	Any health care service proposed to be performed or performed via transmitted electronic imaging or telemedicine under this subsection shall be subject to the applicable utilization review criteria and requirements of the insurer. Terminology in a health and accident insurance policy or contract that either discriminates against or prohibits such a method of transmitted electronic imaging or telemedicine shall be void as against public policy of providing the highest quality health care to the citizens of the state.

TELEMEDICINE

STATE	CITATION	SUMMARY
ME (1/24)	24-A M.R.S.A. § 4316	A carrier offering a health plan may not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a health care provider. Services through telemedicine shall not exceed the deductibles, copayments, or coinsurance required by the individual or group policy of accident or health insurance for the same services provided through in-person consultation.
MD (1/24)	§ 15-139	Shall provide coverage under a health insurance policy or contract for health services appropriately delivered through telemedicine; and may not exclude from coverage a health care service solely because it is provided through telemedicine and is not provided through an in-person consultation or contact between a health care provider and a patient.
MA (1/24)	M.G.L.A. 175 § 47MM	An insurer may limit coverage of telemedicine services to those health care providers in a telemedicine network approved by the insurer. Health care service provided through telemedicine shall not exceed the deductible, copayment or coinsurance applicable to an in-person consultation. Coverage for health care services under this section shall be consistent with coverage for health care services provided through in-person consultation.
MI (1/24)	MCLA 550.1401k MCLA 500.3476	A group or nongroup health care corporation certificate must not require face-to-face contact between a health care professional and patient for services appropriately provided through telemedicine. An expense-incurred hospital, medical, or surgical group or individual policy or certificate delivered, issued for delivery, or renewed in this state and a health maintenance organization group or individual contract shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the insurer or health maintenance organization.
MN (1/24)	§ 256B.0625	Health policies shall include coverage for telehealth benefits in the same manner as any other benefits covered under the policy.
MS (1/24)	§§ 83-9-351; 83-9-353	All health insurance and employee benefit plans in this state must provide coverage and reimbursement for the asynchronous telemedicine services of store and forward telemedicine services and remote patient monitoring services based on the criteria set out in this section.
MO (1/24)	§ 376.1900	Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after 1/1/2014, shall not deny coverage for a health care service on the basis that the health care service is provided through telehealth if the same service would be covered if provided through face-to-face diagnosis, consultation, or treatment.
MT (1/24)	§ 33-22-138	Each group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or health care services agreement that provides coverage for health care services must provide coverage for health care services provided by a health care provider or health care facility by means of telemedicine if the services are otherwise covered by the policy, certificate, contract, or agreement.

TELEMEDICINE

STATE	CITATION	SUMMARY
NE (1/24)	§ 44-312	Health policies shall provide upon request to a policyholder a description of the telehealth and telemonitoring services covered under the relevant policy.
	§§ 71-8501 to 71-8508	Face-to-face contact not required for services under the Medical Assistance Act.
NV (1/24)	§§ 630.0257; 689A.0463; 689B.0369; 689C.195; 695A.265; 695C.1708; 695D.216	A policy of health insurance must include coverage for services provided to an insured through telehealth to the same extent as though provided in person or by other means. Plans for dental care must include coverage for services provided to a member through telehealth to the same extent as though provided in person or by other means.
NH (1/24)	N.H. Rev. Stat. § 415-J:3	An insurer offering a health plan in this state may not deny coverage on the sole basis that the coverage is provided through telemedicine if the health care service would be covered if it were provided through in-person consultation between the covered person and a health care provider.
NJ (1/24)	§ 52:14-17.29w	A policy of health insurance must include coverage for services provided to an insured through telehealth on the same basis as when the services are delivered through in-person contact.
NM (1/24)	§§ 59A-23-7.12; 59A-22-49.3; 59A-46-50.3; 59A-47-45.3	An individual or group policy or contract that is delivered, issued for delivery or renewed shall provide coverage for services provided via telemedicine to the same extent that the health insurance plan, policy or contract covers the same services when those services are provided via in-person consultation or contact. An insurer shall not impose any unique condition for coverage of services provided via telemedicine. Coverage for health care services provided through telemedicine shall be determined in a manner consistent with coverage for health care services provided through in-person consultation.
	§ 13-7-14	Group health coverage under the Health Care Purchasing Act shall allow covered benefits to be provided through telemedicine services.
NY (1/24)	§§ 3216; 3221; 4303	Every policy delivered or issued for delivery in this state which provides comprehensive coverage for hospital, medical or surgical care shall make available and, if requested by a policy holder, provide coverage for services which are otherwise covered under the policy that are provided via telemedicine.
	§ 3217-h; 4306-g	A corporation shall not exclude from coverage a service that is otherwise covered under a contract that provides comprehensive coverage because the service is delivered via telehealth.
	§ 4406-g	A health maintenance organization shall not exclude from coverage a service that is otherwise covered under an enrollee contract of a health maintenance organization because the service is delivered via telehealth, provided, however, that a health maintenance organization may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the enrollee contract.

TELEMEDICINE

STATE	CITATION	SUMMARY
ND (1/24)	§ 26.1-36-09.15	An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage unless that policy provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.
OK (1/24)	36 Okl.St.Ann. §§ 6801 to 6803	Shall not require face-to-face contact for services provided by telemedicine.
OR (1/24)	§§ 743A.058; 743A.185	A health benefit plan must provide coverage of a telemedical health service provided if the plan provides coverage of in-person health service and the service is medically necessary.
RI (1/24)	§§ 27-81-1 to 27-81-4	Every insurer shall provide coverage for the cost of covered health-care services provided through telemedicine.
SD (1/24)	SDCL § 58-17-169	A health insurance policy, contract, or plan providing for third-party payment may not discriminate between coverage benefits for health care services that are provided in person and the same health care services that are delivered through telehealth as long as the services are appropriate to be provided through telehealth.
TN (1/24)	§ 56-7-1002	A health insurance entity shall provide coverage under a health insurance policy or contract for covered healthcare services delivered through telehealth and shall not exclude from coverage a healthcare service solely because it is provided through telehealth and is not provided through an in-person encounter.
TX (1/24)	I.C. § 1455.004	May not exclude a service from coverage solely because service was provided through telemedicine rather than face-to-face contact.
VT (1/24)	8 V.S.A. § 4100k	All health insurance plans in VT shall provide coverage for telemedicine services delivered to a patient in a health care facility to the same extent that the services would be covered if they were provided through an in-person consultation.
VA (1/24)	§ 38.2-3418.16	Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each HMO providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services. An insurer, corporation, or HMO shall not exclude service solely because the service is provided through telemedicine and is not provided through face-to-face contact.

TELEMEDICINE

STATE	CITATION	SUMMARY
VI (1/24)	22 V.I.C. §§ 1901; 1902	A health care insurer that offers, issues for delivery, delivers, executes, adjusts, uses, or renews a health care insurance plan shall provide coverage for the costs of telemedicine services and treatment that are medically necessary.
WA (1/24)	§ 48.43.735	A health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine if the plan provides coverage of the health care service when provided in person by the provider, the service is medically necessary, the service is one recognized as an essential health benefit, the service is determined to be safely and effectively provided through telemedicine or store and forward technology.

TEMPOROMANDIBULAR JOINT DISORDERS (TMJ)

STATE	CITATION	SUMMARY
AR (1/24)	§ 23-79-150	Carriers must offer optional coverage for musculoskeletal disorders affecting the face, head or neck, including TMJ. Coverage shall be the same as provided for any other musculoskeletal disorder.
CA (1/24)	Ins. § 10123.21	Individual and group policies must provide coverage for conditions directly affecting the upper or lower jawbone or associated bone joints.
CT (1/24)	Bulletin HC-47	TMJ treated as any other illness or injury and must be covered, whether surgical or nonsurgical.
FL (1/24)	§§ 627.65735; 641.31094	Group policies that provide coverage for any diagnostic or surgical procedure involving bones or joints may not discriminate for similar care for bones or joints of the jaw and facial region.
GA (1/24)	§§ 33-29-20; 33-30-14	No policy may exclude surgical or nonsurgical treatment to correct TMJ by physicians or dentists.
IL (1/24)	215 ILCS 5/356q	Group accident and health policies with hospital, medical or surgical treatment coverage shall offer reasonable and necessary medical treatment of TMJ and craniomandibular disorders. Maximum lifetime benefit is not to be lower than $2,500.
KY (1/24)	§§ 304.17-319; 304.18-0365; 304.32-1585; 304.38-1937	If cover skeletal disorders, must cover TMJ disorders.
LA (1/24)	§ 22:1055	Every hospital, health, or medical expense insurance policy shall include coverage for diagnostic, therapeutic, or surgical procedures related to the temporomandibular joint and associated musculature and neurological conditions.
MD (1/24)	COMAR 31.11.06.06; 31.11.12.06	TMJ is excluded from coverage in group comprehensive standard health benefit plans and group limited benefit plans.
MN (1/24)	§ 62A.043	Policies other than specified disease policies must specifically provide coverage for surgical and nonsurgical treatment of TMJ and craniomandibular disorder.
MS (1/24)	§ 83-9-45	Must offer coverage for diagnostic and surgical treatment of TMJ and craniomandibular disorder, same level as for any other joint in the body. Can be administered by physician or dentist.
NE (1/24)	§ 44-789	Must offer coverage for surgical and nonsurgical treatment of bone or joint of face, neck or head.
NV (1/24)	§§ 689A.0465; 689B.0379; 695B.1931; 695C.1755	Health policy shall cover the temporomandibular joint up to specified limits. Can exclude methods of treatment recognized as dental procedures, including the extraction of teeth.

TEMPOROMANDIBULAR JOINT DISORDERS (TMJ)

STATE	CITATION	SUMMARY
NM (1/24)	§ 59A-16-13.1	Policies other than specified disease policies must specifically provide coverage for surgical and nonsurgical treatment of TMJ and craniomandibular disorder. Not required to cover orthodontic appliances unless disorder is related to trauma.
NC (1/24)	§ 58-3-121	If pay for any procedures involving bones or joints, may not exclude same coverage for procedures involving bones and joints of face. Coverage to TMJ must include splinting and use of intraoral prosthetic devices subject to maximum limits.
ND (1/24)	§ 26.1-36-09.3	Mandates coverage for surgical and nonsurgical treatment of TMJ and craniomandibular disorder; $10,000 maximum for surgery, $2,500 maximum for nonsurgical treatment.
TX (1/24)	I.C. §§ 1360.001 to 1360.004	If provide coverage for treatment of skeletal joints, provide comparable benefits for TMJ if medically necessary as a result of accident, trauma, congenital defect, developmental defect, or a pathology.
UT (1/24)	Bulletin 90-3	Department finds that benefits be based on the cause of the problem and the nature and appropriateness of the treatment. Insurers may not systematically deny coverage by classifying treatment as either “dental” in a medical policy or “medical” in a dental policy.
VT (1/24)	8 V.S.A. § 4089g Bulletin 63	Cover diagnosis and treatment for a musculoskeletal disorder that affects any bone or joint in the face, neck or head if caused by an accident, trauma, congenital defect, developmental defect, or pathology. May be administered by a physician or a dentist. All insurers writing health insurance will honor claims for treatment of temporomandibular joint syndrome.
VA (1/24)	§ 38.2-3418.2	If provide coverage for treatment of skeletal joints, provide comparable benefits for TMJ.
WA (1/24)	§§ 48.21.320; 48.44.460; 48.46.530	Must offer optional coverage for TMJ disorders. Insurers may not systematically deny coverage by classifying treatment as either “dental” in a medical policy or “medical” in a dental policy.
WV (1/24)	§ 33-16-3f	The insurance commissioner shall promulgate rules and regulations regarding the diagnosis and treatment for temporomandibular joint disorder and craniomandibular disorder coverage in accident and sickness policies.
WI (1/24)	§ 632.895	If offer coverage for diagnostic or surgical procedure involving bone, joint, tissue or muscle, required coverage for surgical and nonsurgical treatment of TMJ disorders, if condition is caused by congenital, developmental or acquired deformity, disease or injury.

THERAPY

STATE	CITATION	SUMMARY
AK (1/24)	§ 21.55.110	State health insurance plan required to cover services of a licensed physical therapist rendered under the direction of a physician.
AZ (1/24)	§§ 20-1376.04; 20-1406.04	If a disability insurance contract provides coverage for occupational or physical therapy services and provides both an in-network and out-of-network benefit, an insurer shall not deny a claim for covered occupational or physical therapy services obtained out-of-network solely on the basis that a physician did not refer the insured to the occupational or physical therapist or prescribe specific occupational or physical therapy services.
	§§ 20-1402.03; 20-1057.11; 20-1404.03; 20-826.04; 20-1057.11	Shall not exclude or deny coverage for medically necessary behavioral therapy services. To be eligible for coverage, behavioral therapy services shall be provided or supervised by a licensed or certified provider.
	§ 36-2939	Long-term home or community based services may include physical therapy, occupational therapy, or speech and audiology services provided by a home health agency may be provided in accordance with federal law.
AR (1/24)	§ 23-79-157	An insurer shall not impose a copayment, coinsurance, or an office visit deductible amount for services rendered by a licensed physical therapist, occupational therapist, or speech-language pathologist that is greater than the copayment, coinsurance, or deductible amount charged to the insured for an office visit for the service of a licensed primary care physician or osteopath.
CA (1/24)	Ins. § 10232.9	Long-term care policies that provide services for home health care must provide physical therapy, occupational therapy, speech therapy, and audiology services. Health policies must cover physical therapy during inpatient care.
CO (1/24)	§ 10-16-104	Minimum of 20 therapy benefits per year for physical, occupational or speech therapy for congenital defects or birth abnormalities.
CT (1/24)	§§ 38a-523; 38a-524	Any insurer providing group health coverage shall offer rehabilitation services and occupational therapy.
DC (1/24)	§§ 31-3271; 31-3272	A health insurer shall provide coverage of habilitative services for children under the age of 21 years and may do so through a managed care system, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function.
IL (1/24)	215 ILCS 5/356z.8	A group or individual policy must provide coverage for medically necessary preventative physical therapy for insureds diagnosed with multiple sclerosis.

THERAPY

STATE	CITATION	SUMMARY
IN (1/24)	405 IAC 13-7-2	Physical, speech, occupational, and respiratory therapy for children is limited to a maximum of 50 visits per member per rolling 12-month period for each type of therapy.
KY (1/24)	KRS § 304.17A-177	An insurer shall not impose a copayment or coinsurance amount charged to the insured for services rendered for each date of service by an occupational therapist licensed under KRS Chapter 319A or a physical therapist licensed under KRS Chapter 327 that is greater than the copayment or coinsurance amount charged to the insured for the services of a physician, or an osteopath licensed under KRS Chapter 311 for an office visit.
LA (1/24)	§ 22:1042	Every policy shall include an option covered benefits for speech and language pathology therapy, physical therapy, rehabilitative services, and occupational therapy.
ME (1/24)	24-A M.R.S.A. § 4258	Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist are required coverage for the treatment when working with children from birth to 36 months of age with an identified developmental disability or delay.
MD (1/24)	Ins. § 15-835 COMAR 31.11.06.03	Insurers shall provide coverage of occupational therapy, physical therapy, and speech therapy for the treatment of congenital or genetic birth defects for children under the age of 19 years and may do so through a managed care system. Standard health benefit plan includes 30 physical therapy visits per condition per year, 30 speech therapy visits per condition per year, and 30 occupational therapy visits per condition per year.
MO (1/24)	§ 376.1218; 20 CSR § 400-2.170	Coverage required for early intervention services (medically necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology devices) for children from birth to age 3 who qualify for services under Part C of the early intervention system.
MT (1/24)	Mont. Admin. R. 6.6.2508 §§ 33-30-1018; 33-30-1019	An HMO must provide coverage for medically necessary physical therapy in both inpatient and outpatient facilities. Health service corporation shall provide coverage for health services provided by a speech-language pathologist or audiologist. Shall also provide coverage for health services provided by a licensed physical therapist.
NH (1/24)	§ 415:6-n N.H. Code Admin. R. Ins. 403.04	Shall provide coverage for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay. Standard wellness plan shall include benefits for short-term therapy, including physical therapy, speech therapy, and occupational therapy, subject to a $50 per visit copay.

THERAPY

STATE	CITATION	SUMMARY
NJ (1/24)	N.J.A.C. 11:24-5.2	HMO plans must provide for physical therapy when medically necessary.
	N.J.S.A. 17B:27A-19.20	When the covered person's primary diagnosis is autism or another developmental disability, the carrier shall provide coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.
	N.J.S.A. 26:2J-4.34; 17:48E-35.33; 52:14-17.29p; 17:48A-7ff; 52:14-17.46.6b; 17B:27A-7.16; 17B:27-46.1ii; 17B:26-2.1cc; 17:48-6ii	Individual health plans shall provide inpatient and outpatient physical therapy.
NM (1/24)	N.M. Admin Code 13.10.21.8(E)	Short-term rehabilitation services and physical therapy shall be provided under managed health care plans where the enrollee's primary care physician or other appropriate treating physician to whom the enrollee has been referred by the primary care physician determines that such services and therapy can be expected to result in the significant improvement of an enrollee's physical condition within a period of 2 months.
NY (1/24)	§§ 3221; 3216; 4303; 4322	Shall provide physical, occupational or speech therapy if provided by the home health service or agency.
ND (1/24)	ND ADC 45-06-07-06	An HMO must include coverage for physical therapy.
OK (1/24)	OAC 365:40-5-20	Basic health care services under an HMO shall include outpatient and inpatient physical therapy.
OR (1/24)	§ 743A.190	A health benefit plan must cover a child enrolled in the plan who is under 18 who has been diagnosed with a pervasive developmental disorder, including rehabilitation services that are medically necessary and are otherwise covered under the plan. "Rehabilitation services" means physical therapy, occupational therapy, or speech therapy services to restore or improve function.

THERAPY

STATE	CITATION	SUMMARY
RI (1/24)	§§ 27-18-64; 27-20-50; 27-41-68; 27-19-55	Every individual or group hospital or medical expense insurance policy or contract providing coverage for dependent children shall include coverage of speech and language therapy, occupational therapy and physical therapy.
SC (1/24)	Regulations R. 69-22	An HMO shall provide inpatient hospital services and outpatient services for physical therapy.
TX (1/24)	28 TAC 11.508	Group and individual policies must include coverage for outpatient rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy.
VA (1/24)	§ 38.2-3418.5	Each insurer shall provide coverage for early intervention services, including medically necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology services for dependents from birth to age 3 who are certified as eligible for services under Part H of the Individuals with Disabilities Act.
WA (1/24)	§§ 48.21.310; 48.44.450 § 284-43-5642	Each employer-sponsored group contract shall include coverage for neurodevelopmental therapies, including occupational therapy, speech therapy, and physical therapy for covered individuals age 6 and under. A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as rehabilitative services: outpatient physical therapy, occupational therapy and speech therapy for rehabilitative purposes.

TRANSPLANTS

STATE	CITATION	SUMMARY
AZ (1/24)	§ 36-2907 § 36-2989	Contractors shall provide nonexperimental transplants approved for Title XIX reimbursement. Nonexperimental transplants do not include pancreas only transplants. Under the Children's Health Insurance Program, the following are covered: medically necessary pancreas, heart, liver, kidney, cornea, lung and heart-lung transplants and autologous and allogeneic bone marrow transplants and immunosuppressant medications.
AR (1/24)	Ark. Admin. Code 054.00.18-7	Any policy coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
CA (1/24)	Health & Safety § 1374.17	A health insurer shall not deny coverage that is otherwise available under the health insurance policy for the costs of solid organ or other tissue transplantation services based upon the insured or policyholder being infected with the human immunodeficiency virus.
CT (1/24)	Regs. Conn. State Agencies § 38a-505-9	Any policy coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
DE (1/24)	18 Del. Admin. Code 1304-7.0	Any policy coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
FL (1/24)	§ 627.4236	May not exclude coverage for bone marrow transplant procedures, if the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty and not experimental. Must include costs associated with the donor-patient to the same extent and limitations as costs associated with the insured.
GA (1/24)	§§ 33-29-3.1; 33-30-4.1 §§ 33-29-3.3; 33-30-4.4	Mandated offering of benefits for heart transplants; coverage levels same as for other physical illnesses. Mandated offer of benefits for bone marrow transplant for treatment of breast cancer or Hodgkin's disease.

TRANSPLANTS

STATE	CITATION	SUMMARY
IL (1/24)	215 ILCS 5/356K; 215 ILCS 125/4-5; 215 ILCS 165/15.14	For HMOs, cannot deny reimbursement on basis that transplant is considered experimental or investigational.
	5 ILCS 375/6.14	If donor and donee are members of the same family and are both covered by the same benefit plan, the plan must pay 100% of the donor's costs without imposing a co-payment or deductible.
IN (1/24)	405 IAC 13-12-1	Organ transplants are not covered by the Children's Health Insurance Program.
IA (1/24)	IAC 191-36.6	Any policy coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
KY (1/24)	§§ 304.17-3165; 304.17A-135; 304.18-0985; 304.32-1595; 304.38-1936	High-dose chemotherapy and autologous bone marrow transplant as treatment for breast cancer with same coinsurance and deductibles as for other procedures.
ME (1/24)	02-031 CMR Ch. 755, § 6	A major medical expense policy may also have special or internal limitations for transplants.
MD (1/24)	COMAR 31.11.06.03; 31.11.12.03	The comprehensive standard health benefit plan and limited benefit plan includes autologous and nonautologous bone marrow, cornea, kidney, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants.
MA (1/24)	M.G.L.A. 175 § 47R; 176A § 8O; 176B § 4O; 176G § 4F; 32A § 17D	Shall provide coverage for bone marrow transplant for person diagnosed with breast cancer that has progressed to metastatic disease.
	M.G.L.A. 175 § 47V; 176B § 4V; 176A § 8V; 176G § 4Q	Shall provide coverage for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability.
MO (1/24)	§ 376.1200	Shall offer coverage for dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for treatment of breast cancer. Policy may contain a provision imposing a lifetime benefit maximum of not less than $100,000 for the chemotherapy/bone marrow transplant or stem cell transplants.

TRANSPLANTS

STATE	CITATION	SUMMARY
MT (1/24)	Admin. Reg. 37.86.5007	An HMO must provide transplant services.
NJ (1/24)	N.J.S.A. 17:48-6K; 17:48A-7j; 17:48E-35.8; 17B:26-2.1j; 17B:27-46.1j	Shall offer to provide benefits for the treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants.
	N.J.S.A. 17:48-6f; 17:48A-7e; 17:48E-35.3; 17B: 26-2.1d; 17B:27-46.1e; 26:2J-4.8; 26:2J-4.1; N.J.A.C. 11:24-5.6	Shall provide health care services to any enrollee for the treatment of Wilm's tumor, including autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful.
NC (1/24)	§ 58-3-256	When a person or that person's health care provider or representative requests that person's insurer to determine whether a transplant is eligible for benefits under that person's health benefit coverage, the insurer shall, within 10 business days after receipt of the request and medical documentation necessary to determine if there is coverage, inform the requesting person as to whether there is coverage; provided coverage exists at the time of the transplant.
OK (1/24)	Okla. Admin. Code 365:10-5-5	Any policy coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
PA (1/24)	31 Pa. Code § 88.126	Any policy coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
RI (1/24)	230-RICR-20-30-1.7	Any policy coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
SC (1/24)	Regulations R. 69-34	Any policy coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
TN (1/24)	§ 56-7-2504	All insurers shall offer coverage for the treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

TRANSPLANTS

STATE	CITATION	SUMMARY
TX (1/24)	28 TAC § 3.3040	Any policy coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
VT (1/24)	Vt. Admin. Code 4-3-8:7	Any policy coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
WV (1/24)	§§ 114-12-5; 114-39-5	Any policy coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
WA (1/24)	RCWA 48.43.680	A health benefit plan that provides coverage for organ and tissue transplants may not permit a separate lifetime limit on transplants of any less than $350,000. Donor-related services may apply to the lifetime limit on transplants.
	WAC 284-43-5642	A health benefit plan must include transplant services, supplies and treatment for donors and recipients, including the transplant or donor facility fees performed in a hospital or outpatient setting.
	WAC 284-50-330	Any policy coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
WI (1/24)	Ins. § 8.72	Each plan shall provide coverage for medically necessary organ transplants that are covered by Medicare.

MISCELLANEOUS MANDATES
AIDS VACCINE

STATE	CITATION	SUMMARY
CA (1/24)	Ins. § 10145.2; Gov. § 22853.1; Health & Safety § 1367.45	Provide coverage for a vaccine for AIDS that is approved by the FDA.

CHIROPRACTIC CARE

STATE	CITATION	SUMMARY
AL (1/24)	§§ 27-1-10; 27-59-2	Any policy for insurance must reimburse or pay for health services provided by a doctor of chiropractic care.
AK (1/24)	§ 21.86.075	An HMO enrollee may use the services of a licensed chiropractor of the enrollee's choosing and may not be required to obtain the prior approval.
AZ (1/24)	§ 20-1057.03 Circular Letter 95-5 (August 10, 1995)	Every health care services organization shall provide coverage for chiropractic services provided by network chiropractic providers. An enrollee may obtain medically necessary chiropractic services from a network chiropractic provider through self-referral for a minimum of 12 visits in an annual contract period. There is no mandated coverage for chiropractic benefits in policies issued outside of Arizona.
AR (1/24)	Opinion 2001-251	Requires insurance companies to cover service rendered by a chiropractor if the service rendered is service that could also be rendered by a doctor.
CT (1/24)	§§ 38a-507; 38a-534	Every individual health insurance policy shall provide coverage for services rendered by a chiropractor licensed under chapter 372 to the same extent coverage is provided for services rendered by a physician, if such services treat a condition covered under such policy and are within those services a chiropractor is licensed to perform.
DE (1/24)	24 Del.C. § 716	If a chiropractor is authorized by law to perform a particular service, the chiropractor shall be entitled to compensation for that chiropractor's services under such plans and contracts.
FL (1/24)	§ 627.419	When any health insurance policy, health care services plan, or other contract provides for the payment for medical expense benefits or procedures, such policy, plan, or contract shall be construed to include payment to a chiropractic physician who provides the medical service benefits or procedures which are within the scope of a chiropractic physician's license.
GA (1/24)	§ 33-24-27	All individual, group, and blanket policies must provide that any person covered shall be reimbursed for chiropractic services.

MISCELLANEOUS MANDATES
CHIROPRACTIC CARE

STATE	CITATION	SUMMARY
IN (1/24)	§§ 27-8-6-4; 27-8-6-1	A group or individual policy providing comprehensive accident and health benefits must reimburse an insured for service rendered by a provider licensed as a chiropractor in the state within the scope of that provider's license.
IA (1/24)	I.C.A. § 509.3	All group accident or health insurance policies shall cover diagnosis and treatment of ailments for payment or reimbursement for necessary diagnosis or treatment provided by a chiropractor licensed in the state if the treatment is provided within the scope of the chiropractor's license.
	IAC 191-75.10; 191-71.14	A provision shall be made in the basic health benefit plan and the standard health benefit plan covering diagnosis and treatment of human ailments for payment or reimbursement for necessary diagnosis and treatment provided by a chiropractor licensed under Iowa Code chapter 151, if the diagnosis or treatment is provided within the scope of the chiropractor's license.
KY (1/24)	§§ 304.17A-171; 304.17-305; 304.18-095	Requirements for health benefit plans that include chiropractic benefits.
LA (1/24)	§ 22:247	HMO will reimburse chiropractic services.
ME (1/24)	24-A M.R.S.A. §§ 2840-A; 2748; 4236	Group or blanket health care contracts shall provide coverage for chiropractic services that are within the lawful scope of practice.
MD (1/24)	COMAR 31.11.06.03; 31:11:12.03	Chiropractic services shall be covered up to 20 visits per condition per year.
MA (1/24)	§ 175:108D	Shall be entitled to reimbursement for such services, whether such services are performed by a medical physician or a chiropractor licensed by the commonwealth, notwithstanding any provision contained in such policy, contract, agreement, plan or certificate to the contrary.
MI (1/24)	Att'y Gen. Opinion 5503	Three years after initial licensure a HMO must provide chiropractic services to its subscribers.
	M.C.L.A. 500.3475; Att'y Gen. Opinion 6797	Shall reimburse a chiropractor who performs a service covered by the insurance policy that is within the scope of chiropractic practice permitted by law.
MN (1/24)	§ 62A.15	Group policies must include chiropractic treatment.

MISCELLANEOUS MANDATES
CHIROPRACTIC CARE

STATE	CITATION	SUMMARY
MS (1/24)	§ 83-41-215	Whenever any policy of insurance provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed chiropractor, then such service may be performed by a duly licensed chiropractor, and the insured or other person entitled to benefits under such policy, plan or contract shall be entitled to reimbursement for such services.
MO (1/24)	§ 376.1230 § 376.391	A health benefit plan shall provide coverage for treatment of a chiropractic care condition, with no greater financial burden on the insured than for access to other care. A health benefit plan shall not impose any co-payment that exceeds 50% of the total cost of providing a single chiropractic service to its enrollees.
NV (1/24)	§§ 689A.049; 695B.198; 695C.178; 689B.039	Individual health insurance policies must not limit coverage or reimbursements for treatments by a chiropractor to a number less than for treatments by other physicians.
NJ (1/24)	N.J.S.A. 17:48A-33; 17:48E-12 N.J.S.A. 17B:27-51.1	Benefits shall not be denied to any eligible individual for eligible services when such services are performed by a licensed chiropractor within the scope of his practice. Whenever such a group health insurance policy or contract provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed chiropractor, a person covered under such group health policy or contract or the chiropractor rendering such service shall be entitled to reimbursement for such service when the said service is performed by a chiropractor.
NM (1/24)	§ 59A-47-28	All individual and group subscriber contracts delivered or issued for delivery in New Mexico, which, on a service basis or on an indemnity basis, or both, provide for treatment of persons for the prevention, cure or correction of any illness or physical or mental condition shall include coverage for the services of a chiropractor.
NY (1/24)	NY INS. §§ 4303; 3216; 3221 OGC Opinion No. 07-09-29	Shall provide coverage for chiropractic care. Different reimbursement methods for chiropractors are permissible so long as the reimbursement methods are not discriminatory to chiropractic care and are not more restrictive than those applied under the same policy to other health professionals for the same or similar services.
NC (1/24)	§ 58-50-30	Where a health benefit plan provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice.
ND (1/24)	§ 26.1-36-06	Must provide policyholder with the option for chiropractic care to be covered.

MISCELLANEOUS MANDATES
CHIROPRACTIC CARE

STATE	CITATION	SUMMARY
OH (1/24)	§ 3923.23	Reimbursement for chiropractic services shall not be denied when the service is provided by a licensed person.
OK (1/24)	36 Okl.St.Ann. § 6933	Health maintenance organization shall provide basic health care services, including chiropractic services provided on a referral basis within the network at the request of an enrolled if a referral is necessitated in the judgment of the primary care physician and treatment falls within the licensed scope of a chiropractor.
OR (1/24)	OAR 836-053-0012	Health benefit plan may not exclude services provided by a chiropractor if the services are otherwise covered by the plan and the chiropractor is acting within the scope of their license.
PA (1/24)	40 P.S. § 982-3	Health insurance policy that provides for services by a licensed chiropractor may not subject an insured to more than one copayment per visit or deplete more than one visit with any one provider.
SC (1/24)	§ 38-71-210	If an insurer offers a policy containing a provision for medical expense benefits that does not provide payment for chiropractic services, it shall offer as a part thereof an optional rider or endorsement.
SD (1/24)	§ 58-17-54.1	No health insurer may impose any copayment or coinsurance amount on an insured for services rendered by a chiropractor that is greater than the copayment or coinsurance amount imposed on the insured for the services of a primary care physician.
TN (1/24)	§ 56-7-2404	Whenever any policy provides for reimbursement for any service that is within the lawful scope of practice of a duly licensed chiropractor, the insured or other person entitled to benefits under the policy shall be entitled to reimbursement for the chiropractic services.
VT (1/24)	§ 4088a	A health insurance plan shall provide coverage for clinically necessary health care services provided by a chiropractic physician licensed in Vermont.
WA (1/24)	RCWA 48.44.310; 48.20.412; 48.21.142	Each group contract for comprehensive health care service between a health care service contractor and the person or persons to receive such care shall offer coverage for chiropractic care on the same basis as any other care.
WI (1/24)	§ 632.87	No policy may exclude coverage for diagnosis or treatment of a condition by a licensed chiropractor within the scope of the chiropractor's license if the policy covers diagnosis or treatment of the condition by a licensed physician or osteopath.

MISCELLANEOUS MANDATES
FOOTWEAR

STATE	CITATION	SUMMARY
CA (1/24)	Ins. Code § 10123.141; Health & Safety § 1367.19	Every policy shall offer coverage as an option for special footwear needed by persons who suffer from foot disfigurement.
GA (1/24)	GA ADC 120-2-82-.06	Coverage required for therapeutic shoes, custom fitted inserts and related orthopedic footwear associated with the prevention and treatment of diabetes and diabetes related complications.
MD (1/24)	COMAR 10.67.06.24	Managed care organizations shall provide diabetes related therapeutic footwear, orthopedic shoes, arch supports, orthotic devices, in shoe supports, elastic support, or examinations for prescription or fitting and related services to prevent or delay a foot amputation that would be highly probable in the absence of the specialized footwear.
MA (1/24)	M.G.L.A. 176G § 4H; 176A § 8P; 176B § 4S; 175 § 47N; 32A § 17G	Coverage for therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist if such items are within a category of benefits or services for which coverage is otherwise afforded by the contract, have been prescribed by a health care professional legally authorized to prescribe such items and if the items are medically necessary for the diagnosis or treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes.
NM (1/24)	§ 59A-46-43	Each individual and group HMO contract shall provide coverage for individuals with diabetes including medically necessary podiatric appliances including therapeutic shoes.
RI (1/24)	§ 27-18-38	Every individual or group health insurance contract, plan, or policy shall include coverage for the following equipment and supplies for the treatment of insulin treated diabetes, non-insulin treated diabetes, and gestational diabetes, if medically appropriate and prescribed by a physician: therapeutic/molded shoes for the prevention of amputation.
TX (1/24)	28 TAC 21.2605	Health benefit plans shall provide coverage for podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes.
WV (1/24)	114 CSR 52-2	Major medical coverage shall include podiatric appliances and therapeutic footwear for the treatment and/or management of diabetes.

MISCELLANEOUS MANDATES
HEMOPHILIA

STATE	CITATION	SUMMARY
IL (1/24)	410 ILCS 420/3	Act extends financial assistance to eligible persons in order that they may obtain blood and blood derivatives for use in hospitals, in medical and dental facilities, or at home.
MS (1/24)	§ 41-22-3	The State Board of Health is authorized to establish a program for the care and treatment of persons suffering from hemophilia. The program shall assist persons who require continuing treatment with blood and blood derivatives to avoid crippling, extensive hospitalization and other effects associated with this bleeding condition, but who are unable to pay for the entire cost of such services on a continuing basis despite the existence of various types of hospital and medical insurance.
MO (1/24)	§ 191.335	Health and welfare program shall assist persons who require continuing treatment with blood and blood derivatives to avoid crippling, extensive hospitalization and other effects associated with this critical chronic bleeding condition.
NJ (1/24)	§§ 17B:27-46.1c; 17B:26-2.1c; 17:48E-35.1; 17:48-6d	Mandated coverage of blood products and equipment for at-home treatment. Covered to some extent as other illness.
NY (1/24)	McKinney's Public Health Law § 2510	"Covered health care services" means outpatient blood clotting factor products and other treatments and services furnished in connection with the care of hemophilia and other blood clotting protein deficiencies.
RI (1/24)	§ 23-12.1-3	The hemophilia care program shall extend financial assistance to persons suffering from hemophilia in obtaining blood, blood derivatives and concentrates, and other efficacious agents for use in hospital, medical, and dental facilities, and at home, or participate in the cost of blood processing to the extent that this support will facilitate the supplying of blood, blood derivatives and concentrates, and other efficacious agents to hemophiliac patients at an economical cost.
TN (1/24)	§ 68-41-102	The program shall assist persons who require continuing treatment with blood and blood derivatives to avoid crippling, extensive hospitalization and other effects associated with this bleeding condition, but who are unable to pay for the entire cost of such services on a continuing basis despite the existence of various types of hospital and medical insurance.
VA (1/24)	§ 38.2-3418.3	Mandated coverage for hemophilia and congenital bleeding disorders.
WI (1/24)	§ 49.685	Program assists persons suffering from hemophilia and other related congenital bleeding disorders to purchase the blood derivatives and supplies necessary for home care.

MISCELLANEOUS MANDATES
HOSPICE SERVICE

STATE	CITATION	SUMMARY
AL (1/24)	AAC 482-1-071-.17	Standard Medicare supplement plans must provide coverage for hospice care services to a person who is terminally ill.
AK (1/24)	§ 21.55.110	Coverage required for hospice services for up to 6 months in a calendar year.
AZ (1/24)	§ 36-2939 § 36-2989	Coverage required for hospice services for palliative and supportive care for terminally ill members and their families or caregivers. Hospice care is covered by the Children's Health Insurance Program.
AR (1/24)	§ 23-86-120	Group policies must provide coverage for hospice facilities and hospice programs.
CA (1/24)	Ins. § 10232.9 Health & Safety § 1368.2	Long-term care policies must provide coverage for hospice services. Every group health care service plan contract shall include a provision for hospice care.
CO (1/24)	§ 10-16-104 3 CCR 702-4:4-2-8	Policyholder shall be offered the opportunity to purchase coverage for benefits for the costs of home health services and hospice care which have been recommended by a physician as medically necessary. Policy offerings shall provide that hospice care services are to be covered when such services are provided under active management through a hospice which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished. Benefit levels for home health care services shall not be less than the deductible, coinsurance, and stop loss provisions of the overall policy or certificate. No policy may provide fewer than 60 home health visits in a calendar year.
HI (1/24)	§§ 431:10A-119; 432:1-608	All authorized insurers that provide for payment of or reimbursement for hospice care shall reimburse hospice care services for each insured policyholder covered for hospice care.
ID (1/24)	IDAPA 18.04.08.038	Hospice care is an optional benefit in individual disability and group supplemental disability policies.
IL (1/24)	215 ILCS 105/8	Covered services include the services of a licensed hospice for no more than 180 days during a policy year.

MISCELLANEOUS MANDATES
HOSPICE SERVICE

STATE	CITATION	SUMMARY
IN (1/24)	405 IAC 13-2-1	Coverage required for hospice services under the Children's Health Insurance Program.
IA (1/24)	I.C.A. § 514I.5	The benefits to be included in a qualified child health plan which are those included in a benchmark or benchmark equivalent plan and which comply with Tit. XXI of the federal Social Security Act. Benefits covered shall include hospice services.
KY (1/24)	§§ 304.17A-250; 304.17A-096	Insurers required to cover hospice services.
ME (1/24)	24-A M.R.S.A. §§ 2847-J; 2759; 4250	Policies must provide coverage for hospice care services to a person who is terminally ill.
MD (1/24)	Ins. § 15-809 COMAR 31.10.09.04	Policies written on an expense incurred basis must offer benefits for hospice care services. Hospice care benefit shall include 30 days of inpatient care per insured, part-time nursing care, counseling for insured and family, and bereavement counseling.
MA (1/24)	M.G.L.A. 176G § 4L; 176B § 4Q; 32A § 17B; 175 § 47S; 176A § 8R	Individual and group policies shall provide coverage for licensed hospice services to terminally ill patients with a life expectancy of 6 months or less.
MI (1/24)	§ 500.3406c § 550.1417	An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for inpatient hospital care shall offer to include coverage for hospice care. A health care corporation shall offer to include benefits for hospice care in each certificate that provides benefits for inpatient hospital care.
MN (1/24)	§ 62A.616	An insurer may offer a health plan that covers nursing home care for the terminally ill, personal care attendants, and hospice care.
MT (1/24)	§§ 33-22-1001 to 33-22-1003	Disability policies shall contain benefits for home health care, which includes hospice service.
NE (1/24)	210 NE ADC Ch. 44, § 007	Hospice care is a covered service under the Nebraska Comprehensive Health Insurance Pool.

MISCELLANEOUS MANDATES
HOSPICE SERVICE

STATE	CITATION	SUMMARY
NV (1/24)	§§ 695C.176; 689B.030; 689A.030	Each insurance policy must provide benefits for hospice care.
NY (1/24)	§§ 4303; 3221; 4322	Shall provide coverage for hospice care, up to 210 days.
UT (1/24)	§ 58-85-105	An insurer may not deny coverage to an eligible patient for palliative or hospice care that has been treated with an investigational drug or device, but is no longer receiving curative treatment with the investigational drug or device.
VA (1/24)	§ 38.2-3418.11	Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each HMO providing a health care plan for health care services shall provide coverage for hospice services under such policy.
WA (1/24)	§§ 48.21.220; 48.44.320	Hospice care coverage shall provide benefits for terminally ill patients for an initial period of care of not less than 6 months and may provide benefits for an additional 6 months of care in cases where the patient is facing imminent death or is entering remission if certified in writing by the attending physician.

LYME DISEASE

STATE	CITATION	SUMMARY
CT (1/24)	§§ 38a-492(h); 38a-518(h)	Individual and group plans must cover Lyme disease treatment, including antibiotic therapy.
MA (1/24)	M.G.L.A. 176b § 4JJ; Bulletin B-2016-13 (November 8, 2016)	Insurers that offer health coverage in the state shall provide coverage for long-term antibiotic therapy for patients with Lyme disease when determine to be medically necessary and ordered by a licensed physician.
MN (1/24)	§ 62A.265	All health plans must cover treatment for diagnosed Lyme disease. No special restrictions may be imposed that the health plan does not apply to nonpreven tative treatment in general.
RI (1/24)	§§ 27-18-62; 27-19-53; 27-20-48; 27-41-65; 5-37.5-5	Group and individual policies must cover diagnostic testing and long-term antibiotic treatment for chronic Lyme disease.

MISCELLANEOUS MANDATES
OBESITY

STATE	CITATION	SUMMARY
GA (1/24)	§ 33-24-59.7	Every policy providing major medical benefits must offer coverage for treatment of morbid obesity, defined as at least 100 pounds overweight or twice the ideal weight for size.
IN (1/24)	§§ 27-8-14.1-4; 27-13-7-14.5	Policy shall offer coverage for nonexperimental, surgical treatment by a healthcare provider of morbid obesity that has persisted for at least 5 years, and for which supervised, nonsurgical treatment has been unsuccessful for at least 6 consecutive months.
IA (1/24)	IAC 191-71.14(513B); 191-75.10	Except as specifically provided for, no benefits will be provided for services, supplies, or charges for any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the insured's weight or for the treatment of obesity.
MD (1/24)	Ins. § 15-839 Ins. § 15-817	Provide coverage for morbid obesity through surgical treatment. The minimum package for child wellness shall cover all visits for obesity evaluation and management.
NH (1/24)	§§ 415:6-o; 415:18-t	Shall provide coverage for the diseases and ailments caused by obesity and morbid obesity and treatment for such, including bariatric surgery, when the prescribing physician has issued a written order stating that treatment is medically necessary.
PR (1/24)	24 L.P.R.A. § 7072	Every health insurance policy shall include the payment for one of the types of bariatric surgery for the treatment of morbid obesity. The policy may require that insurers and beneficiaries comply with a waiting period that shall not exceed more than 12 months.
VA (1/24)	§ 38.2-3418.13	Mandated offer of coverage for treatment of morbid obesity through gastric bypass surgery or other methods recognized as effective.

MISCELLANEOUS MANDATES
OSTOMY SUPPLIES

STATE	CITATION	SUMMARY
CA (1/24)	10 CCR § 2594.3	Policies must cover essential health benefits which include ostomy and urological supplies.
CT (1/24)	§§ 38a-492j; 38a-518j	Individual and group policies must cover medically necessary appliances and supplies for colostomy, ileostomy and urostomy. Maximum required $2,500 per year.
MD (1/24)	§ 15-848	Insurers and nonprofit health service plans shall provide coverage for all medically appropriate and necessary equipment and supplies used for the treatment of ostomies, including flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts, and catheters used for drainage of urostomies.
MT (1/24)	§ 37.86.5007	HMO policies must provide coverage for ostomy supplies, only if supplied by a participating provider.
NY (1/24)	§§ 3216; 3221; 4303	Every policy which provides medical coverage that includes coverage for physician's services in a physician's office shall include coverage for equipment and supplies used for the treatment of ostomies.

PORT-WINE STAINS

STATE	CITATION	SUMMARY
MN (1/24)	§ 62A.304	All plans must cover Minnesota residents, no increase in rates allowed.

MISCELLANEOUS MANDATES
PROSTHESIS

STATE	CITATION	SUMMARY
AK (1/24)	§ 21.55.110	State insurance plans must provide nondental prosthesis and maxillo-facial prosthesis used to replace any anatomic structure lost during treatment for head and neck tumors or additional appliances essential for the support of the prosthesis.
AR (1/24)	A.C.A. § 23-99-417	A health benefit plan shall provide coverage for eligible charges within limits of coverage that are no less than 80% of Medicare allowable for a prosthetic device or services.
CA (1/24)	10 CCR § 2594.3; 28 CCR § 1300.67.005	Health insurance plans shall cover prosthetic and orthotic services including prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.
CO (1/24)	§ 10-16-104	Must provide coverage for prosthetic device equal to federal law requirements specified in statute. “Prosthetic device” means an artificial device to replace an arm or leg.
CT (1/24)	§§ 38a-504; 38a-542	Shall provide coverage for the surgical removal of tumors and treatment of leukemia, including the cost of any nondental prosthesis including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis.
DE (1/24)	18 Del.C. §§ 3356; 3362; 3571(B); 3571(E)	Every individual health insurance policy, contract or certificate that is delivered or issued for delivery in this state by any health insurer, health service corporation or managed care organization which provide for medical or hospital expenses and also provide coverage for other prostheses, shall provide coverage for expenses for a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease.
FL (1/24)	§ 627.6417	Any health insurance policy that provides coverage for mastectomies must also provide coverage for prosthetic devices and breast reconstructive surgery incident to the mastectomy.
IN (1/24)	§§ 27-8-10-3; 27-8-24.2-5; 27-13-7-19	Policies shall include coverage for prostheses, other than dental.
IA (1/24)	I.C.A. § 514C.25 IAC 191-71.14; 191-75.10	Medically necessary prosthetic devices when prescribed by a physician shall be covered by individual or group accident insurance. Prosthetic devices are covered when medically necessary under small group health benefit plans and individual health benefit plans.

MISCELLANEOUS MANDATES
PROSTHESIS

STATE	CITATION	SUMMARY
LA (1/24)	§ 22:1049	Any specified health coverage plan which is issued for delivery, delivered, renewed, or otherwise contracted for in this state on or after 1/1/2009, shall provide coverage of prosthetic devices and prosthetic services.
ME (1/24)	24-A M.R.S.A. § 4315	Insurers must provide coverage for a prosthetic arm or leg that meets the medical needs of the enrollee. Also covers repair or replacement.
MD (1/24)	Ins. § 15-844	Nonprofit health service plans that provide hospital benefits shall provide hospital benefits for prosthetic devices and orthopedic braces.
MA (1/24)	M.G.L.A. 176G § 4J; 176A § 8T; 176B § 4R; 175 § 47T; 32A § 17E	A contract which provides coverage for any other prosthesis, shall provide coverage for expenses for scalp hair prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia.
MN (1/24)	§§ 62A.28; 62E.06	Accident and health insurance policies must provide coverage for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata.
MO (1/24)	§ 376.1222	Medicaid, CHIP, and any health care plans issued to employees under the Missouri consolidated health care plan shall provide coverage for prostheses and expenses for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata or alopecia totalis for persons 18 years of age or younger who are covered under a policy, program or plan pursuant to this section.
NH (1/24)	§§ 415:18-n; 415:6-j §§ 420-A:14; 415:18-d; 420-B:8-f	Plans with hospital expenses must provide coverage for prosthesis to replace arm or leg. May not impose separate lifetime maximum on coverage for prosthetic devices. Shall provide coverage for expenses for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent loss of scalp hair due to injury.
NJ (1/24)	N.J.S.A. 17B:27A-7.13	Every individual health benefits plan that provides hospital or medical expense benefits shall provide benefits to any person covered thereunder for expenses incurred in obtaining an orthotic or prosthetic appliance from any licensed orthotist or prosthetist, or any certified pedorthist, as determined medically necessary by the covered person's physician.
OK (1/24)	36 Okl.St.Ann. § 6060.9	Any health benefit plan that provides medical and surgical benefits with respect to the treatment of cancer and other conditions treated by chemotherapy or radiation therapy shall provide coverage for wigs or other scalp prostheses necessary for the comfort and dignity of the covered person.
OR (1/24)	§ 743A-148	Maxillofacial prosthetic devices included for group policies.

MISCELLANEOUS MANDATES
PROSTHESIS

STATE	CITATION	SUMMARY
RI (1/24)	§§ 27-18-68; 27-19-59; 27-20-54; 27-41-71	Shall provide coverage for expenses for scalp hair prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia.
SC (1/24)	§ 38-71-240	Any policy with dependent coverage shall cover prosthetic treatment of cleft palate and lip, including as obdurators, speech appliances, and feeding appliances.
TX (1/24)	§ 1371.003	A health benefit plan must provide coverage for prosthetic devices and the repair and replacement of a prosthetic device.
UT (1/24)	§ 31A-22-638	An insurer that provides a health benefit plan shall offer at least one plan that provides coverage for benefits for prosthetics.
VT (1/24)	8 V.S.A. § 4088f	A health insurance plan shall provide coverage for prosthetic devices in all health plans at least equivalent to that provided by the federal Medicare program.
VA (1/24)	§ 38.2-3418.15	Each insurer shall offer and make available coverage for medically necessary prosthetic devices, the repair, fitting, replacement, and components with exceptions.
WA (1/24)	WAC 284-43-5642	A health benefit plan must cover braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatus used to support, align or correct deformities or to improve the function of moving parts.

SCREENING FOR SEXUALLY TRANSMITTED DISEASES

STATE	CITATION	SUMMARY
CT (1/24)	C.G.S.A. § 38a-530f	Each group health insurance policy providing coverage shall provide coverage for chlamydia, cervical, gonorrhea, human immunodeficiency virus, and human papillomavirus screenings for any sexually-active woman.
GA (1/24)	§ 31-17-4.1	Insurer must provide coverage for annual routine Chlamydia screening test for covered females who are not more than 29 years old.
HI (1/24)	HRS § 432:1-618	Each hospital or medical service plan contract issued or renewed in this state, except for plan contracts that only provide coverage for specified diseases or other limited benefit coverage, shall provide coverage for annual screenings for sexually transmitted diseases, including screenings for human immunodeficiency virus and acquired immunodeficiency syndrome.

MISCELLANEOUS MANDATES
SCREENING FOR SEXUALLY TRANSMITTED DISEASES

STATE	CITATION	SUMMARY
MD (1/24)	Ins. § 15-829	Provide coverage for annual routine Chlamydia screening for women under 20 who are sexually active, women 20 years and more with multiple risk factors, and men with multiple risk factors. Provide screening for human papillomavirus screening according to guidelines of American College of OB/GYN.
NM (1/24)	§ 59A-22-40	Each individual and group health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state shall provide coverage for cytologic and human papillomavirus screening.
PR (1/24)	Uncodified HB 3973 § 3 (August 30, 2012) 2012 Puerto Rico Laws Act 218	Health insurance companies shall include as part of their coverage sexually transmitted diseases screening tests.
TN (1/24)	§ 56-7-2606	Offer coverage for annual Chlamydia screening.

MISCELLANEOUS MANDATES
SICKLE CELL ANEMIA

STATE	CITATION	SUMMARY
AL (1/24)	§ 27-5-13	Insurer must not deny coverage on basis applicant is diagnosed with sickle cell anemia.
AR (1/24)	§ 23-79-129	Coverage of newborn children shall include testing for sickle cell anemia and genetic disorders.
FL (1/24)	§ 626.9707	No insurer authorized to transact insurance in this state shall refuse to issue and deliver in this state any policy of disability insurance solely because the person to be insured has the sickle cell trait.
LA (1/24)	§ 22:1097	No insurance company shall charge unfair discriminatory premiums, policy fees or rates for, or refuse to provide any policy, subscriber agreement, or contract of life insurance, life annuity, or policy containing disability coverage for a person solely because the applicant therefor has sickle cell trait. No insurance company shall unfairly discriminate in the payments of dividends, other benefits payable under a policy, or in any of the terms and conditions of such policy or contract solely because the insured of the policy or contract has sickle cell trait.
MD (1/24)	§ 27-208	Unless there is actuarial justification, an insurer may not refuse to insure or make or allow a differential in ratings, premium payments, or dividends in connection with life insurance and annuity contracts solely because the applicant or policyholder has the sickle cell trait.
MO (1/24)	§ 191.365	A program for the care and treatment of persons suffering from sickle cell anemia and the identification and counseling of individuals that have sickle cell traits.
NJ (1/24)	N.J.S.A. 17B:27A-7.18; 17B:27A-19.22; 17:48E-35.35; 17:48A-7hh; 17B:26-2.1ee; 17:48-6kk	Shall provide coverage for medical expenses incurred by a covered person for the treatment of sickle cell anemia and, if the contract provides benefits for expenses incurred in the purchase of the outpatient drugs, then the contract shall provide coverage for prescription drug expenses incurred by a covered person for the treatment of sickle cell anemia.
	N.J.S.A. 26:2J-4.36	HMOs shall provide coverage for sickle cell anemia.
NC (1/24)	§§ 58-65-70; 58-51-45; 58-58-25	Shall not refuse to issue or deliver policy or contract on account of the fact that the person who is to be insured possesses sickle cell trait or hemoglobin C trait.
TN (1/24)	§ 56-7-207	No insurance company shall refuse to issue or deliver any policy of life insurance solely by reason of the fact that the person to be insured possesses sickle cell trait or hemoglobin C trait.

MISCELLANEOUS MANDATES
ULCERATIVE COLITIS

STATE	CITATION	SUMMARY
MA (1/24)	M.L.G.A. 175 § 47I; 176A § 8L; 176B § 4K; 176G § 4D; 32A § 17A	Shall provide coverage for nonprescription enteral formulas for malabsorption caused by Crohn's Disease, ulcerative colitis, etc.
RI (1/24)	§§ 27-18-70; 27-19-61; 27-20-56; 27-41-74	Shall provide coverage for nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastro-esophageal reflux, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

