Preventive Care Services

Policy Number: BIP133.J
Effective Date: July 1, 2021

Instructions for Use

Table of Contents Page

Related Benefit Interpretation Policies

- Educational Programs for Members
- Hearing Services
- Immunizations/ Vaccinations
- Vision Care and Services

Related Medical Management Guideline

- Preventive Care Services

Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below

Federal

Throughout this document the following abbreviation are used:

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

Patient Protection and Affordable Care Act

UnitedHealthcare covers certain medical services under the Preventive Care Services benefit. Effective for plan years on or after September 23, 2010, of the federal Patient Protection and Affordable Care Act (PPACA) requires non-grandfathered plans to cover certain “recommended preventive services” identified by PPACA under the Preventive Care Services benefit.

For non-grandfathered plans, UnitedHealthcare will cover the recommended preventive services under the Preventive Care Services benefit as mandated by PPACA, with no cost sharing when provided by a Network provider. These services are described in the United States Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the CDC, and Health Resources and Services Administration (HRSA) Guidelines including the American Academy of Pediatrics Bright Futures periodicity guidelines.
In addition to these mandated services, under the Preventive Care Services benefit, UnitedHealthcare also provides screening using CT colonography, prostate specific antigen (PSA), and screening mammography for adult women without age limits.

visit http://www.ncsl.org/documents/health/ppaca-consolidated.pdf for legislation.

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

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

profit organization under Internal Revenue Code section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii)." 45 C.F.R. §147.130(a)(1)(iv)(B).

California Code of Regulations Title 28 Managed Health Care Article 7 Standards § 1300.67 Scope of Basic Health Care Services

https://govt.westlaw.com/calregs/Document/IC8C4B7D0D44911DEB97CF67CD0B99467?contextData=%28sc.Default%29&bhcp=1&bhhash=1&transitionType=Default#:~:text=67.%20Scope%20of%20Basic%20Health%20Care%20Services.%20The,or%20limitation%20of%20which%20the%20Director%20may%20approve%3A

Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a physician's supervision:

(a) Reasonable health appraisal examinations on a periodic basis;
(b) A variety of voluntary family planning services;
(c) Prenatal care;
(d) Vision and hearing testing for persons through age 16;
(e) Immunizations for children in accordance with the recommendations of the American Academy of Pediatrics, and immunizations for adults as recommended by the U.S. Public Health Service;
(f) Venereal disease tests;
(g) Cytology examinations on a reasonable periodic basis
(h) Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan

California Health and Safety Code § 1367.695 OB-GYN Direct Access

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.695&lawCode=HSC

b) Health care service plan contract issued, amended, renewed, or delivered in this state, except a specialized health care service plan, shall allow an enrollee the option to seek obstetrical and gynecological physician services directly from a participating obstetrician and gynecologist or directly from a participating family practice physician and surgeon designated by the plan as providing obstetrical and gynecological services.

California Health and Safety Code § 1367.64 Prostate Cancer Screening

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.64&lawCode=HSC

a) Every individual or group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 1999, shall be deemed to provide coverage for the screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when medically necessary and consistent with good professional practice.
b) Nothing in this section shall be construed to establish a new mandated benefit or to prevent application of deductible or copayment provisions in a policy or plan, nor shall this section be construed to require that a policy or plan be extended to cover any other procedures under an individual or a group health care service plan contract. Nothing in this section shall be construed to authorize an enrollee to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, unless the enrollee is referred to that provider by a participating physician or nurse practitioner providing care.

California Health and Safety Code § 1367.66: Cervical Cancer Screening Test

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.66&lawCode=HSC

Cervical Cancer Screening Test (SB1245-Compliance date 1/1/07; Effective for policies issued, amended, or renewed, on or after January 1, 2002)

Is amended to read:
Every individual or group health care service plan contract, except for a specialized health care service plan, that is issued, amended, or renewed, on or after January 1, 2002, and that includes coverage for treatment or surgery of cervical cancer shall also be deemed to provide coverage for an annual cervical cancer screening test upon the referral of the patient's physician and surgeon, a nurse practitioner, or certified nurse midwife, providing care to the patient and operating within the scope of practice otherwise permitted for the licensee.

The coverage for an annual cervical cancer screening test provided pursuant to this section shall include the conventional Pap test, a human papillomavirus screening test that is approved by the federal Food and Drug Administration, and the option of any cervical cancer screening test approved by the federal Food and Drug Administration, upon the referral of the patient's health care provider.

Nothing in this section shall be construed to establish a new mandated benefit or to prevent application of deductible or copayment provisions in an existing plan contract. The Legislature intends in this section to provide that cervical cancer screening services are deemed to be covered if the plan contract includes coverage for cervical cancer treatment or surgery.

California. Health & Safety Code §1367.6, 1367.65 Breast Cancer Screening

1367.6

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.6&lawCode=HSC

(a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, shall provide coverage for screening for, diagnosis of, and treatment for, breast cancer.
(b) No health care service plan contract shall deny enrollment or coverage to an individual solely due to a family history of breast cancer, or who has had one or more diagnostic procedures for breast disease but has not developed or been diagnosed with breast cancer.
(c) Every health care service plan contract shall cover screening and diagnosis of breast cancer, consistent with generally accepted medical practice and scientific evidence, upon the referral of the enrollee’s participating physician.

1367.65

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.65&lawCode=HSC

(a) On or after January 1, 2000, each health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed shall be deemed to provide coverage for mammography for screening or diagnostic purposes upon referral by a participating nurse practitioner, participating certified nurse-midwife, participating physician assistant, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law.
(b) This section does not prevent application of copayment or deductible provisions in a plan, nor shall this section be construed to require that a plan be extended to cover any other procedures under an individual or a group health care service plan contract.

This section does not authorize a plan enrollee to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, unless the plan enrollee is referred to that provider by a participating physician, nurse practitioner, or certified nurse-midwife providing care.

California Health and Safety Code, §1367.3

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.3&lawCode=HSC

(a) Every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer benefits for the comprehensive preventive care of children. This section shall apply to children 17 and 18 years of age, except as provided in subparagraph (D) of paragraph (2) of subdivision (b). Every plan shall communicate the availability of these benefits to all group contract holders and to all prospective group contract holders with whom they are negotiating. This section shall apply to a plan that, by rule or order of the director, has been exempted from subdivision (i) of Section 1367, insofar as that section and the rules thereunder relate to the provision of the preventive health care services described herein.
(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:
    (1) Be consistent with both of the following:
        (A) The most recent Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics.
        (B) The most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American

Academy of Family Physicians, unless the State Department of Public Health determines, within 45 days of the published date of the schedule, that the schedule is not consistent with the purposes of this section.

(2) Provide for the following:
   (A) Periodic health evaluations.
   (B) Immunizations.
   (C) Laboratory services in connection with periodic health evaluations.
   (D) Screening for blood lead levels in children of any age who are at risk for lead poisoning, as determined by a physician and surgeon affiliated with the plan, if the screening is prescribed by a health care provider affiliated with the plan.

(c) For purposes of this section, a health care provider is any of the following:
   (1) A person licensed to practice medicine pursuant to Article 3 (commencing with Section 2050) of Chapter 5 of Division 2 of the Business and Professions Code.
   (2) A nurse practitioner licensed to practice pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.
   (3) A physician assistant licensed to practice pursuant to Article 3 (commencing with Section 3513) of Chapter 7.7 of Division 2 of the Business and Professions Code.

California Health & Safety Code §1367.35

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.35&lawCode=HSC

(a) On and after January 1, 1993, every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall provide benefits for the comprehensive preventive care of children 16 years of age or younger under terms and conditions agreed upon between the group subscriber and the plan. Every plan shall communicate the availability of these benefits to all group contract holders and to all prospective group contract holders with whom they are negotiating. This section shall apply to each plan that, by rule or order of the director, has been exempted from subdivision (i) of Section 1367, insofar as that section and the rules thereunder relate to the provision of the preventive health care services described in this section.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:
   (1) Be consistent with both of the following:
      (A) The Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics in September of 1987.
      (B) The most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians, unless the State Department of Health Services determines, within 45 days of the published date of the schedule, that the schedule is not consistent with the purposes of this section.
   (2) Provide for all of the following:
      (A) Periodic health evaluations
      (B) Immunizations
      (C) Laboratory services in connection with periodic health evaluations

California Health & Safety Code §1367.665

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.665&lawCode=HSC

Every individual or group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after July 1, 2000, shall be deemed to provide coverage for all generally medically accepted cancer screening tests, subject to all terms and conditions that would otherwise apply.

California Section 2594.3

http://carules.elaws.us/code/t.10_ch.5_subch.3_art22_sec.2594.3

(b) Essential Health Benefits Routine
   (1) Routine non-pediatric eye exam services for refraction to determine the need for vision correction and provide a prescription for eyeglass lenses, but not excluding examination of the eye for other purposes, including preventive screening for conditions such as hypertension, diabetes, glaucoma, or macular degeneration

State Market Plan Enhancements

None

Covered Benefits

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

Notes:

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

Not Covered

Refer to the Medical Management Guideline titled Preventive Care Services.

Policy History/Revision Information

Date	Summary of Changes
07/01/2021	**Federal/State Mandated Regulations** • Added reference link to *California Code of Regulations Title 28 Managed Health Care, Article 7 Standards, § 1300.67* • Revised language pertaining to *Section 2594.3* **Supporting Information** • Archived previous policy version BIP133.I

Instructions for Use

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