OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
Adopted Children	Policies shall provide that the health insurance benefits applicable for any natural child of the subscriber shall be payable with respect to any adopted child of the subscriber from the date of placement of the child in the custody of the insured or subscriber, provided the insurer is notified within thirty-one (31) days in writing. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement of the child in the custody of the insured or subscriber. Nothing in this section shall be construed to require coverage of costs incurred for such medical conditions prior to the date of placement of the child in the custody of the insured or subscriber. Subject to the terms and conditions of the policy, contract or agreement, coverage shall also include the actual and documented medical costs associated with the birth of an adopted child who is eighteen (18) months of age or younger. If requested, the insured shall provide copies of medical bills and records associated with the birth of the adopted child and proof that the insured paid or is responsible for payment of the medical bills associated with the birth and that the cost of the birth was not covered by another health care plan including Medicaid. Any reference to the name of the natural parents of the adopted child shall be deleted from the records so provided. The coverage required by this subsection shall be subject to the same annual deductibles and coinsurance as may be deemed appropriate and as are consistent with those established for other covered benefits. The coverage shall also be subject to the terms of the insurers contract, if any, with hospitals and physicians. "Placement" means the assumption by the insured or subscriber of	Applies to all individual and group health insurance policies providing coverage on an expense incurred, fixed, or capitated basis, and all individual and group insurance policies, certificates, service or indemnity type contracts issued by insurance companies, health maintenance organizations, nonprofit corporations, charitable and benevolent corporations established for the purposes of operating a nonprofit hospital service or indemnity plan and/or a nonprofit medical or indemnity, fixed, or capitated plan, and all self-insurers which provide coverage for a family member of the insured or subscriber. Exemptions: This benefit does not apply to ERISA exempted self-funded plans.	36 O.S. § 6059

*These services shall be provided for Health Maintenance Organization members as needed and without limitations as to time and cost.

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
	the physical custody of the adopted child and the financial responsibility for the support and care of the adopted child. For purposes of this section, a child who is in the custody of the insured, pursuant to an interlocutory decree issued under Section 7505-6.1 of Title 10 of the Oklahoma Statutes vesting temporary care of the child in the insured, is an adopted child during the pendency of the adoption proceeding, regardless of whether a final decree of adoption is ultimately issued.		
Annual Obstetrical/ Gynecological Exams	Any health benefit plan, including the State and Education Employees Group Health Insurance plan, that is offered, issued or renewed in Oklahoma on or after January 1, 2005, that provides medical and surgical benefits shall provide coverage for routine annual obstetrical/gynecological examinations. The benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under a health benefit plan. Nothing in this section of law shall be construed as requiring such routine annual examination to be performed by an obstetrician, gynecologist, or obstetrician/gynecologist.	Applies to any group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. The term shall not include short-term, accident, fixed indemnity or specified disease policies, disability income contracts, limited benefit or credit disability insurance, workers' compensation insurance coverage, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance. Exemptions: The provisions of this section shall not apply to policies or certificates issued to individuals or groups with fewer than fifty employees or to ERISA exempted self-funded plans.	36 O.S. § 6060.3a

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
Arrest or Pretrial Detention	Health Plans shall not exclude otherwise allowable claims which occur in conjunction with the arrest or pretrial detention of the policyholder prior to adjudication of guilt and sentencing to incarceration of such policyholder. The reimbursement rate for out-of-network claims for these services shall be set at the current Medicare rate.	Health benefit plans, including, but not limited to, the State and Education Employees Group Health Insurance Plan, that are offered, issued or renewed in the state on or after January 1, 2009.	36 O.S. § 6060.4a
Audiological Exams and Hearing Aids for Children	Plans shall provide coverage for audiological services and hearing aids for children up to eighteen (18) years of age. Such coverage shall only apply to hearing aids that are prescribed, filled and dispensed by a licensed audiologist, and may limit the hearing aid benefit payable for each hearing-impaired ear to every forty-eight (48) months; provided, however, such coverage may provide for up to four additional ear molds per year for children up to two (2) years of age. Nothing in this law shall be construed to extend the practice or privileges of any health care provider beyond that provided in the laws governing the provider's practice and privileges.	Includes individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. Exemptions: The term "health benefit plan" shall not include individual plans; plans that only provide coverage for a specified disease, accidental death, or dismemberment for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury or as a supplement to liability insurance; Medicare supplemental policies as defined in Section 1882(g)(1) of the federal Social Security Act (42 U.S.C., Section 1395ss); workers' compensation insurance coverage; medical payment insurance issued as a part of a motor vehicle insurance policy; or long term care policies including nursing home fixed indemnity policies, unless the Insurance Commissioner determines that the policy provides comprehensive benefit	36 O.S. § 6060.7

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
		coverage sufficient to meet the definition of a health benefit plan.	
Autistic Children	Requires that insurance companies provide children with autism the same coverage for non-autism-related illnesses, diseases and injuries that children without autism are provided and states that such coverage does not constitute coverage for autism-related treatments. "Autistic disorder" is defined as a neurological disorder that is marked by severe impairment in social interaction, communication, and imaginative plan, with onset during the first three (3) years of life and is included in a group of disorders known as autism spectrum disorders.	All individual and group health insurance policies that provide medical and surgical benefits.	36 O.S. § 6060.20
Birth Defect	The coverage for newly born children shall include injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Such coverage shall also include transportation necessary for the provision of medical care for such newly born children when (1) the newly born is transported to the nearest hospital capable of providing the medically necessary treatment on a timely basis, and (2) the mode of transportation is the most economical consistent with the well-being of the newly born. Transportation coverage shall not exceed the reasonable costs of providing such service and an itemized statement of costs shall accompany each claim. Applicable to HMOs only: 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, and	All individual and group health insurance policies providing coverage on an expense incurred basis, and all individual and group service or indemnity type contracts issued by a nonprofit corporation and all self-insurers which provide coverage for a family member of the insured or subscriber shall, as to such family member's coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one	36 O.S. § 6058 OAC 365:40-5-20(12)*

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
	otologic, audiological, and speech/language treatment.	(31) days after the date of birth in order to have the coverage continue beyond such thirty-one-day period. Exemptions: The provisions of this subsection shall not apply to policies involving Medicare and supplements to Medicare or to ERISA exempted self-funded plans.	
Bone Density	All individual and group health insurance policies providing coverage on an expense incurred basis, and all individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a female forty-five (45) years of age or older in this state, except for policies that provide coverage for specified disease or other limited benefit coverage, shall include the coverage specified by this section for a bone density test to qualified individuals covered by the policy when such test is requested by a primary care or referral physician. The test shall be subject to the policy deductible, co-payments and coinsurance limits of the plan; provided, however, no policy or contract shall be required to reimburse more than One Hundred Fifty Dollars ($150.00) for any such test. "Qualified individual" means an individual: (a) with an estrogen hormone deficiency, (b) with: (1) vertebral abnormalities, (2) primary hyperparathyroidism, or (3) a history of fragility bone fractures, (c) who is receiving long-term glucocorticoid, or (d) who is currently under treatment for osteoporosis. "Bone density test" means a medically accepted measurement of bone mass used to detect low bone mass and to determine a qualified individual's risk for osteoporosis.	All individual and group health insurance policies providing coverage on an expense incurred basis, and all individual and group service or indemnity type contracts issued by a nonprofit corporation. Exemptions: This benefit does not apply to ERISA exempted self-funded plans.	36 O.S. § 6060.1

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
Breast Cancer	Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 1998, that provides medical and surgical benefits with respect to the treatment of breast cancer and other breast conditions shall ensure that coverage is provided for not less than forty-eight (48) hours of inpatient care following a mastectomy and not less than twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer. Health plans shall also provide coverage for reconstructive breast surgery performed as a result of a partial or total mastectomy. Because breasts are a paired organ, any such reconstructive breast surgery shall include coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed, provided that the reconstructive surgery and any adjustments made to the nondiseased breast must occur within twenty-four (24) months of reconstruction of the diseased breast. "Women's Health and Cancer Rights Act of 1998" requires that a plan providing medical and surgical benefits with respect to a mastectomy shall provide, in case of a member who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications, all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the PCP.	Includes individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. Exemptions: The term "health benefit plan" shall not include individual plans; plans that only provide coverage for a specified disease, accidental death, or dismemberment for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury or as a supplement to liability insurance; Medicare supplemental policies as defined in Section 1882(g)(1) of the federal Social Security Act (42 U.S.C., Section 1395ss); workers' compensation insurance coverage; medical payment insurance issued as a part of a motor vehicle insurance policy; or long term care policies including nursing home fixed indemnity policies, unless the Insurance Commissioner determines that the policy provides comprehensive benefit coverage sufficient to meet the definition of a health benefit plan.	36 O.S. § 6060.5 Women's Health and Cancer Rights Act of 1998

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
Chemical Dependency – Detoxification	Diagnosis, medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs, including: Diagnosis and medical treatment for the abuse of or addiction to alcohol and drugs including detoxification for alcoholism or drug abuse on either an outpatient or inpatient basis, whichever is medically determined to be appropriate, in addition to the other required basic health care services for the treatment of other medical conditions. Referral services for either medical or for nonmedical ancillary services. Medical ancillary services shall be a part of basic health care services; nonmedical ancillary services (such as vocational rehabilitation and employment counseling) and prolonged rehabilitation services in a specialized inpatient or residential facility need not be a part of basic health care services.	Applies exclusively to Health Maintenance Organizations	OAC 365:40-5-20(7)*
Children	An insurer shall not deny enrollment of a child under the health plan of the child's parent on the grounds that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area. If a child has health coverage through an insurer of a noncustodial parent the insurer shall: 1. Upon request, provide complete information to the custodial person, the designated agency administering the State Medicaid Program, the state agency administering the provisions of 42	Applies to licensed insurance company, not-for-profit hospital service or medical indemnity corporation, a fraternal benefit society, a health maintenance organization, a prepaid plan, a preferred provider organization, a multiple employer welfare arrangement, a self-insured, the State and Education Employees Group Insurance Board, or any other entity providing a plan of health insurance or health benefits in this state. If child support services are being provided under the state child support plan as provided under Section 237 of Title 56 of	36 O.S. § 6058A

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Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
	U.S.C., Sections 5 through 669, or the Child Support Enforcement Division of the Department of Human Services, regarding any insurance benefits to which the child is entitled, and any forms, publications, or documents necessary to apply for or to utilize the benefits available through that coverage; 2. Permit the custodial person, the designated agency administering the State Medicaid Program, or the provider with approval, to submit claims for covered services without the approval of the noncustodial parent; and 3. Make payments on claims submitted in accordance with paragraph 2 of this subsection directly to the custodial person, the provider, or the designated agency administering the State Medicaid Program. When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall be required: 1. To permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions; 2. To enroll the child under family coverage and deduct the employee's cost of the coverage from the employee's wages. The enrollment shall be made upon application to the employer by the custodial person, the designated agency administering the State Medicaid Program, or the state agency administering the provisions of 42 U.S.C., Sections 5 to 669, the Child Support Enforcement	the Oklahoma Statutes, the Child Support Enforcement Division shall notify the parent's employer to enroll the child in health care coverage available under the employer's plan by sending the employer a National Medical Support Notice issued pursuant to Section 466(a)(19) of the Social Security Act, and Section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974, as soon as the National Medical Support Notice is promulgated by the United States Department of Health and Human Services. The insurer, upon receipt from the employer of Part B of the National Medical Support Notice to Plan Administrator, shall comply with Part B of the National Medical Support Notice. The insurer may be fined up to Two Hundred Dollars ($200.00) per month per child for each failure to comply with the requirements of the National Medical Support Notice. Fines collected shall be remitted to the Child Support Revenue Enhancement Fund created pursuant to Section 225 of Title 56 of the Oklahoma Statutes.	

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
	Division; and 3. Not to disenroll, or eliminate coverage for the child unless the insurer is provided satisfactory written evidence that: a. the court or administrative order is no longer in effect, or b. the child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment; provided, however, the provisions of this subsection shall not apply where the coverage is through a group plan and the group's coverage through the insurer is discontinued or the noncustodial parent ceases to be eligible for participation in the group plan.		
Chiropractic Services	Chiropractic services shall be provided on a referral basis within the network at the request of an enrollee who has a condition of an orthopedic or neurological nature if: A referral is necessitated in the judgment of the primary care physician; and, treatment for the condition falls within the licensed scope of practice of a chiropractic physician.	Applies exclusively to Health Maintenance Organizations	36 O.S. § 6933
Colorectal Cancer Screenings	Any health benefit plan, including the State and Education Employees Group Health Insurance Plan, that is offered, issued or renewed in this state on or after January 1, 2002, which provides medical and surgical benefits, shall offer coverage for colorectal cancer examinations and laboratory tests for cancer for any nonsymptomatic covered individual, in accordance with standard, accepted published medical practice guidelines for colorectal cancer screening, who is: At least fifty (50) years of age; or less than fifty (50) years of age and at high risk for colorectal cancer according to the standard, accepted published medical practice	Includes individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. Exemptions: does not apply to policies or certificates issued to	36 O.S. § 6060.8a

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Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
	guidelines. The coverage provided for by this section shall be subject to the same annual deductibles, co-payments or coinsurance limits as established for other covered benefits under the health plan. To minimize costs for nonsymptomatic screening, third-party reimbursement may be at the existing Medicaid rate, which shall be payment in full.	individuals or to groups with fifty (50) or fewer employees, or to plans offered under the state Medicaid program. Does not include individual plans; plans that only provide coverage for a specified disease, accidental death, or dismemberment for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury or as a supplement to liability insurance; Medicare supplemental policies as defined in Section 1882(g)(1) of the federal Social Security Act (42 U.S.C., Section 1395ss); workers' compensation insurance coverage; medical payment insurance issued as a part of a motor vehicle insurance policy; or long term care policies including nursing home fixed indemnity policies, unless the Insurance Commissioner determines that the policy provides comprehensive benefit coverage sufficient to meet the definition of a health benefit plan.	
Dental Anesthesia	Plans shall cover anesthesia expenses including anesthesia practitioner expenses for the administration of the anesthesia, and hospital and ambulatory surgical center expenses associated with any medically necessary dental procedure when provided to a covered person who is: 1. Severely disabled; or 2. A minor eight (8) years of age or under, and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care. A health benefit plan may require prior authorization for either inpatient or outpatient hospitalization for dental care in the same	Includes individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. Exemptions: The term "health benefit plan" shall not include individual plans; plans that only provide coverage for a specified disease, accidental death, or dismemberment for wages or payments in lieu of wages for a period during which	36 O.S. § 6060.6

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Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
	manner that prior authorization is required for hospitalization for other covered diseases or conditions. Coverage provided for shall be subject to the same annual deductibles, copayments or coinsurance limits as established for all other covered benefits under the health benefit plan.	an employee is absent from work because of sickness or injury or as a supplement to liability insurance; Medicare supplemental policies as defined in Section 1882(g)(1) of the federal Social Security Act (42 U.S.C., Section 1395ss); workers' compensation insurance coverage; medical payment insurance issued as a part of a motor vehicle insurance policy; or long term care policies including nursing home fixed indemnity policies, unless the Insurance Commissioner determines that the policy provides comprehensive benefit coverage sufficient to meet the definition of a health benefit plan.	
Diabetic Products and Diabetic Self-Management Training	Policies shall include coverage for the following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes, when medically necessary and when recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under the laws of this state: blood glucose monitors; blood glucose monitors for the legally blind; test strips for glucose monitors; visual reading and urine testing strips; insulin; injection aids; cartridges for the legally blind; syringes; insulin pumps and appurtenances thereto; insulin infusion devices; oral agents for controlling blood sugar; podiatric appliances for prevention of complications associated with diabetes; diabetic self-management training, podiatric health care provider services as are deemed medically necessary to prevent complications from diabetes. "Diabetes self-management training" means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management	For policies, contracts or agreements issued or renewed on and after November 1, 1996, any individual or group health insurance policy, contract or agreement providing coverage on an expense-incurred basis; any policy, contract or agreement issued for individual or group coverage by a not-for-profit hospital service and indemnity and medical service and indemnity corporation; contracts issued by health benefit plans including, but not limited to, health maintenance organizations, preferred provider organizations, health services corporations, physician sponsored networks, or physician hospital organizations; medical coverage provided by self-insureds that includes coverage for physician services in a physician's office, including coverage through private third-party payors; coverage provided through the State and Education Employees Group Insurance Board; and every policy, contract, or agreement which provides medical, major medical or similar comprehensive type coverage, group or blanket accident and health coverage, or medical expense, surgical, medical	36 O.S. § 6060.2

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Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
	of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Diabetes self-management training shall comply with standards developed by the State Board of Health in consultation with a national diabetes association affiliated with this state and at least three (3) medical directors of health benefit plans selected by the State Department of Health. Such coverage for diabetes self-management training, including medical nutrition therapy relating to diet, caloric intake, and diabetes management, but excluding programs the only purpose of which are weight reduction, shall be limited to the following: (1) visits medically necessary upon the diagnosis of diabetes, (2) a physician diagnosis which represents a significant change in the patient's symptoms or condition making medically necessary changes in the patient's self-management, and (3) visits when reeducation or refresher training is medically necessary; provided, however, payment for the coverage required for diabetes self-management training pursuant to the provisions of this section shall be required only upon certification by the health care provider providing the training that the patient has successfully completed diabetes self-management training. Diabetes self-management training shall be supervised by a licensed physician or other licensed health care provider legally authorized to prescribe under the laws of this state. Diabetes self-management training may be provided by the physician or other appropriately registered, certified, or licensed health care professional as part of an office visit for diabetes diagnosis or treatment. Training provided by appropriately registered, certified,	equipment, medical supplies, or drug prescription benefits. Exemptions: The provisions of this section shall not apply to: (a.) health benefit plans designed only for issuance to subscribers eligible for coverage under Title XVIII of the Social Security Act or any similar coverage under a state or federal government plan, (b.) a health benefit plan which covers persons employed in more than one state where the benefit structure was the subject of collective bargaining affecting persons employed in more than one state, and (c.) agreements, contracts, or policies that provide coverage for a specified disease or other limited benefit coverage. This benefit does not apply to ERISA exempted self-funded plans.	

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
	or licensed health care professionals may be provided in group settings where practicable. Coverage for diabetes self-management training and training related to medical nutrition therapy, when provided by a registered, certified, or licensed health care professional, shall also include home visits when medically necessary and shall include instruction in medical nutrition therapy only by a licensed registered dietician or licensed certified nutritionist when authorized by the patient's supervising physician when medically necessary.		
Diagnostic and Therapeutic Radiology	Diagnostic laboratory and diagnostic and therapeutic radiological services in support of basic health care services.	Applies exclusively to Health Maintenance Organizations	OAC 365:40-5-20(8)*
Domestic Abuse Victims	Prohibits health benefit plans from denying coverage, refusing to issue or renew, canceling or otherwise terminating, restricting or excluding any person from any health benefit plan issued or renewed on or after November 1, 2010, on the basis of the applicant's or insured's status as a victim of domestic abuse as defined in Section 60.1 of Title 22 of the Oklahoma Statutes. In order to comply with the provisions of this section, the acts constituting the domestic abuse shall be reported to a law enforcement agency setting forth the relevant facts.	"Health benefit plan" includes individual or group coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, any program funded under Title XIX of the Social Security Act or such other publicly funded program, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions.	36 O.S. § 6060.10A
Elective Abortions	Prohibits health insurance contracts, plans, or policies delivered or issued for delivery in Oklahoma from providing coverage for elective abortions, except by an optional rider for which there shall be paid an additional premium.	All nonprofit hospital, medical, surgical, dental, and health service corporations; all health insurers subject to the laws of Oklahoma; and all health maintenance organizations.	63 O.S. § 1-741.2

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
	An "elective abortion" is defined as an abortion for any reason other than a spontaneous miscarriage or to prevent the death of the female upon whom the abortion is performed or when the pregnancy resulted from an act of forcible rape which was reported to the proper law enforcement authorities or when the pregnancy resulted from an act of incest committed against a minor and the perpetrator has been reported to the proper law enforcement authorities.	This mandate is applicable only to contracts, plans, or policies written, issued, renewed, or revised after November 1, 2007. If new premiums are charged for a contract, plan, or policy, it shall be determined to be a new contract, plan, or policy.	
Emergency Services	Decisions by a health maintenance organization to authorize or deny coverage for an emergency service shall be based on the patient presenting symptoms arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious: 1. Jeopardy to the health of the patient; 2. Impairment of bodily function; or 3. Dysfunction of any bodily organ or part. Health maintenance organizations shall not deny an otherwise covered emergency service based solely upon lack of notification to the HMO. Health maintenance organizations shall compensate a provider for patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of the patient requires emergency service. If the provider determines that the patient does not require emergency service, coverage for services rendered subsequent to that determination shall be governed by the HMO contract.	Applies exclusively to Health Maintenance Organizations	36 O.S. § 6907 OAC 365:40-5-20(5)*

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
Eye Care	Medically necessary eye care services for detection and treatment of diseases or injury to the eye.	Applies exclusively to Health Maintenance Organizations	OAC 365:40-5-20(11)*
Home Health Services	Home health services provided at an enrollee's home by health care personnel, as prescribed or directed by the responsible physician or their authority designated by the HMO.	Applies exclusively to Health Maintenance Organizations	OAC 365:40-5-20(9)*
Immunizations	A health benefit plan delivered, issued for delivery or renewed in this state on or after January 1, 1998, that provides benefits for the dependents of an insured individual shall provide coverage for each child of the insured, from birth through the date such child is eighteen (18) years of age for immunization against: diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, haemophilus influenzae type B, hepatitis A, and any other immunization subsequently required for children by the State Board of Health. Benefits required pursuant to this section shall not be subject to a deductible, co-payment, or coinsurance requirement.	Includes any plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, and is offered by any insurance company, group hospital service corporation, the State and Education Employees Group Insurance Board, or health maintenance organization that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage, or, to the extent permitted by the Employee Retirement Income Security Act of 1974, 29 U.S.C., Section 1001 et seq., by a multiple employer welfare arrangement as defined in Section 3 of the Employee Retirement Income Security Act of 1974, or any other analogous benefit arrangement, whether the payment is fixed or by indemnity. Exemptions: The term "health benefit plan" shall not include (a) a plan that provides coverage: (1) only for a specified disease, (2) only for accidental death or dismemberment, (3) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury, or (4) as a supplement to liability insurance, (b) a Medicare supplemental policy as defined by Section 1882(g)(1) of the Social Security Act (42 U.S.C., Section	36 O.S. § 6060.4

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Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
		1395ss), (c) worker's compensation insurance coverage, (d) medical payment insurance issued as part of a motor vehicle insurance policy, (e) a long-term care policy, including a nursing home fixed indemnity policy, unless a determination is made that the policy provides benefit coverage so comprehensive that the policy meets the definition of a health benefit plan, (f) or short-term health insurance issued on a nonrenewable basis with a duration of six (6) months or less or to ERISA exempted self-funded plans.	
Inpatient Services	Inpatient hospital services including room and board, general nursing care, meals and special diets when medically necessary, use of operating room and related facilities, use of intensive care unit and services, x-ray services, laboratory, and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, perfusion, and administration of whole blood and blood plasma.	Applies exclusively to Health Maintenance Organizations	OAC 365:40-5-20(3)*
Laboratory Services	Diagnostic laboratory services in support of basic health care services.	Applies exclusively to Health Maintenance Organizations	OAC 365:40-5-20(8)*
Mammography Screening	Females thirty-five (35) years old or older shall be entitled to a routine mammography screening for the presence of occult breast cancer. Any female thirty-five (35) through thirty-nine (39) years of age shall be entitled to coverage for a mammography screening once every five (5) years. Any female forty (40) years of age or older shall be entitled to coverage for an annual mammography screening.	All individual and group health insurance policies providing coverage on an expense incurred basis, and all individual and group service or indemnity type contracts issued by a nonprofit corporation, including the Oklahoma State and Education Employees Group Insurance Board. Exemptions: This benefit does not apply to ERISA exempted self-funded plans or to policies that provide coverage for	36 O.S. § 6060

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
	Such coverage shall not: 1. Be subject to the policy deductible, co-payments and co-insurance limits of the plan; or 2. Require that a female undergo a mammography screening at a specified time as a condition of payment. The reimbursement amount shall not exceed One Hundred Fifteen Dollars ($115.00).	specified disease or other limited benefit coverage	
Maternity, Newborn & Postpartum Care	Every health benefit plan contract issued, amended, renewed or delivered in this state on or after July 1, 1996, that provides maternity benefits shall provide for coverage of: 1. A minimum of forty-eight (48) hours of inpatient care at a hospital, or a birthing center licensed as a hospital, following a vaginal delivery for the mother and newborn infant after childbirth, except as otherwise provided in this section; 2. A minimum of ninety-six (96) hours of inpatient care at a hospital following a delivery by caesarean section for the mother and newborn infant after childbirth, except as otherwise provided in this section; and 3. a. Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within forty-eight (48) hours of childbirth by a licensed health care provider whose scope of practice includes providing postpartum care. Visits shall include, at a minimum: (1) physical assessment of the mother and the newborn infant, (2) parent education, to include, but not be limited to: (a) the recommended childhood immunization	Includes all individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. A plan may limit coverage to a shorter length of hospital inpatient stay for services related to maternity and newborn infant care provided that: In the sole medical discretion or judgment of the attending physician licensed by the Oklahoma State Board of Medical Licensure and Supervision or the Oklahoma Board of Osteopathic Examiners or certified nurse midwife licensed by the Oklahoma Board of Nursing providing care to the mother and to the newborn infant, it is determined prior to discharge that an earlier discharge of the mother and newborn infant is appropriate and meets medical criteria contained in the most current treatment standards of the American Academy of	36 O.S. § 6060.3 Newborns' and Mothers' Health Protection Act of 1996

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
	schedule, (b) the importance of childhood immunizations, and (c) resources for obtaining childhood immunizations, (3) training or assistance with breast or bottle feeding, and (4) the performance of any medically necessary and appropriate clinical tests. Inpatient care shall include, at a minimum: 1. Physical assessment of the mother and the newborn infant; 2. Parent education, to include, but not be limited to: a. the recommended childhood immunization schedule, b. the importance of childhood immunizations, and c. resources for obtaining childhood immunizations; 3. Training or assistance with breast or bottle feeding; and 4. The performance of any medically necessary and appropriate clinical tests. In the event the coverage required by this section is provided under a contract that is subject to a capitated or global rate, the plan shall be required to provide supplementary reimbursement to providers for any additional services required by that coverage if it is not included in the capitation or global rate. No health benefit plan subject to the provisions of this section shall terminate the services of, reduce capitation payments for, refuse payment for services, or otherwise discipline a licensed health care provider who orders care consistent with the provisions of this section.	Pediatrics and the American College of Obstetricians and Gynecologists, that determine the appropriate length of stay based upon: a. evaluation of the antepartum, intrapartum and postpartum course of the mother and newborn infant, b. the gestational age, birth weight and clinical condition of the newborn infant, c. the demonstrated ability of the mother to care for the newborn infant postdischarge, and d. the availability of postdischarge follow-up to verify the condition of the newborn infant in the first forty-eight (48) hours after delivery. A plan shall adopt these guidelines by July 1, 1996. The plan covers one home visit, within forty-eight (48) hours of discharge, by a licensed health care provider whose scope of practice includes providing postpartum care. Such visits shall include, at a minimum: a. physical assessment of the mother and the newborn infant, b. parent education, to include, but not be limited to: (1) the recommended childhood immunization schedule, (2) the importance of childhood immunizations, and (3) resources for obtaining childhood immunizations, c. training or assistance with breast or bottle feeding, and d. the performance of any medically necessary and clinical tests. Exemptions: This benefit does not apply to ERISA exempted self-funded plans.	
Mental Health	Twenty outpatient visits per enrollee per year, as may be necessary and appropriate for short-term evaluative or crisis intervention mental health services, or both.	Applies exclusively to Health Maintenance Organizations	OAC 365:40-5-20(6)* Mental Health

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
			Parity Act of 1996
Newborn Children	Coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Such coverage shall also include transportation necessary for the provision of medical care for such newly born children when (1) the newly born is transported to the nearest hospital capable of providing the medically necessary treatment on a timely basis, and (2) the mode of transportation is the most economical consistent with the well-being of the newly born. Transportation coverage shall not exceed the reasonable costs of providing such service and an itemized statement of costs shall accompany each claim.	All individual and group health insurance policies providing coverage on an expense incurred, fixed, or capitated basis, and all individual and group insurance policies, certificates, service or indemnity type contracts issued by insurance companies, health maintenance organizations, nonprofit corporations, or charitable and benevolent corporations established for the purpose of operating a nonprofit hospital service, indemnity, fixed or capitated plan, or a nonprofit medical or indemnity plan, and all self-insurers which provide coverage for a family member of the insured or subscriber shall, as to such family member's coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. Exemptions: Does not apply to policies involving Medicare and supplements to Medicare. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one (31) days after the date of birth in order to have the coverage continue beyond such thirty-one day period.	36 O.S. § 6058
Outpatient	Outpatient services including diagnostic services, treatment	Applies exclusively to Health Maintenance Organizations	OAC 365:40-

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
Services	services and x-ray services, for patients who are ambulatory and may be provided in a non-hospital based health care facility or at a hospital.		5-20(2)*
Physician Services	Physician services including consultant and referral services by a physician, and other health professional services as necessary to provide allopathic, osteopathic, chiropractic, podiatric, optometric, and psychological services. If a service of a physician may also be provided under applicable State law by another type of health professional, an HMO may provide the service through these other health professionals.	Applies exclusively to Health Maintenance Organizations	OAC 365:40-5-20(1)*
Prescription Drugs	Any group or non-group HMO contract which provides for prescription drugs shall also provide coverage of off-label uses of prescription drugs used in the treatment of cancer or the study of oncology.	Applies exclusively to Health Maintenance Organizations	63 O.S. § 1-2605
Preventive Services	Preventive health services, which shall be made available to enrollees and shall include at least the following: (A) Services for children from birth to age 21 as determined by the American Academy of Pediatrics in "Guidelines for Health Supervision"; (B) Immunizations for adults and children as recommended by the Advisory Committee on Immunization Practices (ACIP) Centers for Disease Control and Prevention, except those required for foreign travel and employment; (C) Periodic health evaluations for adults to include voluntary family planning services; and (D) Preventive services identified through the HMO quality assurance program designed to contribute to achieving the U.S.	Applies exclusively to Health Maintenance Organizations	OAC 365:40-5-20(10)*

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
	Department of Health and Human Services "Healthy People 2010" objectives.		
Prostate Exams	Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 2000, which provides coverage to men forty (40) years old or older in the state, shall offer coverage for annual screening for the early detection of prostate cancer in men over the age of fifty (50) years and in men over the age of forty (40) years who are in high-risk categories. The coverage shall not be subject to policy deductibles. The coverage shall not exceed: The actual cost of the prostate cancer screening up to a maximum of Sixty-five Dollars ($65.00) per screening. The benefit required to be provided shall in no way diminish or limit diagnostic benefits otherwise allowable under a health benefit plan. The prostate cancer screening coverage shall be offered as follows: 1. The screening shall be performed by a qualified medical professional including, but not limited to, a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner, or physician assistant; 2. The screening shall consist, at a minimum, of the following tests: a. a prostate-specific antigen blood test, and b. a digital rectal examination; 3. At least one per year shall be covered for any man fifty (50) years of age or older; and 4. At least one screening per year shall be covered for any man from forty (40) to fifty (50) years of age who is at increased risk of developing prostate cancer as determined by a physician.	Includes individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. Exemptions: The term "health benefit plan" shall not include individual plans, short-term, accident, fixed indemnity, or specified disease policies, disability income contracts, limited benefit or credit disability insurance, workers' compensation insurance coverage, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance, or Medicare supplemental policies as defined in Section 1882(g)(1) of the federal Social Security Act (42 U.S.C., Section 1395ss); medical payment insurance issued as a part of a motor vehicle insurance policy; or long term care policies including nursing home fixed indemnity policies, unless the Insurance Commissioner determines that the policy provides comprehensive benefit coverage sufficient to meet the definition of a health benefit plan.	36 O.S. § 6060.8
Rehabilitation	Outpatient services and inpatient hospital services including short-	Applies exclusively to Health Maintenance Organizations	OAC 365:40-

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
Physical Therapy	term rehabilitation services and physical therapy which the HMO expects can result in the significant improvement of an enrollee's condition within two months		5-20(4)*
Scalp Prosthesis	Any health benefit plan, including the State and Education Employees Group Health Insurance Plan, that is offered, issued, or renewed in this state on or after January 1, 2001, 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. The coverage provided for by this section shall be subject to the same annual deductibles, co-payments, or coinsurance limits as established for all other covered benefits under the health benefit plan not to exceed One Hundred Fifty Dollars ($150.00) annually.	Includes individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. Exemptions: does not apply to policies or certificates issued to individuals or to groups with fifty (50) or fewer employees, or to plans offered under the state Medicaid program. The term "health benefit plan" shall not include individual plans; plans that only provide coverage for a specified disease, accidental death, or dismemberment for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury or as a supplement to liability insurance; Medicare supplemental policies as defined in Section 1882(g)(1) of the federal Social Security Act (42 U.S.C., Section 1395ss); workers' compensation insurance coverage; medical payment insurance issued as a part of a motor vehicle insurance policy; or long term care policies including nursing home fixed indemnity policies, unless the Insurance Commissioner determines that the policy provides comprehensive benefit coverage sufficient to meet the definition of a health benefit plan.	36 O.S. § 6060.9

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OKLAHOMA STATE MANDATED BENEFITS

Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
Severe Mental Illness	Any health benefit plan that is offered, issued, or renewed in this state on or after the effective date of this act shall provide benefits for treatment of severe mental illness. "Severe mental illness" means any of the following biologically based mental illnesses for which the diagnostic criteria are prescribed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders: schizophrenia, bipolar disorder (manic-depressive illness), major depressive disorder, panic disorder, obsessive-compulsive disorder, and schizoaffective disorder. B. Benefits required by this section shall be equal to benefits for treatment of and shall be subject to the same preauthorization and utilization review mechanisms and other terms and conditions as all other physical diseases and disorders, including, but not limited to: 1. Coverage of inpatient hospital services for either twenty-six (26) days or the limit for other covered illnesses, whichever is greater; 2. Coverage of outpatient services; 3. Coverage of medication; 4. Maximum lifetime benefits; 5. Co-payments; 6. Coverage of home health visits; 7. Individual and family deductibles; and 8. Co-insurance.	Includes individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. Exemptions: does not apply to policies or certificates issued to individuals or to groups with fifty (50) or fewer employees, or to plans offered under the state Medicaid program. The term "health benefit plan" shall not include individual plans; plans that only provide coverage for a specified disease, accidental death, or dismemberment for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury or as a supplement to liability insurance; Medicare supplemental policies as defined in Section 1882(g)(1) of the federal Social Security Act (42 U.S.C., Section 1395ss); workers' compensation insurance coverage; medical payment insurance issued as a part of a motor vehicle insurance policy; or long term care policies including nursing home fixed indemnity policies, unless the Insurance Commissioner determines that the policy provides comprehensive benefit coverage sufficient to meet the definition of a health benefit plan.	36 O.S. § 6060.11 "Mental Health Parity Act"
Vision Services	With respect to optometric services, such covered services shall be provided on a referral basis within the medical group or network at	Applies exclusively to Health Maintenance Organizations	36 O.S. § 6933

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Benefit	Description of Services Required	Applicability to Health Plans	Legal Authority
	the request of an enrollee who has a condition requiring vision care or medical diagnosis and treatment of the eye if: a. a referral is necessitated in the judgment of the primary care physician, and b. treatment for the condition falls within the licensed scope of practice of an optometrist. Nothing in this law shall be construed to: (a) prohibit any health maintenance organization that offers services for vision care or medical diagnosis and treatment for the eye from determining the adequacy of the size of its network or (b) limit, expand or otherwise affect the scope of practice of optometry. No health maintenance organization shall require a provider of vision care or medical diagnosis and treatment for the eye to have hospital privileges if hospital privileges are not usual and customary for the services the provider provides.		

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