

Abortions

Policy Number: BIP002.L
Effective Date: January 1, 2024

[Instructions for Use](#)

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| Related Policies |
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| None |

Federal/State Mandated Regulations

Oklahoma

[Oklahoma-2016-HB1409](#)

Section 1-738.2

<https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=443331>

- (A) No abortion shall be performed in this state except with the voluntary and informed consent of the woman upon whom the abortion is to be performed.
- (B) Except in the case of a medical emergency, consent to an abortion is voluntary and informed if and only if:
 1. a) Not less than seventy-two (72) hours prior to the performance of the abortion, the woman is told the following, by telephone or in person, by the physician who is to perform the abortion, or by a referring physician, or by an agent of either physician:
 - (1) The name of the physician who will perform the abortion,
 - (2) The medical risks associated with the particular abortion procedure to be employed,
 - (3) The probable gestational age of the unborn child at the time the abortion is to be performed,
 - (4) The medical risks associated with carrying her child to term, and
 - (5) That ultrasound imaging and heart tone monitoring that enable the pregnant woman to view her unborn child or listen to the heartbeat of the unborn child are available to the pregnant woman. The physician or agent of the physician shall inform the pregnant woman that the website and printed materials described in Section 1-738.3 of this title, contain phone numbers and addresses for facilities that offer such services at no cost,
 - b) The information required by this paragraph may be provided by telephone without conducting a physical examination or tests of the woman. If the information is supplied by telephone, the information shall be based on facts supplied to the physician,
 - c) The information required by this paragraph shall not be provided by a tape recording, but shall be provided during a consultation in which the physician is able to ask questions of the woman and the woman is able to ask questions of the physician
 - d) If a physical examination, tests, or other new information subsequently indicates, in the medical judgment of the physician, the need for a revision of the information previously supplied to the woman, that revised information may be communicated to the woman at any time prior to the performance of the abortion, and
 - e) Nothing in subparagraph a of this paragraph may be construed to preclude provision of the required information in a language understood by the woman through a translator;

2. Not less than seventy-two (72) hours prior to the abortion, the woman is informed, by telephone or in person, by the physician who is to perform the abortion, by a referring physician, or by an agent of either physician:
 - a) That medical assistance benefits may be available for prenatal care, childbirth, and neonatal care,
 - b) That the father is liable to assist in the support of her child, even in instances in which the father has offered to pay for the abortion,
 - c) That:
 - (1) She has the option to review the printed materials described in Section 1-738.3 of this title,
 - (2) Those materials have been provided by the State Board of Medical Licensure and Supervision, and
 - (3) They describe the unborn child and list agencies that offer alternatives to abortion, and
 - d) (1) If the woman chooses to exercise her option to view the materials in a printed form, they shall be mailed to her, by a method chosen by the woman, or
 - (2) If the woman chooses to exercise her option to view the materials via the Internet, the woman shall be informed at least seventy-two (72) hours before the abortion of the specific address of the Internet website where the material can be accessed.

The information required by this paragraph may be provided by a tape recording if provision is made to record or otherwise register specifically whether the woman does or does not choose to review the printed materials.
 3. The woman certifies in writing, prior to the abortion, that she has been told the information described in subparagraph a of paragraph 1 of this subsection and in subparagraphs a, b and c of paragraph 2 of this subsection and that she has been informed of her option to review or reject the printed information described in Section 1-738.3 of this title; and
 4. Prior to the abortion, the physician who is to perform the abortion or the agent of the physician receives a copy of the written certification prescribed by paragraph 3 of this subsection.
- (C) The State Board of Medical Licensure and Supervision and the State Board of Osteopathic Examiners shall promulgate rules to ensure that physicians who perform abortions and referring physicians or agents of either physician comply with all the requirements of this section.
- (D) Before the abortion procedure is performed, the physician shall confirm with the patient that she has received information regarding:
1. The medical risks associated with the particular abortion procedure to be employed;
 2. The probable gestational age of the unborn child at the time the abortion is to be performed; and
 3. The medical risks associated with carrying the unborn child to term.

317:30-5-6 Abortions

<https://oklahoma.gov/ohca/policies-and-rules/xpolicy/medical-providers-fee-for-service/individual-providers-and-specialties/physicians/abortions.html>

- (a) Payment is made only for abortions in those instances where the abortion is necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, or where the pregnancy is the result of an act of rape or incest. Medicaid coverage for abortions to terminate pregnancies that are the result of rape or incest will only be provided as long as Congress considers abortions in cases of rape or incest to be medically necessary services and federal financial participation is available specifically for these services.
- (1) For abortions necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, the physician must certify in writing that the abortion is being performed due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. The mother's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.
 - (2) For abortions in cases of rape or incest, there are two requirements for the payment of a claim. First, the patient must fully complete the Patient Certification For Medicaid Funded Abortion. Second, the patient must have made a police report or counselor's report of the rape or incest. In cases where an official report of the rape or incest is not available, the physician must certify in writing and provide documentation that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the requirement. The statement explains the reason the rape or incest was not reported. The mother's name and address must be included in the certification and the certification must be signed and dated by the physician. In cases where a physician provides certification and documentation of a client's inability to file a report, the Authority will perform a prepayment review of all records to ensure there is sufficient documentation to support the physician's certification.

- (b) The Oklahoma Health Care Authority performs a "look-behind" procedure for abortion claims paid from Medicaid funds. This procedure will require that this Agency obtain the complete medical records for abortions paid under Medicaid. On a post-payment basis, this Authority will obtain the complete medical records on all claims paid for abortions.
- (c) Claims for spontaneous abortions, including dilation and curettage do not require certification. The following situations also do not require certification:
 - (1) If the physician has not induced the abortion, counseled or otherwise collaborated in inducing the abortion; and
 - (2) If the process has irreversibly commenced at the point of the physician's medical intervention.
- (d) Claims for the diagnosis "incomplete abortion" require medical review.
- (e) The appropriate diagnosis codes should be used indicating spontaneous abortion, etc., otherwise the procedure will be denied.

OK, Title 63, Chapter 1 Oklahoma Public Health Code, Section 1-741.3 Health Plans, Coverage for Abortion, Elective Abortion Coverage, Employers

<http://ok.elaws.us/os/63-1-741.3>

- (A) Pursuant to the Patient Protection and Affordable Care Act, P.L. 111-148, all qualified health plans offered through an Exchange established in the state are prohibited from including elective abortion coverage. Nothing in this section shall be construed as preventing anyone from purchasing optional supplemental coverage for elective abortions for which there must be paid a separate premium in accordance with subsection D of this section in the health insurance market outside of the Exchange.
- (B) No health plan, including health insurance contracts, plans or policies, offered outside of an Exchange, but within the state, shall provide coverage for elective abortions except by optional separate supplemental coverage for abortion for which there must be paid a separate premium in accordance with subsection D of this section.
- (C) For purposes of this section, "elective abortion" means an abortion for any reason other than to prevent the death of the mother upon whom the abortion is performed; provided, however, that an abortion may not be deemed one to prevent the death of the mother based on a claim or diagnosis that she will engage in conduct which will result in her death.
- (D) The issuer of any health plan providing elective abortion coverage shall:
 - 1. Calculate the premium for such coverage so that it fully covers the estimated cost of covering elective abortions per enrollee as determined on an average actuarial basis. In calculating such premium, the issuer of the plan shall not take into account any cost reduction in any health plan covering an enrollee estimated to result from the provision of abortion coverage, including prenatal care, delivery or postnatal care;
 - 2. If the enrollee is enrolling in a health plan providing any other coverage at the same time as the enrollee is enrolling in a plan providing elective abortion coverage, require a separate signature, distinct from that to enroll in the health plan providing other coverage, in order to enroll in the separate supplemental plan providing elective abortion coverage; and
 - 3. Provide a notice to enrollees at the time of enrollment that:
 - a. specifically states the cost of the separate premium for coverage of elective abortions distinct and apart from the cost of the premium for any health plan providing any other coverage in any health plan covering an enrollee,
 - b. states that enrollment in elective abortion coverage is optional, and
 - c. if the enrollee is enrolling in a health plan providing any other coverage at the same time as the enrollee is enrolling in a plan providing elective abortion coverage, states that the enrollee may choose to enroll in the plan providing other coverage without enrolling in the plan providing elective abortion coverage.
- (E) The issuer of any health plan providing any coverage other than elective abortion shall not discount or reduce the premium for such coverage on the basis that an enrollee has elective abortion coverage.
- (F) Any employer who offers employees a health plan providing elective abortion coverage shall, at the time of beginning employment and at least once in each calendar year thereafter, provide each employee the option to choose or reject the separate supplemental elective abortion coverage.
- (G) Any entity offering a group health plan providing separate supplemental elective abortion coverage, other than employers offering such a plan to their employees, shall, at the time each group member begins coverage and at least once in each calendar year thereafter, provide each group member the option to choose or reject the separate supplemental elective abortion coverage.
- (H) Nothing in this section shall be construed to apply in circumstances in which federal law preempts state health insurance regulation.

Oregon

743A.067 Reproductive Health Services

Prior to 07/13/2023

<https://www.oregonlaws.org/ors/743A.067>

- (1) As used in this section:
 - (a) “Contraceptives” means health care services, drugs, devices, products or medical procedures to prevent a pregnancy.
 - (b) “Enrollee” means an insured individual and the individual’s spouse, domestic partner and dependents who are beneficiaries under the insured individual’s health benefit plan.
 - (c) “Health benefit plan” has the meaning given that term in ORS 743B.005, excluding Medicare Advantage Plans and including health benefit plans offering pharmacy benefits administered by a third party administrator or pharmacy benefit manager.
 - (d) “Prior authorization” has the meaning given that term in [ORS 743B.001](#)
 - (e) “Religious employer” has the meaning given that term in ORS 743A.066.
 - (f) “Utilization review” has the meaning given that term in [ORS 743B.001 \(Definitions\)](#).
- (2) A health benefit plan offered in this state must provide coverage for all of the following services, drugs, devices, products and procedures:
 - (a) Well-woman care prescribed by the Department of Consumer and Business Services by rule consistent with guidelines published by the United States Health Resources and Services Administration
 - (b) Counseling for sexually transmitted infections, including but not limited to human immunodeficiency virus and acquired immune deficiency syndrome
 - (c) Screening for:
 - (A) Chlamydia;
 - (B) Gonorrhea;
 - (C) Hepatitis B;
 - (D) Hepatitis C;
 - (E) Human immunodeficiency virus and acquired immune deficiency syndrome;
 - (F) Human papillomavirus;
 - (G) Syphilis;
 - (H) Anemia;
 - (I) Urinary tract infection;
 - (J) Pregnancy;
 - (K) Rh incompatibility;
 - (L) Gestational diabetes;
 - (M) Osteoporosis;
 - (N) Breast cancer; and
 - (O) Cervical cancer.
 - (d) Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic mutations is indicated and counseling related to the BRCA1 or BRCA2 genetic mutations if indicated.
 - (e) Screening and appropriate counseling or interventions for:
 - (A) Tobacco use; and
 - (B) Domestic and interpersonal violence
 - (f) Folic acid supplements
 - (g) Abortion
 - (h) Breastfeeding comprehensive support, counseling and supplies
 - (i) Breast cancer chemoprevention counseling
 - (j) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, subject to all of the following:
 - (A) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, a health benefit plan may provide coverage for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.
 - (B) If a contraceptive drug, device or product covered by the health benefit plan is deemed medically inadvisable by the enrollee’s provider, the health benefit plan must cover an alternative contraceptive drug, device or product prescribed by the provider.

- (C) A health benefit plan must pay pharmacy claims for reimbursement of all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.
- (D) A health benefit plan may not infringe upon an enrollee's choice of contraceptive drug, device or product and may not require prior authorization, step therapy or other utilization control techniques for medically appropriate covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.
- (k) Voluntary sterilization
- (l) As a single claim or combined with other claims for covered services provided on the same day:
 - (A) Patient education and counseling on contraception and sterilization
 - (B) Services related to sterilization or the administration and monitoring of contraceptive drugs, devices and products, including but not limited to:
 - i. Management of side effects;
 - ii. Counseling for continued adherence to a prescribed regimen;
 - iii. Device insertion and removal; and
 - iv. Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the enrollee's provider.
- (m) Any additional preventive services for women that must be covered without cost sharing under 42 U.S.C. 300gg-13, as identified by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services as of January 1, 2017.
- (3) A health benefit plan may not impose on an enrollee a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage required by this section. A health care provider shall be reimbursed for providing the services described in this section without any deduction for coinsurance, copayments or any other cost-sharing amounts.
- (4) Except as authorized under this section, a health benefit plan may not impose any restrictions or delays on the coverage required by this section.
- (5) This section does not exclude coverage for contraceptive drugs, devices or products prescribed by a provider, acting within the provider's scope of practice, for:
 - (a) Reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause; or
 - (b) Contraception that is necessary to preserve the life or health of an enrollee.
- (6) This section does not limit the authority of the Department of Consumer and Business Services to ensure compliance with ORS 743A.063 and 743A.066.
- (7) This section does not require a health benefit plan to cover:
 - (a) Experimental or investigational treatments;
 - (b) Clinical trials or demonstration projects, except as provided in ORS 743A.192;
 - (c) Treatments that do not conform to acceptable and customary standards of medical practice;
 - (d) Treatments for which there is insufficient data to determine efficacy; or
 - (e) Abortion if the insurer offering the health benefit plan excluded coverage for abortion in all of its individual, small employer and large employer group plans during the 2017 plan year.
- (8) If services, drugs, devices, products or procedures required by this section are provided by an out-of-network provider, the health benefit plan must cover the services, drugs, devices, products or procedures without imposing any cost-sharing requirement on the enrollee if:
 - (a) There is no in-network provider to furnish the service, drug, device, product or procedure that is geographically accessible or accessible in a reasonable amount of time, as defined by the Department of Consumer and Business Services by rule consistent with the requirements for provider networks in ORS 743B.505; or
 - (b) An in-network provider is unable or unwilling to provide the service in a timely manner.
- (9) An insurer may offer to a religious employer a health benefit plan that does not include coverage for contraceptives or abortion procedures that are contrary to the religious employer's religious tenets only if the insurer notifies in writing all employees who may be enrolled in the health benefit plan of the contraceptives and procedures the employer refuses to cover for religious reasons.
- (10) If the Department of Consumer and Business Services concludes that enforcement of this section may adversely affect the allocation of federal funds to this state, the department may grant an exemption to the requirements but only to the minimum extent necessary to ensure the continued receipt of federal funds.
- (11) An insurer that is subject to this section shall make readily accessible to enrollees and potential enrollees, in a consumer-friendly format, information about the coverage of contraceptives by each health benefit plan and the coverage of other services, drugs, devices, products and procedures described in this section. The insurer must provide the information:

- (a) On the insurer’s website; and
 - (b) In writing upon request by an enrollee or potential enrollee.
- (12) This section does not prohibit an insurer from using reasonable medical management techniques to determine the frequency, method, treatment or setting for the coverage of services, drugs, devices, products and procedures described in subsection (2) of this section, other than coverage required by subsection (2)(g) and (j) of this section, if the techniques:
- (a) Are consistent with the coverage requirements of subsection (2) of this section; and
 - (b) Do not result in the wholesale or indiscriminate denial of coverage for a service. [2017 c.721 §2; 2019 c.284 §5]

Notes:

- Section 12, chapter 721, Oregon Laws 2017, provides:
 - Sec. 12. Section 2 of this 2017 Act [743A.067] applies to health benefit plan policies or certificates issued, renewed, modified or extended on or after January 1, 2019. [2017 c.721 §12]
- See 743A.001
- 743A.067 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.
- Section 3, chapter 721, Oregon Laws 2017, provides:
 - Sec. 3. No later than September 15, 2019, the Department of Consumer and Business Services shall report to the interim committees of the Legislative Assembly related to health on the degree of compliance by insurers with section 2 of this 2017 Act [743A.067] and of any actions taken by the department under ORS 731.988 to enforce compliance with section 2 of this 2017 Act. [2017 c.721 §3]

743A.067 Effective 07/23/2023

<https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/HB2002/Enrolled>

Section 12, ORS 743A.067, as amended by section 12, chapter 45, Oregon Laws 2022, is amended to read:
743A.067

- (1) As used in this section:
- (a) “Contraceptives” means health care services, drugs, devices, products or medical procedures to prevent a pregnancy.
 - (b) “Enrollee” means an insured individual and the individual’s spouse, domestic partner and dependents who are beneficiaries under the insured individual’s health benefit plan.
 - (c) “Health benefit plan” has the meaning given that term in ORS 743B.005, excluding Medicare Advantage Plans and including health benefit plans offering pharmacy benefits administered by a third party administrator or pharmacy benefit manager.
 - (d) “Prior authorization” has the meaning given that term in ORS 743B.001.
 - (e) “Religious employer” has the meaning given that term in ORS 743A.066.
 - (f) “Utilization review” has the meaning given that term in ORS 743B.001.
- (2) A health benefit plan offered in this state must provide coverage for all of the following services, drugs, devices, products and procedures:
- (a) Well-woman care prescribed by the Department of Consumer and Business Services by rule consistent with guidelines published by the United States Health Resources and Services Administration.
 - (b) Counseling for sexually transmitted infections, including but not limited to human immunodeficiency virus and acquired immune deficiency syndrome.
 - (c) Screening for:
 - (A) Chlamydia;
 - (B) Gonorrhea;
 - (C) Hepatitis B;
 - (D) Hepatitis C;
 - (E) Human immunodeficiency virus and acquired immune deficiency syndrome;
 - (F) Human papillomavirus;
 - (G) Syphilis;
 - (H) Anemia;
 - (I) Urinary tract infection;
 - (J) Pregnancy;
 - (K) Rh incompatibility; Enrolled House Bill 2002 (HB 2002-C) Page 5

- (L) Gestational diabetes;
 - (M) Osteoporosis;
 - (N) Breast cancer; and
 - (O) Cervical cancer.
- (d) Screening to determine whether counseling related to the BRCA1 or BRCA2 genetic mutations is indicated and counseling related to the BRCA1 or BRCA2 genetic mutations if indicated.
 - (e) Screening and appropriate counseling or interventions for:
 - (A) Tobacco use; and
 - (B) Domestic and interpersonal violence.
 - (f) Folic acid supplements.
 - (g) Abortion.
 - (h) Breastfeeding comprehensive support, counseling and supplies.
 - (i) Breast cancer chemoprevention counseling.
 - (j) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, subject to all of the following:
 - (A) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, a health benefit plan may provide coverage for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.
 - (B) If a contraceptive drug, device or product covered by the health benefit plan is deemed medically inadvisable by the enrollee's provider, the health benefit plan must cover an alternative contraceptive drug, device or product prescribed by the provider.
 - (C) A health benefit plan must pay pharmacy claims for reimbursement of all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.
 - (D) A health benefit plan may not infringe upon an enrollee's choice of contraceptive drug, device or product and may not require prior authorization, step therapy or other utilization review techniques for medically appropriate covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.
 - (k) Voluntary sterilization.
 - (l) As a single claim or combined with other claims for covered services provided on the same day:
 - (A) Patient education and counseling on contraception and sterilization.
 - (B) Services related to sterilization or the administration and monitoring of contraceptive drugs, devices and products, including but not limited to:
 - (i) Management of side effects;
 - (ii) Counseling for continued adherence to a prescribed regimen;
 - (iii) Device insertion and removal; and
 - (iv) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the enrollee's provider.
 - (n) Any additional preventive services for women that must be covered without cost sharing under 42 U.S.C. 300gg-13, as identified by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services as of January 1, 2017.
- (3) A health benefit plan may not impose on an enrollee a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage required by this section. A health care provider shall be reimbursed for providing the services described in this section without any deduction for coinsurance, copayments or any other cost-sharing amounts.
 - (4) Except as authorized under this section, a health benefit plan may not impose any restrictions or delays on the coverage required by this section. Enrolled House Bill 2002 (HB 2002-C) Page 6
 - (5) This section does not exclude coverage for contraceptive drugs, devices or products prescribed by a provider, acting within the provider's scope of practice, for:
 - (a) Reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause; or
 - (b) Contraception that is necessary to preserve the life or health of an enrollee.
 - (6) This section does not limit the authority of the Department of Consumer and Business Services to ensure compliance with ORS 743A.063 and 743A.066.
 - (7) This section does not require a health benefit plan to cover:
 - (a) Experimental or investigational treatments;
 - (b) Clinical trials or demonstration projects, except as provided in ORS 743A.192;

- (c) Treatments that do not conform to acceptable and customary standards of medical practice;
- (d) Treatments for which there is insufficient data to determine efficacy; or
- (e) Abortion if the insurer offering the health benefit plan:
 - (A) Has a certificate of authority to transact insurance in this state issued by the Department of Consumer and Business Services; and
 - (B) Excluded coverage for abortion in all of its individual, small employer and large employer group plans during the 2017 plan year.
- (8) If services, drugs, devices, products or procedures required by this section are provided by an out-of-network provider, the health benefit plan must cover the services, drugs, devices, products or procedures without imposing any cost-sharing requirement on the enrollee if:
 - (a) There is no in-network provider to furnish the service, drug, device, product or procedure that is geographically accessible or accessible in a reasonable amount of time, as defined by the Department of Consumer and Business Services by rule consistent with the requirements for provider networks in ORS 743B.505; or
 - (b) An in-network provider is unable or unwilling to provide the service in a timely manner.
- (9) An insurer may offer to a religious employer a health benefit plan that does not include coverage for contraceptives or abortion procedures that are contrary to the religious employer's religious tenets only if the insurer notifies in writing all employees who may be enrolled in the health benefit plan of the contraceptives and procedures the employer refuses to cover for religious reasons.
- (10) If the Department of Consumer and Business Services concludes that enforcement of this section may adversely affect the allocation of federal funds to this state, the department may grant an exemption to the requirements but only to the minimum extent necessary to ensure the continued receipt of federal funds.
- (11) An insurer that is subject to this section shall make readily accessible to enrollees and potential enrollees, in a consumer-friendly format, information about the coverage of contraceptives by each health benefit plan and the coverage of other services, drugs, devices, products and procedures described in this section. The insurer must provide the information:
 - (a) On the insurer's website; and
 - (b) In writing upon request by an enrollee or potential enrollee.
- (12) This section does not prohibit an insurer from using reasonable medical management techniques to determine the frequency, method, treatment or setting for the coverage of services, drugs, devices, products and procedures described in subsection (2) of this section, other than coverage required by subsection (2)(g) and (j) of this section, if the techniques:
 - (a) Are consistent with the coverage requirements of subsection (2) of this section; and
 - (b) Do not result in the wholesale or indiscriminate denial of coverage for a service.
- (13) This section is exempt from ORS 743A.001.

Texas

Section 1369.104 Exclusion or Limitation Prohibited

<https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1369&Phrases=1369.104&HighlightType=1&ExactPhrase=False&QueryText=1369.104>

A health benefit plan that provides benefits for prescription drugs or devices may not exclude or limit benefits to enrollees for:

- c. This section does not require a health benefit plan to cover abortifacients or any other drug or device that terminates a pregnancy.

Chapter 1218. Coverage for Elective Abortion; Prohibitions and Requirements

Section 1218.001

<https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1218&Phrases=1218.&HighlightType=1&ExactPhrase=False&QueryText=1218.>

Definition: In this chapter, "elective abortion" means an abortion, as defined by Section 245.002, Health and Safety Code, other than an abortion performed due to a medical emergency as defined by Section 171.002, Health and Safety Code.

Section 1218.002 Applicability of Chapter

<https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1218&Phrases=1218.002&HighlightType=1&ExactPhrase=False&QueryText=1218.002>

- (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or

insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) An insurance company
 - (2) A group hospital service corporation operating under Chapter 842
 - (3) A fraternal benefit society operating under Chapter 885;
 - (4) A stipulated premium company operating under Chapter 884;
 - (5) An exchange operating under Chapter 942;
 - (6) A health maintenance organization operating under Chapter 843;
 - (7) A multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
 - (8) An approved nonprofit health corporation that holds a certificate of authority under Chapter 844.
- (b) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.
- (c) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:
- (1) A basic coverage plan under Chapter 1551;
 - (2) A basic plan under Chapter 1575;
 - (3) A primary care coverage plan under Chapter 1579;
- and**
- (4) Basic coverage under Chapter 1601.
- (d) Notwithstanding Section 1501.251 or any other law, this chapter applies to coverage under a small or large employer health benefit plan subject to Chapter 1501.
- (e) Notwithstanding Section 1507.003 or 1507.053 or any other law, this chapter applies to a standard health benefit plan provided under Chapter 1507.

Section 1218.003 Certain Coverage Not Affected

<https://codes.findlaw.com/tx/insurance-code/ins-sect-1218-003.html>

This chapter does not apply to health benefit plan coverage provided to an enrollee for any abortion other than an elective abortion as defined by Section 1218.001.

Section 1218.004 Coverage By Health Benefit Plan

<https://codes.findlaw.com/tx/insurance-code/ins-sect-1218-004.html>

A health benefit plan may provide coverage for elective abortion only if:

- (1) The coverage is provided to an enrollee separately from other health benefit plan coverage offered by the health benefit plan issuer;
- (2) The enrollee pays the premium for coverage for elective abortion separately from, and in addition to, the premium for other health benefit plan coverage, if any; and
- (3) The enrollee provides a signature for coverage for elective abortion, separately and distinct from the signature required for other health benefit plan coverage, if any, provided to the enrollee by the health benefit plan issuer.

Section 1218.005 Calculation of Premium

<https://codes.findlaw.com/tx/insurance-code/ins-sect-1218-005.html>

- (a) A health benefit plan issuer that provides coverage for elective abortion shall calculate the premium for the coverage so that the premium fully covers the estimated cost of elective abortion per enrollee, determined on an actuarial basis.
- (b) In calculating a premium under Subsection (a), the health benefit plan issuer may not take into account any cost savings in other health benefit plan coverage offered by the health benefit plan issuer that is estimated to result from coverage for elective abortion.
- (c) A health benefit plan issuer may not provide a premium discount to or reduce the premium for an enrollee for other health benefit plan coverage on the basis that the enrollee has coverage for elective abortion.

Section 1218.006 Notice by Issuer

<https://codes.findlaw.com/tx/insurance-code/ins-sect-1218-006.html>

A health benefit plan issuer that provides coverage for elective abortion shall at the time of enrollment in other health benefit plan coverage provide each enrollee with a notice that:

- (1) Coverage for elective abortion is optional and separate from other health benefit plan coverage offered by the health benefit plan issuer;
- (2) The premium cost for coverage for elective abortion is a premium paid separately from, and in addition to, the premium for other health benefit plan coverage offered by the health benefit plan issuer; and
- (3) The enrollee may enroll in a health benefit plan without obtaining coverage for elective abortion.

Washington

WAC 284-170-350

Issuer standards for women's right to directly access certain health care practitioners for women's health care services.

<https://apps.leg.wa.gov/wac/default.aspx?cite=284-170-350>

- (1) (a) "Women's health care services" means organized services to provide health care to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The services include, but are not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include: Contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

Notes

Findings – Declarations – 2018 c 119

<http://lawfilesexxt.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/Senate/6219-S.SL.pdf?cite=2018%20c%20119%20%A7%201>.

"The legislature finds and declares that:

- (1) Washington has a long history of protecting gender equity and women's reproductive health;
- (2) Access to the full range of health benefits and preventive services, as guaranteed under the laws of this state, provides all Washingtonians with the opportunity to lead healthier and more productive lives;
- (3) Reproductive health care is the care necessary to support the reproductive system, the capability to reproduce, and the freedom and services necessary to decide if, when, and how often to do so, which can include contraception, cancer and disease screenings, abortion, preconception, maternity, prenatal, and postpartum care. This care is an essential part of primary care for women and teens, and often reproductive health issues are the primary reason they seek routine medical care;
- (4) Neither a woman's income level nor her type of insurance should prevent her from having access to a full range of reproductive health care, including contraception and abortion services;
- (5) Restrictions and barriers to health coverage for reproductive health care have a disproportionate impact on low-income women, women of color, immigrant women, and young women, and these women are often already disadvantaged in their access to the resources, information, and services necessary to prevent an unintended pregnancy or to carry a healthy pregnancy to term;
- (6) This state has a history of supporting and expanding timely access to comprehensive contraceptive access to prevent unintended pregnancy;
- (7) Existing state and federal law should be enhanced to ensure greater contraceptive coverage and timely access for all individuals covered by health plans in Washington to all methods of contraception approved by the federal food and drug administration;
- (8) Nearly half of pregnancies in both the United States and Washington are unintended. Unintended pregnancy is associated with negative outcomes, such as delayed prenatal care, maternal depression, increased risk of physical violence during pregnancy, low birth weight, decreased mental and physical health during childhood, and lower education attainment for the child;
- (9) Access to contraception has been directly connected to the economic success of women and the ability of women to participate in society equally;

- (10) Cost-sharing requirements and other barriers can dramatically reduce the use of preventive health care measures, particularly for women in lower income households, and eliminating cost sharing and other barriers for contraceptives leads to sizable increases in the use of preventive health care measures;
- (11) It is vital that the full range of contraceptives are available to women because contraindications may restrict the use of certain types of contraceptives and because women need access to the contraceptive method most effective for their health;
- (12) Medical management techniques such as denials, step therapy, or prior authorization in public and private health care coverage can impede access to the most effective contraceptive methods;
- (13) Many insurance companies do not typically cover male methods of contraception, or they require high cost sharing despite the critical role men play in the prevention of unintended pregnancy; and
- (14) Restrictions on abortion coverage interfere with a woman's personal, private pregnancy decision making, with his or her health and well-being, and with his or her constitutionally protected right to safe and legal medical abortion care." [[2018 c 119 § 1.](#)]

[RCW 48.43.073](#)

<https://lawfilesexternal.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5242.SL.pdf>

Required Abortion Coverage, Limitations

- (1) (a) Except as provided in subsection (5) of this section, if a health plan issued or renewed on or after January 1, 2019, provides coverage for maternity care or services, the health plan must also provide a covered person with substantially equivalent coverage to permit the abortion of a pregnancy. Except as provided in subsection (5) of this section, if a student health plan, including student health plans deemed by the insurance commissioner to have a short-term limited purpose or duration or to be guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, issued or renewed on or after January 1, 2022, provides coverage for maternity care or services, the health plan must also provide a covered person with substantially equivalent coverage to permit the abortion of a pregnancy.
 - (b) Except as provided in (c) of this subsection, for health plans issued or renewed on or after January 1, 2024, a health carrier 3 may not impose cost sharing for abortion of a pregnancy.
 - (c) For a health plan that provides coverage for abortion of a pregnancy and is offered as a qualifying health plan for a health savings account, the health carrier shall establish the plan's cost sharing for the coverage required by this section at the minimum level necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health 10 savings account under internal revenue service laws and regulations.
- (2) (a) Except as provided in (b) of this subsection, a health plan or student health plan subject to subsection (1) of this section may not limit in any way a person's access to services related to the abortion of a pregnancy.
 - (b) (i) Coverage for the abortion of a pregnancy may be subject to terms and conditions generally applicable to the health plan or student health plan's coverage of maternity care or services.
 - (ii) A health plan or student health plan is not required to cover abortions that would be unlawful under RCW [9.02.120](#).
- (3) Nothing in this section may be interpreted to limit in any way an individual's constitutionally or statutorily protected right to voluntarily terminate a pregnancy.
- (4) This section does not, pursuant to 42 U.S.C. Sec. 18054(a)(6), apply to a multistate plan that does not provide coverage for the abortion of a pregnancy.
- (5) If the application of this section to a health plan or student health plan results in noncompliance with federal requirements that are a prescribed condition to the allocation of federal funds to the state, this section is inapplicable to the plan to the minimum extent necessary for the state to be in compliance. The inapplicability of this section to a specific health plan or student health plan under this subsection does not affect the operation of this section in other circumstances.

State Market Plan Enhancements

Oregon

Elective abortions and selective fetal reductions are covered with a referral from the Primary Care Physician/medical group.

Washington

Elective abortions and selective fetal reductions are covered as part of the Women's Health Care Law. Women may self-refer to any UnitedHealthcare contracted women's health care provider for professional services; however, they are not covered for the member's dependent children. Refer to the member's EOC/SOB.

Covered Benefits

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

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

- Termination of pregnancy; surgically or non-surgically or drug induced
- Services for the care and treatment of spontaneous abortions (miscarriage)

Not Covered

Non-medically necessary selective fetal reductions unless member has the benefit as stated in *Federal/State Mandated Regulations* and/or *State Market Plan Enhancements* sections.

Policy History/Revision Information

| Date | State(s) Affected | Summary of Changes |
|------------|-------------------|---|
| 01/01/2024 | All | Supporting Information <ul style="list-style-type: none">• Archived previous policy version BIP002.K |
| | Oregon | Federal/State Mandated Regulations <ul style="list-style-type: none">• Revised language pertaining to <i>Oregon Revised Statute Section 743A.067</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.