Preventive Care Services

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➲ Instructions for Use

Table of Contents **Page**

Federal/State Mandated Regulations 1
State Market Plan Enhancements 8
Covered Benefits 8
Not Covered 8
Policy History/Revision Information 8
Instructions for Use 9

Related Benefit Interpretation Policies

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

Related Medical Policy

- Preventive Care Services

Federal/State Mandated Regulations

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

Federal

Throughout this document the following abbreviations are used:

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

Patient Protection and Affordable Care Act

UnitedHealthcare covers certain medical services under the preventive care services benefit. The federal Patient Protection and Affordable Care Act (PPACA) requires non-grandfathered health plans to cover certain "recommended preventive services" as identified by PPACA under the preventive care services benefit, without cost sharing to members when provided by network providers. This includes:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Visit https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf for legislation.

Update to the Health Resources and Services Administration-Supported Women's Preventive Services Guidelines

https://www.federalregister.gov/documents/2024/12/30/2024-31228/update-to-the-health-resources-and-services-administration-supported-womens-preventive-services

The Health Resources and Services Administration (HRSA) of the Department of Health and Human Services has released updated guidelines for certain preventive services for women. Under the Affordable Care Act, the revised HRSA guidelines address the following: (a) screening and counseling for intimate partner and domestic violence: (b) breast cancer screening for women of average risk; and (c) patient navigation services for breast and cervical cancer screening. Non-Grandfathered group health plans and health insurance issuers offering group or individual health insurance

coverage must cover without cost sharing the services and screenings listed on the updated Women's Preventive Services Guidelines for plan years (in the individual market, policy years) that begin 1 year after the date of the Notice.

Acceptance of Recommendation

https://www.hrsa.gov/womens-guidelines
On December 20, 2024, the HRSA Administrator accepted WPSI's recommendations, which are revised as described above, and, as such, updated the HRSA-supported Women's Preventive Services Guidelines. The final Guidelines for these topics read as follows:

Screening and Counseling for Intimate Partner and Domestic Violence

The final Guideline for Screening and Counseling for Intimate Partner and Domestic Violence reads: "The Women's Preventive Services Initiative recommends screening adolescent and adult women for intimate partner and domestic violence, at least annually, and, when needed, providing or referring to intervention services. Intimate partner and domestic violence includes physical violence, sexual violence, stalking and psychological aggression (including coercion), reproductive coercion, neglect, and the threat of violence, abuse, or both. Intervention services include, but are not limited to, counseling, education, harm reduction strategies, and appropriate supportive services."

Breast Cancer Screening for Women at Average Risk

The final Guideline for Breast Cancer Screening for Women at Average Risk reads: "The Women's Preventive Services Initiative recommends that women at average risk of breast cancer initiate mammography screening no earlier than age 40 years and no later than age 50 years. Screening mammography should occur at least biennially and as frequently as annually. Women may require additional imaging to complete the screening process or to address findings on the initial screening mammography. If additional imaging (e.g., magnetic resonance imaging (MRI), ultrasound, mammography) and pathology evaluation are indicated, these services also are recommended to complete the screening process for malignancies. Screening should continue through at least age 74 years, and age alone should not be the basis for discontinuing screening.

Women at increased risk also should undergo periodic mammography screening, however, recommendations for additional services are beyond the scope of this recommendation."

Patient Navigation Services for Breast and Cervical Cancer Screening

The final Guideline for Patient Navigation Services for Breast and Cervical Cancer Screening reads: "The Women's Preventive Services Initiative recommends patient navigation services for breast and cervical cancer screening and follow-up, as relevant, to increase utilization of screening recommendations based on an assessment of the patient's needs for navigation services. Patient navigation services involve person-to-person (e.g., in-person, virtual, hybrid models) contact with the patient. Components of patient navigation services should be individualized. Services include, but are not limited to, person-centered assessment and planning, health care access and health system navigation, referrals to appropriate support services (e.g., language translation, transportation, and social services), and patient education."

Non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage must cover without cost-sharing the services and screenings listed on the updated Women's Preventive Services Guidelines for plan years (in the individual market, policy years) that begin 1 year after this date. Thus, for most plans, this update will take effect for purposes of the Section 2713 coverage requirement in 2026. Additional information regarding the Women's Preventive Services Guidelines can be accessed at the following link: https://www.hrsa.gov/womens-guidelines.

Authority: Section 2713(a)(4) of the Public Health Service Act, 42 U.S.C. 300gg-13(a)(4).

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

HHS also released an amendment to the prevention regulation that allows religious institutions that offer insurance to their employees the choice of whether or not to cover contraception services. Group health plans sponsored by certain religious employers, and group health insurance coverage in connection with such plans, are exempt from the requirement to cover contraceptive services. With respect to religious and moral exemptions in connection with coverage of certain preventative health services, refer to 45 CFR 147.132 and 45 CFR 147.133.

California

California Code of Regulations (CCR) Title 28, Managed Health Care, Article 7, Standards, Section 1300.67, Scope of Basic Health Care Services

https://govt.westlaw.com/calregs/Document/I944154734C8A11ECA45D000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

(f) Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a physician's supervision:
  (1) Reasonable health appraisal examinations on a periodic basis;
  (2) A variety of voluntary family planning services;
  (3) Prenatal care;
  (4) Vision and hearing testing for persons through age 16;
  (5) Immunizations for children in accordance with the recommendations of the American Academy of Pediatrics, and immunizations for adults as recommended by the U.S. Public Health Service;
  (6) Venereal disease tests;
  (7) Cytology examinations on a reasonable periodic basis;
  (8) Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

Health and Safety Code (HSC) Section 1316.7, Hepatitis B and C Screening

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1316.7.&lawCode=HSC

(a) An adult patient who receives primary care services in a facility, clinic, unlicensed clinic, center, office, or other setting where primary care services are provided, shall be offered a hepatitis B screening test and a hepatitis C screening test, to the extent these services are covered under the patient's health insurance, based on the latest screening indications recommended by the United States Preventive Services Task Force, unless the health care provider reasonably believes that one of the following conditions applies:
  (1) The patient is being treated for a life-threatening emergency.
  (2) (A) The patient has previously been offered or has been the subject of a hepatitis B screening test or hepatitis C screening test.
    (B) This paragraph does not apply if the health care provider determines that one or both of the screening tests should be offered again.
  (3) The patient lacks capacity to consent to a hepatitis B screening test or hepatitis C screening test, or both.
  (4) The patient is being treated in the emergency department of a general acute care hospital, as defined in subdivision (a) of Section 1250.

(b) (1) If a patient accepts the offer of the hepatitis B screening test and the test is hepatitis B surface antigen (HBsAg) positive, a health care provider shall offer the patient followup health care or refer the patient to a health care provider who can provide followup health care.
  (2) If a patient accepts the offer of the hepatitis C screening test and the test is positive, the health care provider shall offer the patient followup health care or refer the patient to a health care provider who can provide followup health care. The followup health care shall include a hepatitis C diagnostic test (HCV RNA).

(c) The offering of a hepatitis B screening test and hepatitis C screening test under this section shall be culturally and linguistically appropriate.

(d) This section shall not affect the scope of practice of any health care provider or diminish any authority or legal or professional obligation of any health care provider to offer a hepatitis B screening test, hepatitis C screening test, or both, or a hepatitis C diagnostic test, or to provide services or care for the patient of a hepatitis B screening test, hepatitis C screening test, or both, or a hepatitis C diagnostic test.

(e) A health care provider that fails to comply with the requirements of this section shall not be subject to any disciplinary actions related to their licensure or certification, or to any civil or criminal liability, because of the health care provider's failure to comply with the requirements of this section.

(f) For purposes of this section, the following definitions apply:
  (1) "Followup health care" includes providing medical management and antiviral treatment for chronic hepatitis B or hepatitis C according to the latest national clinical practice guidelines recommended by the American Association for the Study of Liver Diseases.
  (2) "Hepatitis B screening test" includes any laboratory tests or tests that detect the presence of hepatitis B surface antigen (HBsAg) and provides confirmation of whether the patient has a chronic hepatitis B infection.
  (3) "Hepatitis C diagnostic test" includes any laboratory test or tests that detect the presence of the hepatitis C virus in the blood and provides confirmation of whether the patient has an active hepatitis C virus infection.

(4) “Hepatitis C screening test” includes any laboratory screening test or tests that detect the presence of hepatitis C virus antibodies in the blood and provides confirmation of whether the patient has ever been infected with the hepatitis C virus.

HSC Section 1367.3, Comprehensive Preventive Care of Children (Children 17 and 18 Years of Age)

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

(a) Every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer benefits for the comprehensive preventive care of children. This section shall apply to children 17 and 18 years of age, except as provided in subparagraph (D) of paragraph (2) of subdivision (b). Every plan shall communicate the availability of these benefits to all group contractholders and to all prospective group contract holders with whom they are negotiating. This section shall apply to a plan that, by rule or order of the director, has been exempted from subdivision (i) of Section 1367, insofar as that section and the rules thereunder relate to the provision of the preventive health care services described herein.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:
  (1) Be consistent with both of the following:
    (A) The most recent Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics.
    (B) The Recommended Childhood Immunization Schedule/United States, jointly adopted as of January 1, 2025, by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Immunizations subject to this subparagraph may be modified or supplemented by the State Department of Public Health pursuant to Section 120164.
  (2) Provide for the following:
    (A) Periodic health evaluations.
    (B) Immunizations.
    (C) Laboratory services in connection with periodic health evaluations.
    (D) Screening for blood lead levels in children of any age who are at risk for lead poisoning, as determined by a physician and surgeon affiliated with the plan, if the screening is prescribed by a health care provider affiliated with the plan.

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

(Amended by Stats. 2025, Ch. 105, Sec. 19. (AB 144) Effective September 17, 2025.)

HSC Section 1367.35, Comprehensive Preventive Care of Children (Children 16 Years of Age and Younger)

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

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

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:
  (1) Be consistent with both of the following:
    (A) The Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics in September of 1987.
    (B) The Recommended Childhood Immunization Schedule/United States, jointly adopted as of January 1, 2025, by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Immunizations subject to this subparagraph may be modified or supplemented by the State Department of Public Health pursuant to Section 120164.
  (2) Provide for all of the following:

(A) Periodic health evaluations.
(B) Immunizations.
(C) Laboratory services in connection with periodic health evaluations.

(Amended by Stats. 2025, Ch. 105, Sec. 20. (AB 144) Effective September 17, 2025.)

HSC Section 1367.6, Breast Cancer Screening

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

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

HSC Section 1367.64, Prostate Cancer Screening

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

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

HSC Section 1367.65, Breast Cancer Screening

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

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

HSC Section 1367.66, Cervical Cancer Screening Test

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

(a) Every individual or group health care service plan contract, except for a specialized health care service plan, issued, amended, or renewed on or after January 1, 2002, shall provide coverage for an annual cervical cancer screening test upon the referral of the patient's physician and surgeon, a nurse practitioner, or a certified nurse-midwife, providing care to the patient and operating within the scope of practice otherwise permitted for the licensee.
    (1) The coverage for an annual cervical cancer screening test provided pursuant to this section shall include the conventional Pap test, a human papillomavirus screening test that is approved by the United States Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA, upon the referral of the patient's health care provider.
    (2) This subdivision does not establish a new mandated benefit or prevent application of deductible or copayment provisions in an existing plan contract. The Legislature intends in this section to provide that cervical cancer screening services are deemed to be covered if the plan contract includes coverage for cervical cancer treatment or surgery.
(b) A health care service plan contract, except for a specialized health care service plan, issued, amended, or renewed on or after January 1, 2024, shall provide coverage for the human papillomavirus vaccine for enrollees for whom the

vaccine is approved by the FDA. A health care service plan contract shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this subdivision.

HSC Section 1367.665, Biomarker Testing

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

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

(b) (1) A health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after July 1, 2022, shall not require prior authorization for either of the following:
  (A) Biomarker testing for an enrollee with advanced or metastatic stage 3 or 4 cancer.
  (B) Biomarker testing for cancer progression or recurrence in the enrollee with advanced or metastatic stage 3 or 4 cancer.
  (2) This subdivision shall also apply to health care service plan contracts and Medi-Cal managed care plan contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(c) For purposes of this section, "biomarker test" means a diagnostic test, such as single or multigene, of the cancer patient's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide patient treatment.

(d) Notwithstanding subdivision (b), this section does not prohibit a health care service plan from requiring prior authorization on biomarker testing that is not for an FDA-approved therapy for advanced or metastatic stage 3 or 4 cancer.

(e) This section does not limit, prohibit, or modify an enrollee's rights to biomarker testing as part of an approved clinical trial under Section 1370.6.

HSC Section 1367.667, Biomarker Testing

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1367.667.

(a) A health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after July 1, 2024, shall cover medically necessary biomarker testing, subject to utilization review management, pursuant to this section. Biomarker testing shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition to guide treatment decisions. Coverage shall include biomarker tests that meet any of the following:
  (1) A labeled indication for a test that has been approved or cleared by the United States Food and Drug Administration (FDA) or is an indicated test for an FDA-approved drug.
  (2) A national coverage determination made by the federal Centers for Medicare and Medicaid Services.
  (3) A local coverage determination made by a Medicare Administrative Contractor for California.
  (4) Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
  (5) Standards set by the National Academy of Medicine.

(b) A health care service plan shall use the process described in Section 1363.5 to determine whether biomarker testing is medically necessary for purposes of this section.

(c) A health care service plan that is subject to this section shall ensure that biomarker testing is provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples. This section does not require coverage of biomarker testing for screening purposes unless otherwise required by this chapter.

(d) Restricted or denied use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of any medical condition is subject to grievance and appeal processes under state and federal law.

(e) (1) This section shall not apply to any Medi-Cal managed care plan contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. For these plans, the biomarker testing coverage pursuant to Section 14132.09 of the Welfare and Institutions Code shall apply.
  (2) This subdivision shall not be construed to remove any obligation that is otherwise applicable to Medi-Cal managed care plans licensed under this chapter.

(f) For purposes of this section, the following definitions apply:
  (1) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacological responses to a specific therapeutic intervention. A biomarker includes, but is not limited to, gene mutations or protein expression.

(2) "Biomarker testing" means the analysis of an individual's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes, but is not limited to, single-analyte tests, multiplex panel tests, and whole genome sequencing.

(g) This section is subject to the provisions of Section 1367.665 as amended by Chapter 605 of the Statutes of 2021 for an enrollee with advanced or metastatic stage III or IV cancer.

HSC Section 1367.668, Colorectal Cancer Screening

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1367.668.

(a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2022, shall provide coverage without any cost sharing for a colorectal cancer screening test assigned either a grade of A or a grade of B by the United States Preventive Services Task Force. The required colonoscopy for a positive result on a test or procedure, other than a colonoscopy, that is a colorectal cancer screening examination or laboratory test identified assigned either a grade of A or a grade of B by the United States Preventive Services Task Force shall also be provided without any cost sharing.

(b) This section does not preclude a health care service plan that has coverage for out-of-network benefits from imposing cost-sharing requirements for the items or services described in this section that are delivered by an out-of-network provider.

[Added by Stats. 2021, Ch. 436, Sec. 1. (AB 342) Effective January 1, 2022.]

HSC Section 1367.695, OB-GYN Direct Access

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

(a) The Legislature finds and declares that the unique, private, and personal relationship between women patients and their obstetricians and gynecologists warrants direct access to obstetrical and gynecological physician services.

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

(c) In implementing this section, a health care service plan may establish reasonable requirements governing utilization protocols and the use of obstetricians and gynecologists, or family physicians and surgeons, as provided for in subdivision (b), participating in the plan network, medical group, or independent practice association, if those requirements are consistent with the intent of this section, are customarily applied to other physicians and surgeons, such as primary care physicians and surgeons, to whom the enrollee has direct access, and are no more restrictive for the provision of obstetrical and gynecological physician services. An enrollee shall not be required to obtain prior approval from another physician, another provider, or the health care service plan prior to obtaining direct access to obstetrical and gynecological physician services, but the plan may establish reasonable requirements for the participating obstetrician and gynecologist or family physician and surgeon, as provided for in subdivision (b), to communicate with the enrollee's primary care physician and surgeon regarding the enrollee's condition, treatment, and any need for follow-up care.

(d) This section does not diminish the requirements of Section 1367.69.

California Insurance Code Section 10123.209, Coverage for Medically Necessary Biomarker Testing

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=10123.209&lawCode=INS

(a) A health insurance policy that is issued, amended, delivered, or renewed on or after July 1, 2024, shall include coverage for medically necessary biomarker testing, subject to utilization review management, pursuant to this section. Biomarker testing shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an insured's disease or condition to guide treatment decisions. Coverage shall include biomarker tests that meet any of the following:
   (1) A labeled indication for a test that has been approved or cleared by the United States Food and Drug Administration (FDA) or is an indicated test for an FDA-approved drug.
   (2) A national coverage determination made by the federal Centers for Medicare and Medicaid Services.
   (3) A local coverage determination made by a Medicare Administrative Contractor for California.
   (4) Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
   (5) Standards set by the National Academy of Medicine.

(b) A health insurer shall use the process described in subdivision (f) of Section 10123.135 to determine whether biomarker testing is medically necessary for purposes of this section.

(c) A health insurance policy that is subject to this section shall ensure that biomarker testing is provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples. This section shall not be construed to require coverage of biomarker testing for screening purposes unless otherwise required by this part.
(d) Restricted or denied use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of any medical condition is subject to grievance and appeal processes under state and federal law, including Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any regulations subsequently adopted thereunder, and the Independent Medical Review System under Article 3.5 (commencing with Section 10169).
(e) For purposes of this section, the following definitions apply:
  (1) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacological responses to a specific therapeutic intervention. A biomarker includes, but is not limited to, gene mutations or protein expression.
  (2) "Biomarker testing" means the analysis of an individual's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes, but is not limited to, single-analyte tests, multiplex panel tests, and whole genome sequencing.
(f) This section is subject to the provisions of Section 10123.20 as amended by Chapter 605 of the Statutes of 2021 for an insured with advanced or metastatic stage III or IV cancer.

State Market Plan Enhancements

None

Covered Benefits

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

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

Notes:
- Refer to state-specific mandated requirements for preventive health services.
- **If no state-mandated requirements, refer to the Medical Policy titled Preventive Care Services.**

Not Covered

Refer to the Medical Policy titled Preventive Care Services.

Policy History/Revision Information

Date	Summary of Changes

06/01/2026	**Federal/State Mandated Regulations**
	• Revised language pertaining to:
	  ○ *Legislative Bulletin: FD1203 Religious Exception to Women's Preventive Care Requirements*
	  ○ *Health and Safety Code (HSC)*:
	  ▪ *Section 1367.3*
	  ▪ *Section 1367.35*
	  ▪ *Section 1367.695*
	• Removed language pertaining to the *California Code of Regulations (CCR) Title 10, Investment, Article 22, Essential Health Benefits, Section 2594.3*
	Supporting Information
	• Archived previous policy version BIP133.P

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.