WE'VE GOT YOU COVERED.

Free preventive services

Most health insurance plans must cover a set of preventive services — such as shots and screening tests — at no cost to you. This includes plans bought through HealthCare.gov. Taking advantage of these free services can help you stay healthy and avoid more expensive care later.

IMPORTANT: These services are free only when delivered by a doctor or other provider in the plan's network.

- Behavioral assessments for children
- Blood pressure screening
- Breast cancer mammography screenings every 1 to 2 years for people over 40
- Cervical cancer screening
- Cholesterol screening
- Colorectal cancer screening for adults older than 50
- Depression screening
- Developmental screening for children under age 3
- Diabetes (Type 2) screening for adults with high blood pressure
- Domestic and interpersonal violence screening and counseling
- Gestational diabetes screening for people 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Hepatitis C one-time screening for adults at increased risk and for everyone born between 1945 and 1965
- HIV screening for everyone ages 15 to 65, and other ages with increased risk
- Human Papillomavirus (HPV) DNA testing every 3 years for people 30 or older with normal cytology results
- Lead screening for children at risk of exposure
- Lung cancer screening for adults ages 55 to 80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years
- Osteoporosis screening for people over age 60 depending on risk factors
- Sexually transmitted infection (STI) prevention counseling and screening
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Urinary tract or other infection screening
- Vision screening for all children
- Well-woman visits to get other recommended services for women under 65

Contraception

Food and Drug Administration-approved birth control or contraceptive methods, sterilization procedures, and patient education and counseling

Counseling

- Alcohol and drug misuse screening and counseling
- Breast cancer genetic test counseling for people at higher risk

Vaccinations

- COVID-19
- Diphtheria, Tetanus, Pertussis (Whooping Cough)
- Haemophilus Influenza
- Type B
- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus (HPV)
- Inactivated Poliovirus
- Influenza (flu shot)
- Measles
- Meningococcal
- Mumps
- Pertussis
- Pneumococcal
- Rotavirus
- Rubella
- Tetanus
- Varicella (Chickenpox)

Essential Health Benefits

Most health insurance plans bought through HealthCare.gov or from an insurer must offer a full package of items and services, known as **essential health benefits**. The cost of these services vary depending on the plan you select. To learn more about the potential costs, contact your insurer.

These benefits include:

- Outpatient care: The kind you get without being admitted to a hospital
  Trips to the emergency room
- Treatment in the hospital for inpatient care
- Care before and after your baby is born
- Mental health and substance use disorder services: This includes behavioral health treatment, counseling, and psychotherapy
- Your prescription drugs
- Services and devices to help you recover if you are injured, or have a disability or chronic condition: This includes physical therapy, occupational therapy, speech therapy, and more
- Your lab tests
- Preventive services, including counseling, screenings, and vaccines to keep you healthy and care for managing a chronic disease
- Pediatric services: This includes dental care and vision care for children younger than 18

If you have questions about what else your health insurance plan covers, review your plan's summary of benefits and coverage or contact your health insurance company. You can find their contact information on the back of your insurance card.

Oregon-specific essential health benefits

- Acupuncture
- Chiropractic care
- Gender-affirming care
- Reproductive health care

Denied claim?

If your insurance company has denied your claim or has agreed to pay less than the billed amount and you disagree with the decision, there are steps you can take.

1. **Review your Explanation of Benefits to see what services were billed to your insurance company.** Sometimes the problem was a medical coding error and can be easily fixed by the billing department.
2. **Ask your insurance company to re-evaluate the decision.** All insurance companies have avenues to resolve issues without having to appeal.
3. **If you still disagree with their decision, file an appeal directly with your health insurance company.** Be sure to follow all steps as laid out by your insurance company. These steps can be found as additional pages of the Explanation of Benefits.
4. **If you disagree with the results of the appeal, file a complaint with Oregon's Division of Financial Regulation.** Their consumer advocates team will step in to assess the claim as a third party.

For more information about this process and to find contact information visit orhim.info/deniedclaim. You may also call the Consumer Hotline at 888-877-4894 or email DFR.InsuranceHelp@dcbs.oregon.gov.

Contact us

855-268-3767 (All relay calls welcome)

info.marketplace@odhsoha.oregon.gov

EXPLORE HEALTH