**RCW 48.43.043 Colorectal cancer examinations and laboratory tests—Required benefits or coverage.** (1) Health plans issued or renewed on or after July 1, 2008, must provide benefits or coverage for colorectal cancer examinations and laboratory tests consistent with the guidelines or recommendations of the United States preventive services task force or the federal centers for disease control and prevention. Benefits or coverage must be provided:

(a) For any of the colorectal screening examinations and tests in the selected guidelines or recommendations, at a frequency identified in such guidelines or recommendations, as deemed appropriate by the patient's physician after consultation with the patient; and

(b) To a covered individual who is:

(i) At least fifty years old; or

(ii) Less than fifty years old and at high risk or very high risk for colorectal cancer according to such guidelines or recommendations.

(2) To encourage colorectal cancer screenings, patients and health care providers must not be required to meet burdensome criteria or overcome significant obstacles to secure such coverage. An individual may not be required to pay an additional deductible or coinsurance for testing that is greater than an annual deductible or coinsurance established for similar benefits. If the health plan does not cover a similar benefit, a deductible or coinsurance may not be set at a level that materially diminishes the value of the colorectal cancer benefit required.

(3)(a) A health carrier is not required under this section to provide for a referral to a nonparticipating health care provider, unless the carrier does not have an appropriate health care provider that is available and accessible to administer the screening exam and that is a participating health care provider with respect to such treatment.

(b) If a health carrier refers an individual to a nonparticipating health care provider pursuant to this section, screening exam services or resulting treatment, if any, must be provided at no additional cost to the individual beyond what the individual would otherwise pay for services provided by a participating health care provider. [2007 c 23 s 1.]