Women's Expanded Preventive Services Q & A

New coverage guidelines under the Patient Protection and Affordable Care Act (PPACA) require new health plans and non-grandfathered plans to cover an expanded list of women's preventive care services with no cost-share (copayment, coinsurance or deductible) as long as services are received in the health plan's network.

1. **What services are included in the expanded coverage provided under the Patient Protection and Affordable Care Act (PPACA) for Women's Preventive Services?**
   The expanded coverage includes:
   - FDA approved contraception methods, sterilization procedures, and contraceptive counseling
   - Breastfeeding support, supplies, and counseling
   - Domestic violence screening and counseling
   - Gestational diabetes screening for all pregnant women
   - HIV counseling and screening for all sexually active women
   - Human papillomavirus DNA testing for all women 30 years and older
   - Sexually transmitted infection counseling for all sexually active women annually
   - Well-woman visits including preconception counseling and routine, low-risk prenatal care

2. **When do the changes outlined above go into effect?**
   The services outlined above are effective as of the first health plan renewal date on or after August 1, 2012.

3. **When will FirstCare implement change?**
   FirstCare will implement change for fully-insured non-grandfathered plans effective 8/01/2012 regardless of plan's renewal date. Self-funded plan will be begin on the plan's first renewal date on or after August 1, 2012.

4. **Are there any plans exempt from making these changes?**
   Yes. The following plans are exempt:
   - Grandfathered status plans.
   - Group health plans sponsored by certain religious employers, and group health insurance coverage in connection with such plans.

5. **What is the definition of a religious employer?**
   A religious employer is one that meets all of the following requirements:
   - has the inculcation of religious values as its purpose
   - primarily employs persons who share its religious tenets
   - primarily serves persons who share its religious tenets; and
   - is a non-profit organization under Internal Revenue Code section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii). 45 C.F.R. §147.130(a)(1)(iv)(B).

6. **What is the process for a religious organization to be exempt contraceptive coverage?**
   Employers will need to "certify" that they qualify for the temporary exemption and provide notice to their enrollees as provided by HHS. For more information on the certification process please contact

your broker and/or review the attached Federal Register link http://www.gpo.gov/fdsys/pkg/FR-2012-02-15/pdf/2012-3547.pdf.

7. **What type of contraceptive medical procedures and devices are covered without cost-share?**
   When performed by a network physician or health care professional, the following contraceptive procedures and devices are covered without cost-share:
   - Intrauterine devices (IUD) including insertion and removal
   - Diaphragms (covered under the pharmacy benefit if purchased by prescription at a network pharmacy)
   - Services to place/remove/inject covered FDA-approved contraceptive methods
   - Sterilization procedures for women, such as tubal ligations

8. **What type of contraceptive drugs is covered without cost-share?**
   Contraceptive drugs on the Formulary List will be available without cost-share to members when Tier value is $0.

9. **What type of services/items will not be covered under the preventive benefit?**
   - Condoms and spermicidal agents
   - Male contraceptives and sterilization such as vasectomies
   - Contraception and contraceptive counseling recommendations for abortion or abortifacient drugs, such as Mifeprex® (mifepristone)

10. **If the Member's Prescription Drug Plan has a deductible, does this have to be met before contraceptives are covered at 100%?**
    No, the Prescription Drug Deductible does not apply for contraceptive devices and drugs covered under Tier value $0.

11. **What happens if a brand name drug is prescribed and the generic equivalent is available?**
    If the Member receives a name brand drug when a generic equivalent is available, the Member is responsible for the cost difference between the generic and the name brand drug, even when the prescription is written "dispense as written." Any cost differentials do not apply towards the Deductible/Out-of-Pocket Maximum. In addition, if the member receives a brand name drug and there is not a generic equivalent, the Member is responsible for paying the applicable brand name copayment, even when the prescription is written "dispense as written."

12. **If the Member fills their contraceptive prescription at an Out-of-Network pharmacy, how will this be covered?**
    HMO Members – Not covered.
    PPO Members – Out-of-Network Benefits apply.