



Understanding preventive care services covered without cost-share

UnitedHealthcare has a long-standing commitment to advancing prevention and early detection of disease for the people we are privileged to serve. UnitedHealthcare is dedicated to helping people live healthier lives, and we encourage our members to receive age- and gender-appropriate preventive care services.

Under the health reform law, members in non-grandfathered health plans are eligible to receive certain preventive care services, based upon age, gender and other factors, without cost-sharing (copayments, coinsurance and deductibles). These preventive services must be provided by doctors and health care professionals within the plan's network. Additional preventive care services for women, including well-woman visits and FDA-approved contraception, were covered on the plan's first renewal date on or after Aug. 1, 2012.

Specific preventive services that must be covered without cost-sharing include:

- ▶ Items or services that have an 'A' or 'B' rating in the recommendations of the U.S. Preventive Services Task Force (USPSTF)⁺
- ▶ Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)
- ▶ Evidence-informed preventive care and screenings for infants, children and adolescents as per Health Resources and Services Administration (HRSA) guidelines, including the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Health Care
- ▶ Evidence-informed preventive care and screenings for women supported by HRSA

This list will be updated on an ongoing basis. The complete and current list of preventive services covered without cost-share under the health reform law can be found at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits>

Under the health reform law, a plan or health insurance issuer may:

- ▶ Provide coverage for services in addition to the recommended preventive services, and impose cost-sharing for those additional services
- ▶ Impose cost-sharing for services delivered by out-of-network doctors, facilities and health care professionals

This preventive services provision applies to both fully insured and self-funded plans. While grandfathered plans are not required to implement these changes, some grandfathered plans have chosen to offer preventive care services without cost-share.

Summary of preventive care services covered without cost-share

Our [Preventive Care Services Coverage Determination Guideline](#) defines the specific services, diagnoses, age and gender requirements, and other requirements for ensuring they are paid with preventive benefits.

In addition to services mandated by the health reform law, UnitedHealthcare also applies preventive care services benefits to certain services above and beyond the health reform law's requirements, including colorectal cancer screening using CT colonography and mammography screening for all adult women. These services are marked with an asterisk.*

All members:

- ▶ Preventive care visits for adults (male* and female)
- ▶ All routine immunizations recommended by ACIP

All members at an appropriate age and/or risk status:

- ▶ Aspirin, when prescribed
- ▶ Colorectal cancer screening* (including CT colonography*, fecal occult blood testing, screening sigmoidoscopy and screening colonoscopy)
- ▶ Cholesterol and lipid disorders screening
- ▶ Certain sexually transmitted diseases including HIV
- ▶ Depression screening
- ▶ Hepatitis C screening
- ▶ High blood pressure screening
- ▶ Diabetes screening
- ▶ Screening and counseling in a primary care setting for:
 - Tobacco use
 - Obesity
 - Diet and nutrition
 - Alcohol abuse
- ▶ Vitamin D supplements, when prescribed

⁺The USPSTF mammography recommendation is the 2002 recommendation.

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Women's health:

- ▶ Mammography (film and digital) for all adult women*
- ▶ Cervical cancer screening including Pap smears
- ▶ Genetic counseling evaluation and lab test for the BRCA breast cancer gene and risk-reducing breast cancer medications, with prior authorization
- ▶ Counseling for cancer prevention strategies for women at high risk for breast cancer
- ▶ Certain sexually transmitted diseases screening including HIV, gonorrhea, chlamydia and syphilis
- ▶ Osteoporosis screening for certain populations*
- ▶ Screening pregnant women for:
 - Iron-deficiency anemia
 - Bacteria in urine
 - Hepatitis B virus
 - Rh incompatibility
- ▶ Counseling to promote and aid breast-feeding

Expanded women's preventive care services (on or after Aug. 1, 2012):

- ▶ Breast-feeding support, supplies and counseling, including costs for obtaining breast-feeding equipment from a network provider or national durable medical equipment supplier
- ▶ Domestic violence screening and counseling
- ▶ FDA-approved contraception methods when prescribed, sterilization procedures and contraceptive counseling
- ▶ Folic acid supplements, when prescribed
- ▶ 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 prenatal care

Men's health:

- ▶ Screening for prostate cancer for men age 40 and older*
- ▶ Screening for abdominal aortic aneurysm in men 65-75 years old who have ever smoked
- ▶ Human papillomavirus vaccine for males ages 9-26

Children:

- ▶ Screening newborns for:
 - Hearing problems
 - Thyroid disease
 - Phenylketonuria (blood test for genetic disorder)
 - Sickle cell anemia
 - Standard metabolic screening panel for inherited enzyme deficiency diseases
- ▶ Screening children for:
 - Counseling to prevent dental cavities
 - Depression
 - Vision
 - Lead
 - Tuberculosis
 - Developmental problems
 - Obesity counseling in a primary care setting
- ▶ Fluoride supplements for children, when prescribed
- ▶ Iron supplements for children, when prescribed

Managing costs of preventive care

Medical management guidelines may be used to determine frequency, method and place of service when not specifically covered by the health reform law. Plans will retain the flexibility to control costs and promote efficient delivery of care by, for example, continuing to charge cost-sharing for branded drugs if a generic version is available and just as effective and safe.

* Services covered by UnitedHealthcare that exceed the health reform law's requirements.

Out-of-network providers

The health reform law states that a plan or issuer is not required to provide coverage for recommended preventive services delivered by out-of-network providers. Plans and issuers also may impose cost-sharing requirements for recommended services delivered by out-of-network providers unless a state law otherwise requires first-dollar coverage for such non-network services. If a plan does not cover out-of-network preventive services, then out-of-network preventive services generally will not be covered. However, if a plan does not cover out-of-network preventive services, but does have out-of-network medical benefits, then UnitedHealthcare will cover out-of-network routine prenatal office visits under the plan's out-of-network medical benefits. Any cost-sharing under the out-of-network medical benefit would apply to the prenatal office visits. Always refer to plan documents for specific coverage information.

Additional preventive services

Under the health reform law, a plan or issuer may provide coverage for services in addition to the recommended preventive services. For such additional preventive services, a plan or issuer may impose cost-sharing requirements at its discretion.

Cost-sharing for treatments

The health reform law clarifies that a plan or issuer may impose cost-sharing for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive health service. In addition, while preventive screenings listed here are provided without cost-sharing, medications prescribed to treat a condition are not covered without cost-sharing under the preventive services benefit.

Preventive vs. diagnostic

UnitedHealthcare has determined that a health service is preventive when performed on a patient without symptoms (when age and gender appropriate) and at the stated intervals supported by scientific evidence. A service is diagnostic when performed on a patient with symptoms or is performed earlier or more frequently than the recommended intervals because of risk factors identified earlier. Unless specified otherwise in the plan, only services defined as preventive will be covered without cost-sharing. Keep in mind that wellness or reward programs may offer incentives for certain services, but only services described in our Coverage Determination Guideline are covered without cost-share.

For more information

Consult your UnitedHealthcare representative if you have questions about preventive care or the expanded list of women's preventive care services. Visit the United for Reform Resource Center at uhc.com/reform and click the preventive services provision for the latest health reform news, educational videos, timelines and frequently asked questions about health reform.

Case example

Lisa, age 45, sees her doctor for her routine office visit and has age appropriate screenings during her annual physical.

Her doctor orders a lipid screening, urinalysis and full blood chemistry panel. The office visit and the lipid screening, recommended by the USPSTF, are covered under the 100% preventive benefit. However, the urinalysis and full blood chemistry panel are not paid as preventive. They are covered under the medical benefit as outlined by the Lisa's plan design. Why? These services are not recommended as preventive services as outlined by the USPSTF. So, Lisa would be subject to any copay, deductible and coinsurance under her plan.



The content is provided for informational purposes only and does not constitute medical advice. Decisions about medical care should be made by the doctor and patient. Always refer to the plan documents for specific benefit coverage and limitations or call the toll-free member phone number on the back of the health plan ID card.

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