Addendum to POS non-grandfathered COC – changes related to women's preventive services

For non-grandfathered groups other than religious-affiliated groups

This Addendum is issued to you in connection with your McLaren health Plan (MHP) Certificate of Coverage. It is effective on the date indicated in notice to your Group. It amends Section 8.04 "Preventive Services".

Section 8.04 PREVENTIVE SERVICES

Preventive Services are screenings, immunizations, lab tests and other services that have been recommended by the United States Preventive Services Task Force that help prevent illness or help find diseases or medical conditions before you experience symptoms. Some services are Preventive Services only for specified age groups or genders. Preventive Services are covered in full with no coinsurance or copayment.

The following are the categories of Preventive Services that are covered. More detailed information is available on MHP's website at www.mclarenhealthplan.org, or visit the government website at www.HealthCare.gov. This information may also be obtained by calling Customer Service at (888) 327-0671.

Physical Exams

Age	Frequency
Newborns	1 exam, 2 – 3 days after discharge.
0 to 2 years	Well-child visits at 2, 4, 6, 9, 12, 18 and 24 months.
3 to 6 years	Routine visit at 30 months. One visit every 12 months for ages 3 to 6 years.
7 to 10 years	One visit every 12 to 24 months.
19 to 21 years	One visit every 2 to 3 years, annually if desired.
22 years to 64 and older	One visit every 24 months, annually if desired.
65 and older	One visit every year.

Immunization vaccines for newborns to age 18

Doses, recommended ages and who should have these immunizations vary, and include but are not limited to:

- Diiphtheria, tetanus, pertussis
- Measles, mumps, rubella
- Influenza

Assessments and screenings newborn to age 18

Recommended ages and who should have these services vary, and include but are not limited to:

- Developmental screening
- Hearing loss screening
- Vision screening
- HIV screening for adolescents
- Sexually transmitted infection screening for sexually active adolescents
- Depression screening for adolescents
- Screening and counseling for obesity

Immunization vaccines for adults

Doses, recommended ages and who should have these immunizations vary, and include but are not limited to:

Vaccine	Preventive Service
Hepatitis A	2 doses for high risk groups.
Hepatitis B	3 doses for high risk groups.
Herpes Zoster	1 dose at age 60 and older
Influenza	Ever year
Pneumococcal	1 dose after age 65. If high risk, 1 dose before age 65 followed by booster dose after age 65.

Preventive services for women

Service	Who	Frequency
Well-woman visits	Adult women	Annually and as needed
Gestational diabetes screening	Women 24-28 weeks pregnant and those at high risk of developing gestational diabetes	Once per pregnancy
HPV DNA testing	Women 30 years or older	Every 3 years
Sexually transmitted infection (STI) counseling	Sexually-active women	Annually
HIV screening and counseling	Sexually-active women	Annually
Contraceptive methods*, sterilization procedures and patient education and counseling	Sexually-active women	As needed
Breastfeeding support, supplies and counseling	Pregnant and postpartum women	Per pregnancy
Interpersonal and domestic violence screening and counseling	All adolescent and adult women	At least annually and as needed

* **NOTE:** "Contraceptive methods" include coverage for Generic and Brand Name contraceptive medications, devices and appliances when prescribed by a MHP provider and obtained through a participating pharmacy. Additional terms and conditions of coverage for contraceptive medications, devices and appliances follow:

Definitions:

1. **Brand Name Covered Drug:** A Formulary Preferred Covered Drug for which the manufacturer markets under a registered trademark or trade name.
2. **Covered Drug:** A Generic or Brand Name Prescription contraceptive medication, device or appliance that is prescribed by a MHP provider and obtained through a participating pharmacy, except as excluded in this Rider.
3. **DAW (Dispense as Written):** A medication, device or appliance is dispensed as written, with no substitutions, such as a generic. A physician or Member can request a DAW but a co-payment will apply if a Generic Covered Drug is available and Preauthorization is required.
4. **Formulary:** A listing of FDA approved prescription drugs that MHP has approved for use and are covered under your Certificate of Coverage.
5. **Generic Covered Drug:** A Formulary Preferred Covered Drug for which the patent has expired, that the FDA has determined to be bioequivalent to Brand Name Drugs and that are not manufactured or marketed under a registered trademark or brand name.
6. **Mail-Order Pharmacy:** A MHP participating mail-order service through which Members may obtain a 90-day supply of certain Covered Drugs. If a co-payment applies to the Covered Drug obtained through a Mail-Order Pharmacy, only two (2) co-payments are required for the 90-day supply.
7. **Non-formulary Covered Drug:** A Prescription medication that is listed on the MHP formulary as "Non-formulary". These drugs require prior authorization and require a co-payment.
8. **Over-the-counter (OTC) Medications, Devices and Appliances:** Contraceptive medications, devices and appliances that can be obtained without a prescription.
9. **Participating Pharmacy:** Licensed, credentialed pharmacies selected by MHP to provide Covered Drugs to Members.
10. **Prescription Drug:** An FDA-approved contraceptive medication, device or appliance that can, under federal and state law, be dispensed only pursuant to a prescription order.
11. **Prior-authorization/Step Therapy Drugs:** Covered Drugs listed on MHP's Formulary that are identified as "Non-formulary" and require review of a Member's medical information to ensure clinical criteria have been met regarding the medical necessity of the Drug. This review is performed prior to approving coverage and may involve the need for documentation of use of previous treatment with a Formulary Preferred Covered Drug or result in the substitution of a Formulary Preferred Covered Drug.

Coverage:
Coverage is provided for:

1. Generic and Brand Name contraceptive medications, devices and appliances when prescribed by a MHP provider and obtained through a Participating Pharmacy, except as excluded in this Rider.

2. Off-label use of an FDA-approved Covered Drug and the reasonable cost of supplies necessary to administer the drug to the extent such use meets the conditions of MCLA 500.3406q(2), is prescribed by a MHP provider, is obtained through a Participating Pharmacy and is preauthorized by MHP.

Co-payments:

<u>Retail Pharmacy</u>	
Generic:	$0
Formulary:	
Brand:	$ 20.00 or, as applicable, Formulary Brand Co-payment amount set forth in your MHP Pharmacy Drug Rider, whichever is less
Brand – Generic available:	$ 20.00 or, as applicable, Formulary Brand Co-payment amount set forth in your MHP Pharmacy Drug Rider, whichever is less, plus the difference in cost between the Brand Name Covered Drug and the Generic Covered Drug (see "Limitations", Paragraph 3 below).
Non-Formulary:	$ 50.00 or, as applicable, Formulary Brand Co-payment amount set forth in your MHP Pharmacy Drug Rider, whichever is less
<u>Mail-Order Pharmacy</u>	
Generic:	$0
Formulary:	
Brand:	$ 40.00 or, as applicable, Formulary Brand Co-payment amount set forth in your MHP Pharmacy Drug Rider, whichever is less
Brand – Generic available:	$ 40.00 or, as applicable, Formulary Brand Co-payment amount set forth in your MHP Pharmacy Drug Rider, whichever is less, plus the difference in cost between the Brand Name Covered Drug and the Generic Covered Drug (see "Limitations", Paragraph 3 below).

Contraceptive Methods - Limitations:

1. Prescriptions covered under this Rider are limited to a 34-day supply except that MHP in its discretion may recognize for benefit purposes the provision of the specific Covered Drugs in quantities exceeding a 34-day supply, or if the Covered Drug is available through the Mail-Order program, where a 90-day supply is dispensed. MHP reserves the right to place a maximum supply limit on certain Covered Drugs. This Rider does not cover any prescription refill in excess of the number specified by the physician or any prescription or refill dispensed after one year from the date of the physician's order.
2. Prescription contraceptive medications, devices and appliances are covered under this Rider only when obtained from participating pharmacies.
3. If a Brand Name Covered Drug is dispensed when a Generic Covered Drug equivalent is on the MHP Formulary, the Member must pay the difference in cost between the Brand Name Covered Drug and the price of its Generic equivalent **in addition to** the applicable co-payment. The Brand Name Covered Drug or a Non-formulary Drug will be covered at the same level as a Generic Covered Drug (with no Member cost sharing), if MHP grants Prior Authorization of the Drug on the basis that the Drug is a medically necessary and appropriate alternative, or if a Generic equivalent is not available. If Prior Authorization is requested, the Member or his/her provider must provide MHP will all information necessary to determine whether the Prior Authorization should be granted. MHP shall provide a decision regarding the request within twenty-four (24) hours after receiving all such information.

Exclusions:

1. There is no coverage for any drug, device or appliance other than FDA-approved contraceptives, devices or appliances described in this Rider.
2. There is no coverage under this Rider for Covered Drugs provided by any private or public agency which are or may be obtained by the Member without cost to the Member.
3. There is no coverage under this Rider for any contraceptive medication, device or appliance which is experimental or which is being used for experimental purposes including, but not limited to, those regarded by the U.S. Food and Drug Administration (FDA) as investigational.
4. There is no coverage under this Rider for any prescription which is filled after the termination of this Rider or which is filled prior to termination of this Rider but provides more than a 34-day supply beyond the termination date.
5. There is no coverage under this Rider for any cosmetic drug or drug used for cosmetic purposes. Cosmetic drug or cosmetic purpose means any prescription legend drug which is intended to be rubbed, poured, sprinkled or sprayed on, introduced into, or otherwise applied to the human body or any part thereof for the purpose of cleaning, beautifying, promoting attractiveness, promoting or reducing hair growth, reducing or eliminating wrinkles or altering the appearance; and any substance intended to be used as a component of the above drugs.
6. There is no coverage under this Rider for any contraceptive medications, devices or appliances to the extent that benefits or coverage are available under Medicare or under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision thereof.
7. There is no coverage under this Rider for any contraceptive medication, device or appliance that was acquired without cost to the provider, or if the cost is included or includable in the cost of other services or supplies provided to or prescribed for the Member in accordance with generally accepted professional procedures.
8. There is no coverage for Prescription Drugs for which there is an Over-the-Counter equivalent in both strength and dosage form.
9. There is no coverage for Over-the-Counter contraceptives, devices or appliances.

Assessments and screenings for adults

Recommended ages and who should have these services vary, and include but are not limited to:

- Blood pressure screening
- Breast cancer screening
- Colorectal cancer screening
- Depression screening
- Diabetes screening
- Alcohol misuse screening

- Medical history
- HIV screening
- Sexually transmitted infection (STI) screening
- Screening and counseling for obesity
- Counseling for tobacco use
- Counseling regarding use of aspirin to prevent cardiovascular disease

Additional assessments and screenings for adult pregnant women include but are not limited to:

- Screening for bacteriuria
- Screening for hepatitis B
- Screening for RH incompatibility
- Screening for syphilis

Drugs other than contraceptive medications (prescription required)

Recommended ages and who should have these services vary and include, but are not limited to:

- Oral fluoride supplements
- Folic acid supplements
- Iron supplements

Note: If your plan covers prescription drugs, the Preventive drugs will be covered according to your prescription drug plan. If your plan does not cover prescription drugs, Preventive drugs other than contraceptive medications described above are not covered by MHP.