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toolkit

Getting the Coverage You Deserve:

What to Do If You Are Charged a Co-Payment, Deductible, or Co-Insurance for a Preventive Service

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Getting the Coverage You Deserve: What to Do If You Are Charged a Co-Payment, Deductible, or Co-Insurance for a Preventive Service

The health care law requires new health plans to cover certain preventive services. This means that, as an increasing number of health plans come under the law's reach over the next few years, more and more people will have access to a wide range of preventive services without co-payments, deductibles, or co-insurance. This is especially important to women, who are more likely than men to avoid needed health care, including preventive care, because of cost. This requirement is a huge step forward for women's health.

The National Women's Law Center has been working hard to make sure women and their families know about the preventive coverage provided through the health care law. We've heard from many women about how much this coverage has helped them but we've also heard about some women encountering problems while trying to get these services without cost sharing. This toolkit is designed to provide women with information on the coverage of preventive services in the health care law and tools they can use if they encounter problems with this coverage. We have also provided detailed instructions on how to file an appeal with insurance companies and draft appeal letters on a range of preventive services.

For Word versions of the letters, please visit: **www.nwlc.org/preventiveservices**

IF YOU HAVE ANY QUESTIONS, CONTACT THE NATIONAL WOMEN'S LAW CENTER AT 1-866-PILL4US or PILL4US@NWLC.ORG.

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FOR ELECTRONIC VERSIONS OF THESE DOCUMENTS VISIT:
WWW.NWLC.ORG/PREVENTIVESERVICES

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Women's Preventive Services in the Affordable Care Act: Frequently Asked Questions

The health care law will not only expand health coverage to approximately 30 million people who now lack insurance, it will also improve health outcomes by making preventive health services more accessible and affordable. This component of the Affordable Care Act is especially important to women, who are more likely than men to go without necessary health care, including preventive care, because of cost. To help address these cost barriers and make sure all women have access to preventive health care, the health care law requires all new and non-grandfathered private insurance plans to cover a wide range of preventive services without co-payments or other cost sharing requirements as of August 2012.[1] The ACA – including the preventive services provision – must be preserved under the new administration as millions of Americans stand to benefit from the provisions of the law.

I heard about this new law that requires health plans to cover preventive care like mammograms and contraceptives. What is it and what does it require?

The health care law requires certain preventive health services and screenings to be covered in all new health insurance plans without cost sharing. This means that, for these services, you will not be charged a co-payment or co-insurance for the services, nor will you need to pay out-of-pocket if you have not yet met your deductible.

What are the Women's Preventive Services that began on August 1, 2012?

As of August 1, 2012, all new health plans must cover a range of women's preventive services without cost sharing. These services have been identified by the Institute of Medicine and endorsed by the Health Resources and Services Administration. They include:

(1) Breastfeeding support, supplies, and counseling;

(2) Screening and counseling for interpersonal and domestic violence;

(3) Screening for gestational diabetes;

(4) DNA testing for high-risk strains of HPV;

(5) Counseling regarding sexually transmitted infections, including HIV;

(6) Screening for HIV;

(7) Contraceptive methods and counseling;[2] and

(8) Well woman visits.[3]

What other preventive services are already covered under the law?

All new health insurance plans must cover, without cost-sharing, preventive services derived from four sets of expert recommendations: (1) services given an "A" or "B" recommended by the U.S. Preventive Services Task Force; (2) all vaccinations recommended by the Center for Disease Control's Advisory Committee on Immunization Practices; (3) a set of evidence-based services for infants, children, and adolescents based on guidelines developed by the American Academy of Pediatrics and the Department of Health and Human Services; and (4) as noted above, a set of additional evidence-based preventive services for women recommended by the Institute of Medicine and supported by the Health Resources and Services Administration.[4]

This coverage includes a number of preventive services that are of critical importance for women, such as:

(1) Mammograms every 1-2 years for women over 40;

(2) Cervical cancer screening every 3 years;

(3) Smoking cessation programs for adults;

(4) A wide range of prenatal screenings and tests;

(5) Diabetes and blood pressure screening; and

(6) Depression screening for adolescents and adults.[5]

The Advisory Committee on Immunization Practices includes a number of vaccines important to women, including vaccines for HPV, the flu, and Hepatitis, among others.

Does this mean I won't have to pay anything for preventive services?

You will be able to get the covered preventive services with no co-payment or other cost-sharing. While some plans previously covered preventive services with no cost sharing requirements, many only paid a portion of the cost, while the patient would have to pay a co-payment or co-insurance. Now, the full range of services will be fully covered by insurance plans and you will not need to make a separate payment to your doctor or pharmacy.

Won't this make my monthly premiums go up?

While we can't say for certain, it is unlikely. There is significant evidence that many of the preventive services included on this list, such as tobacco cessation, obesity reduction services, immunizations and contraceptives, are cost-saving.

When do these new requirements take effect?

Many private insurance plans are already required to provide some of the preventive services without cost sharing—those recommended by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the American Academy of Pediatrics. All new plans are required to cover the additional Women's Preventive Services as of August 1, 2012, but since most plan changes take effect at the beginning of a new plan year, the requirements will be in effect for most plans as of January 1, 2013.

I get health insurance through my employer, how do I know if my plan is new and if these requirements apply to my plan?

Health plans that existed before the health care law are considered "grandfathered" into the new system.[6] Grandfathered plans don't have to follow the new preventive services coverage rules. This means that the plan can continue to operate just as it has until it makes significant changes to the plan. These changes include: cutting benefits significantly; increasing co-insurance, co-payments, or deductibles or out-of-pocket limits by certain amounts; decreasing premium contributions by more than 5%; or, adding or lowering annual limits.[7]

Un-grandfathered plans are group health plans created after March 23, 2010, group health plans that have implemented significant changes, or individual plans purchased after that date, which is when the health care law was signed by the President. All un-grandfathered private health plans have to follow the new preventive health services coverage and cost-sharing rules. When you hear that "all new health plans" have to cover these services, it means that all "un-grandfathered" plans must cover them.

Will my plan ever become "un-grandfathered" and have to follow the new rule?

Yes. A survey found that 90% of all large U.S. companies expect that their health plans will lose grandfathered status by 2014.[8] Eventually all plans will lose their grandfathered status and distinctions between the two types of plans will disappear. At that point, all plans will cover these important preventive health services without cost sharing.

What about women on Medicaid?

Many states already cover a wide range of preventive services for Medicaid enrollees with nominal or no co-payments. While existing Medicaid plans won't be required to cover these services without co-payments, the health care reform law provides a financial incentive for states to do so.[9] The health care law also expands the group of people who are eligible for Medicaid and requires that this new group of Medicaid enrollees have access to the preventive health services, including the full range of contraceptive coverage, without cost sharing.[10] This means that some women with Medicaid coverage in some states may have access to these benefits, but women in other states may not.

What about women who are students and enrolled in a student health plan?

The new provisions apply to both group and individual health insurance.[11] Student health plans are considered a type of individual health insurance,[12] and therefore must generally comply with the preventive health services requirement and cover these services without cost-sharing. However, if you joined your student health plan before enactment of the Affordable Care Act (March 23, 2010) it may still be grandfathered and therefore need not comply with this requirement. Other plans excepted from this requirement are self-funded student health plans.[13]

I've heard about something called the essential health benefits. How are they different from this preventive health services requirement?

Under the health care law, health plans in the individual and small group markets will be required to provide coverage for 10 benefit categories, such as maternity and newborn care, and rehabilitative and habilitative care, which the law calls "essential health benefits." Because all plans in these markets will cover services in these 10 benefit categories, consumers can be sure that the plan they choose will provide this coverage, at a minimum. The Administration has been clear that the preventive services that require coverage without cost-sharing are part of the essential health benefits category referred to as "preventive and wellness services and chronic disease management."[14]

1 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1001, 124 Stat. 119, 131 (2010) (to be codified at 42 U.S.C. § 300gg-13).
2 Some religious employers, such as churches and other houses of worship, are exempt from the contraceptive coverage requirement. In addition, the Department of Health and Human Services has proposed an accommodation that would allow other religious organizations to avoid covering contraception directly, but ensures that the women who work for them still receive contraceptive coverage without cost-sharing. For more information, please see our fact sheet Contraceptive Coverage "Accommodation" of Other "Religious Organizations": Frequently Asked Questions.
3 Coverage of Preventive Health Services, 47 CFR § 147.130 (2011), and Women's Preventive Services: Required Health Plan Coverage Guidelines (Aug. 1, 2011), http://www.hrsa.gov/womensguidelines/.
4 *Id.*
5 For a complete list of the USPSTF recommendations, please visit http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.
6 See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1251, 124 Stat. 119, 161-62 (2010) (to be codified at 42 U.S.C. §18011).
7 Preservation of Right to Maintain Existing Coverage, 45 CFR § 147.140 (2011).
8 Stephen Miller, Society for Human Resources Management, Nine of 10 Big Companies Expect to Lose Grandfathered Status (Aug. 20, 2010), http://www.shrm.org/hrdisciplines/benefits/Articles/Pages/GrandfatherStatus.aspx.
9 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1406 (2010).
10 The Supreme Court held in its decision on the Affordable Care Act that states need not participate in the expansion of Medicaid as a condition of continuing to receive their current Medicaid funding. Nat'l Fed'n of Indep. Bus. et al. v. Sebelius, 567 U.S. ___ (2012).
11 Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 45 CFR § 147.130 (2012).
12 Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets, 45 C.F.R. § 147.145 (2012).
13 While for most university health plans, the student contracts directly with the health insurance company for insurance, a very small number of universities provide self-funded health plans to students. Such self-funded student plans are not considered individual health insurance and are not covered by the preventive services rule.
14 Dep't of Health & Human Srvcs., Ctrs. For Medicare & Medicaid Srvcs., Frequently Asked Questions on Essential Health Benefits 5 (Feb. 17, 2012), *available at* http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

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Contraceptive Coverage in the Health Care Law: Frequently Asked Questions

The health care law makes preventive care more accessible and affordable to millions of Americans. This is especially important to women, who are more likely than men to avoid needed health care, including preventive care, because of cost. To help address these cost barriers and make sure all women have access to preventive health care, one section of the health care law requires all new and non-grandfathered private insurance plans to cover a wide range of preventive services, including services such as mammograms, pap smears, smoking prevention and contraceptives without co-payments or other cost sharing requirements.[1]

I heard about this new law that requires health plans to cover birth control. What is it and what does it require?

The health care law (the Affordable Care Act) requires certain preventive health services and screenings to be covered in all new health insurance plans without cost sharing. This means that, for the preventive health care services included, you will not be charged a co-payment for the services, and the costs of the services will not be applied to your deductible. The list of covered preventive services is extensive and includes services such as mammograms, pap-smears, and smoking cessation supports. For more information on the preventive health services generally, please see www.nwlc.org/preventiveservices.

On August 1, 2011, the list was expanded to include birth control alongside other women's preventive services, such as an annual well-woman visit.

What types of birth control are now covered with no cost sharing?

The full range of FDA-approved contraceptive methods is included. These methods are listed in the Food and Drug Administration's "Birth Control Guide" available online: (http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf) This means a woman can access oral contraception (the pill), injectables, the ring, contraceptive implants, diaphragms, cervical caps, and non-surgical permanent contraceptives without paying a co-payment or having the costs applied to her deductible.* Sterilization for women is also covered with no co-pay or deductible.* The Department of Health and Human Services released a set of "Frequently Asked Questions" about the health care law which provides greater detail on the requirement to cover the full range of contraceptive methods. For an explanation of these details, please see Women's Access to Preventive Services Affirmed by HHS.

Does this mean I won't have to pay anything for my birth control?

You will be able to get your birth control at no out-of-pocket costs, as the full cost will be covered by your monthly premium. Before this new rule, insurance plans usually only covered a portion of the cost of birth control and

Plans will not be able to charge extra payments for these services, such as co-payments or deductibles.* With this new requirement, the cost of birth control will be fully covered by the monthly premium consumers already pay, without any extra payments.

Won't this make my monthly premiums go up?

While we can't say for certain, there is strong evidence that covering contraceptives actually produces cost savings, because maternity, infant, and dependent care are more expensive than family planning services. According to the National Business Group on Health (NBGH), a non-profit organization representing employers' perspectives on national health policy issues, the cost of adding contraceptive coverage to a health plan is more than made up for in expected cost savings.[2] And when contraceptive coverage was added to the federal employee plan, premiums did not increase because there was no resulting health care cost increase.[3]

When do these new requirements take effect?

The requirement that all new plans cover the additional Women's Preventive Services – including contraception – takes effect in the first plan year on or after August 1, 2012. Because most plan years start with the calendar year, the requirements have been in effect for most plans since January 1, 2013. School health plans, which often begin their health plan years around the beginning of the school year, saw the benefits very soon after the August 1st start date.

I get health insurance through my employer, how do I know if my plan is new and if these requirements apply to my plan?

Health plans that existed before the health care law are considered "grandfathered" into the new system under the health care law.[4] Grandfathered plans don't have to follow the new preventive services cost sharing rules. This means that the plan can continue to operate just as it has until it makes significant changes to the plan. These changes include: cutting benefits significantly; increasing co-insurance, co-payments, or deductibles or out-of-pocket limits by certain amounts; decreasing premium contributions by more than 5%; or, adding or lowering annual limits.[5]

Un-grandfathered plans are group health plans created after March 23, 2010 or individual health plans purchased after that date, which is when the health care law was signed by the President. All un-grandfathered private health plans have to follow the new preventive health services coverage and cost-sharing rules. When you hear that "all new health plans" have to cover these services, it means that all "un-grandfathered" plans must cover them.

Will my plan ever become "un-grandfathered" and have to follow the new rule?

Yes. A recent survey found that 90% of all large U.S. companies expect that their health plans will lose grandfathered status by 2014.[6] Eventually all plans will lose their grandfathered status and distinctions between the two types of plans will disappear. At that point, all plans will cover contraception without cost sharing.

What about women on Medicaid?

Most women on Medicaid already have access to contraception without co-payments.[7] However, the new health care law expands the group of people who are eligible for Medicaid and requires that this new group of Medicaid enrollees have access to the preventive health services, including the full range of contraceptive coverage, without cost sharing.[8] This means that some women on Medicaid in some states may have access to these benefits, but others may not.

What about women who are students and enrolled in a student health plan?

The new contraceptive coverage requirement applies to both group and individual health insurance.[9] Student health plans are considered a type of individual health insurance,[10] and therefore must comply with the preventive health services requirement. In other words, student health plans must offer the preventive health services, including contraceptive coverage, without cost-sharing. The only plans excepted from this requirement are self-funded student health plans.[11]

Are religious organizations exempt from these requirements?

A segment of religious employers, such as churches and other houses of worship, will be exempt from this contraceptive coverage requirement. The Administration also has proposed an "accommodation" for other, non-profit "religious organizations" that allows them to avoid providing contraceptive coverage directly, but ensures that the women who work for them still receive contraceptive coverage without a co-pay. Rules implementing this "accommodation" and the final group of religious employers who are exempted should be finalized by Aug. 1, 2013.

I like this part of the health care law, but I have heard that some people are trying to repeal it. What can I do to keep this important new benefit?

You should tell your Member of Congress that you support the health care law and that you support contraceptive coverage for all women, no matter who their employer is. You should also find out where candidates stand on these issues and make sure to vote.

For more information on contraceptive coverage please visit

www.nwlc.org/contraceptivecoverage

* Insurance companies do have some flexibility in implementing this new requirement, like being able to charge a co-pay for a brand name drug where generic equivalents exist.

1 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2713, 124 Stat. 119, 131 (2010) (to be codified at 42 U.S.C. § 300gg-13).

2 KP Campbell, Nat'l Bus. Group on Health, Contraceptive Use Evidence-Statement: Counseling and Preventive Intervention, in A Purchaser's Guide to Clinical Preventive Services: Moving Science into Coverage, (KP Campbell et al. ed., 2006).

3 When the FEHBP contraceptive coverage requirement was implemented, the Office of Personnel Management (OPM), which administers the program, arranged with the health carriers to adjust the 1999 premiums in 2000 to reflect any increased insurance costs due to the addition of contraceptive coverage. But OPM found that no such adjustment was necessary, and reported that "there was no cost increase due to contraceptive coverage." Letter from Janice R. Lachance, Dir., U.S. Office of Pers. Mgmt. (Jan. 16, 2001) (on file with NWLC).

4 See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1251, 124 Stat. 119, 161-62 (2010) (to be codified at 42 U.S.C. §18011).

5 Preservation of Right to Maintain Existing Coverage, 45 CFR § 147.140 (2011).

6 Stephen Miller, Society for Human Resources Management, Nine of 10 Big Companies Expect to Lose Grandfathered Status (Aug. 20, 2010), http://www.shrm.org/hrdisciplines/benefits/Articles/Pages/GrandfatherStatus.aspx.

7 The Kaiser Family Found. & the Guttmacher Inst., Medicaid's Role in Family Planning (2007) *available at* http://www.kff.org/womenshealth/upload/7064_03.pdf.

8 The Supreme Court held in its decision on the Affordable Care Act that states need not participate in the expansion of Medicaid as a condition of continuing to receive their current Medicaid funding. Nat'l Fed'n of Indep. Bus. et al. v. Sebelius, 567 U.S. ___ (2012).

9 Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 45 CFR § 147.130 (2012).

10 Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets, 45 C.F.R. § 147.145 (2012).

11 While for most university health plans, the student contracts directly with the health insurance company for insurance, a very small number of universities provide self-funded health plans to students. Such self-funded student plans are not considered individual health insurance and are not covered by the preventive services rule.

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FACTSHEET

Women's Access to Preventive Services Affirmed by HHS

On February 20, 2013, the Department of Health and Human Services released a set of Frequently Asked Questions (http://www.dol.gov/ebsa/faqs/faq-aca12.html) which clarified many issues related to implementation of the Affordable Care Act's preventive services requirement. The FAQ is an important step towards ensuring that insurance plans and issuers implement the Women's Preventive Health Services provision so that women get the comprehensive and affordable services guaranteed by the Affordable Care Act. While the FAQ leaves some implementation questions unanswered, the National Women's Law Center is pleased that the Department addressed several major issues to make sure that women have the coverage required by the law. The charts below summarize implementation issues and how the FAQ responds to them.

General Issues

Issue	FAQ
Can women get preventive services from an out-of-network provider?	Yes, in some circumstances. For any preventive service, if the plan or issuer does not have a provider in its network who can provide that service, the plan cannot impose cost-sharing when a person accesses the service from an out-of-network provider. (see Question 3 of the FAQ)
Are over-the-counter products that are preventive services covered without cost sharing?	Yes, in some circumstances. When an over-the-counter product is prescribed by a health care provider, it is covered without cost sharing. (see Question 4 of the FAQ) For an over-the-counter contraceptive method to receive the no cost sharing protection, it must be both FDA-approved and prescribed for a woman by her provider. Thus, over-the-counter methods that are prescribed are available without cost-sharing. (see Question 15 of the FAQ)

Specific Preventive Services

Issue	FAQ
Does the no cost sharing requirement extend to the removal of a polyp during a colonoscopy if the colonoscopy is scheduled and performed as a screening procedure?	Yes. Clinical practice and the opinion of multiple medical associations show that polyp removal is an integral part of a colonoscopy. Thus, when the procedure is performed for screening, polyp removal cannot have cost sharing. (see Question 5 of the FAQ)
Does the recommendation for genetic counseling and evaluation for routine breast cancer susceptibility gene (BRCA) testing include the BRCA test itself?	Yes. The recommendation includes both genetic counseling and BRCA testing for a woman if determined appropriate by her health care provider. (see Question 6 of the FAQ)

Women's Preventive Services

Contraceptive Coverage

Issue	FAQ
Are plans and issuers required to cover all contraceptive methods without cost sharing?	Yes. The FAQ requires that women have access to the full range of FDA-approved contraceptive methods. This includes, but is not limited to, barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling. Therefore, women should have coverage of all FDA-approved contraceptive methods, meaning a range of pills, the ring, the patch, the shot, implants, hormonal intrauterine devices, non-hormonal intrauterine devices, barrier methods, and sterilization procedures. (see Question 14 of the FAQ)
Are plans and issuers required to provide coverage of contraceptives other than the pill?	Yes. Plans and issuers cannot limit their contraceptive coverage to only oral contraceptives. The HRSA Guidelines require women to have access to the full range of contraceptive methods. (see Question 14 of the FAQ) Additionally, FDA-approved intrauterine devices (IUDs) and implantable contraceptives, prescribed by a provider, are specifically required to be covered. (see Question 17 of the FAQ)
Are plans and issuers required to cover the specific contraceptive prescribed by a woman's health care provider?	Yes, although plans and issuers have limited use of reasonable medical management techniques to control costs and promote efficient delivery of care. For example, if a provider prescribes a drug and there is a generic equivalent available, a plan or issuer may cover the generic without cost-sharing and impose cost-sharing on the branded drug. If a generic version is not available, then a plan or issuer must provide co-

	verage for the brand name drug without cost-sharing. However, the plan must have a waiver process that enables the woman to access the branded drug without cost-sharing when a generic drug is available but her provider determines that the branded drug is medically appropriate for her. (see Question 14 of the FAQ)
Can plans and issuers use so-called "reasonable medical management techniques" to limit contraceptive coverage?	Yes, in some circumstances. While the FAQ did not clarify the term "reasonable medical management techniques," it requires every plan and issuer to have a waiver process that would enable women to have access to the contraceptive method that her provider determines is medically appropriate for her needs, in consultation with the woman. This waiver process could override a "medical management technique." (see Question 14 of the FAQ)
Are contraceptives for men included in the preventive services?	No. The FAQ states that contraceptives for men, such as condoms and vasectomies, are excluded from the HRSA Guidelines. (see Question 15, footnote 10 of the FAQ)
Will services related to the contraceptive coverage be covered? Such as to remove an IUD?	Yes. All services related to follow-up and management of side effects, counseling for continued adherence, and device removal are part of the services included in the HRSA Guidelines. Therefore, all such services must be covered without cost-sharing. (see Question 16 of the FAQ)
Can plans and issuers place quantity limits on contraceptives of less than one year?	Not addressed in FAQ.
How should plans and issuers update their coverage when new contraceptives are approved by the FDA?	Not specifically addressed in the FAQ, but because plans and issuers have to cover the full range of FDA-approved contraceptives, newly approved products must be covered promptly.

Well-woman Visits

Issue	FAQ
Will plans have to cover multiple well-woman visits without cost sharing each year?	Yes. The Department acknowledged that it is sometimes necessary for a woman to have more than one well-woman visit to obtain all of the necessary preventive services, depending on her individual health status, needs, and other risk factors. If a woman's health care provider determines that more than one well-woman visit is necessary to meet her needs, then the plan must cover the additional visits without cost sharing. (see Question 10 of the FAQ)

What is included in a well-woman visit?	Well-woman visits include the women's preventive services in the HRSA Guidelines, other preventive services in § 2713 of the Public Health Service Act, and preconception and prenatal care. Women should therefore have access to a wide range of clinical services, counseling, and education. (see Question 10 of the FAQ)

Breastfeeding Support, Supplies, and Counseling

Issue	FAQ
Can women get coverage of lactation support, counseling, and equipment the entire time they breastfeed their child?	Yes. The coverage without cost sharing lasts as long as the woman is breastfeeding her child. However, plans can use reasonable medical management techniques to determine the frequency, method, treatment, or setting for the preventive service. (see Question 20 of the FAQ)
How are lactation consultants reimbursed for services under the HRSA Guidelines?	Unanswered. This is outside the scope of the HRSA Guidelines and the Department's regulations. (see Question 19 of the FAQ)

Screening and Counseling for Interpersonal and Domestic Violence

Issue	FAQ
What must health care providers know to conduct "screening" for interpersonal and domestic violence?	The screening can be a few, brief, open-ended questions and can use brochures and forms or other assessment tools. The Department referred providers to the CDC's Abuse Assessment Screening tool and the HHS-funded Domestic Violence Resource Network for resources. (see Question 11 of the FAQ)

HPV Testing

Issue	FAQ
When should the high-risk HPV DNA test be administered to women?	It should be administered to women who are 30 years of age or older and who have normal cytology results, but no more frequently than every three years. (see Question 12 of the FAQ)

Counseling and Screening for HIV

Issue	FAQ
Does "screening" in this recommendation mean testing for HIV?	Yes. All sexually active women will have coverage of annual counseling and testing for HIV. (see Question 13 of the FAQ)

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

FACT SHEET

How To Find Out If Your Health Plan Is Covering Women's Preventive Services with No Co-Pay, as Required by the Health Care Law

Your health plan should be providing coverage for the women's preventive services with no cost-sharing, if your plan is not grandfathered. The best way to find out for sure that you have coverage for the women's preventive services without cost sharing and to get information on how these services will be covered is to call your insurance company.*

Below is a phone script for you to use when talking to your insurance company. ***If you are not getting the answers you need, call the National Women's Law Center PILL4US hotline at 1-866-PILL4US or email pill4us@nwlc.org. We are here to help you if you aren't getting the women's preventive health services without a co-pay, as required by the health care law.***

Who Should You Call?

We recommend you call the phone number on your insurance card. That number should connect you to customer service for your insurance company or plan and should have the most up to date information about your health plan. If you have an employer-sponsored plan, you may have a benefits administrator you can also ask. Remember, the person answering the phone is not the person making the decisions. If the person with whom you are speaking is unable to answer a question you have, you might want to ask to speak with a supervisor. If you do not believe you are being told correct information, you may want to inform your employer or school administration.

What Should You Say?

The phone script provided below includes suggested questions you can ask to find out if your plan is providing the women's preventive services and details about what services they are providing. You do not have to follow the script perfectly. You can use it as a guide. The flowchart also has these questions and can be a useful tool while you are on the phone with your insurance plan.

Opening Question

Hi. I understand that, under the health care law, new health plans must provide coverage for women's preventive services, such as a well woman visit and birth control, with no cost sharing. I am trying to confirm that my plan is providing these services. Can you tell me whether my plan is grandfathered under the health care law?

If the Plan is Not Grandfathered:

If the representative says that the plan is not grandfathered:

Q: *That means the plan should be providing coverage for the women's preventive services without cost sharing. Is that correct?*

If the representative says **NO** (it will not provide coverage):

Q: *Do you know why the plan is not following the requirement?* Non-profit employers, schools, and universities that have a religious objection to providing contraceptive coverage do not have to provide it immediately.* Self-funded student health plans do not have to comply with the preventive services requirement.

Follow-up question if your non-profit employer, school, or university has a religious objection to providing contraceptive coverage: *The temporary delay for employers with a religious objection only applies to contraceptive coverage. Can you confirm that I receive coverage for the other women's preventive health services, such as a well-woman visit?*

Follow-up question if the representative indicates that your student health plan is self-funded: *Do you know if the school is planning on offering coverage of any of the preventive health services without cost-sharing even though it is not required to?*

(If the representative you are speaking with is unable to answer these questions, you may want to ask to speak with a supervisor.)

If they remain firm that the plan is not providing the coverage then call us at **1-866-PILL4US** or email **pill4us@nwlc.org**.

If the representative says **YES** (it will provide coverage):

Q: *Do you have information on what services are covered with no cost-sharing?*

You may want to ask about a particular service you plan to use. For example, you could ask:

Is it possible to find out if a specific birth control pill will be covered without a co-pay? Can I see the formulary to know if prescriptions I use will be covered?

Can you tell me if all costs associated with the placement of an IUD are covered without co-pays, including doctor visits and the cost of the procedure?

Do you have details on how breastfeeding support and supplies will be covered?

If the particular birth control method or other preventive service that you need is not being covered, then call us at **1-866-PILL4US** or email **pill4us@nwlc.org**.

If the Plan is Grandfathered:

If the representative says that the plan is grandfathered:

Q: *Do you know if the plan will still be providing the women's preventive services without cost sharing?*

If the representative says **NO**:

Grandfathered plans do not have to provide the women's preventive services, so your plan does not have to provide these services. If you have employer-sponsored insurance, at the next open enrollment you can look at the materials to see if the plan becomes ungrandfathered or if there is another plan option.

If the representative says **YES** (it will provide coverage):

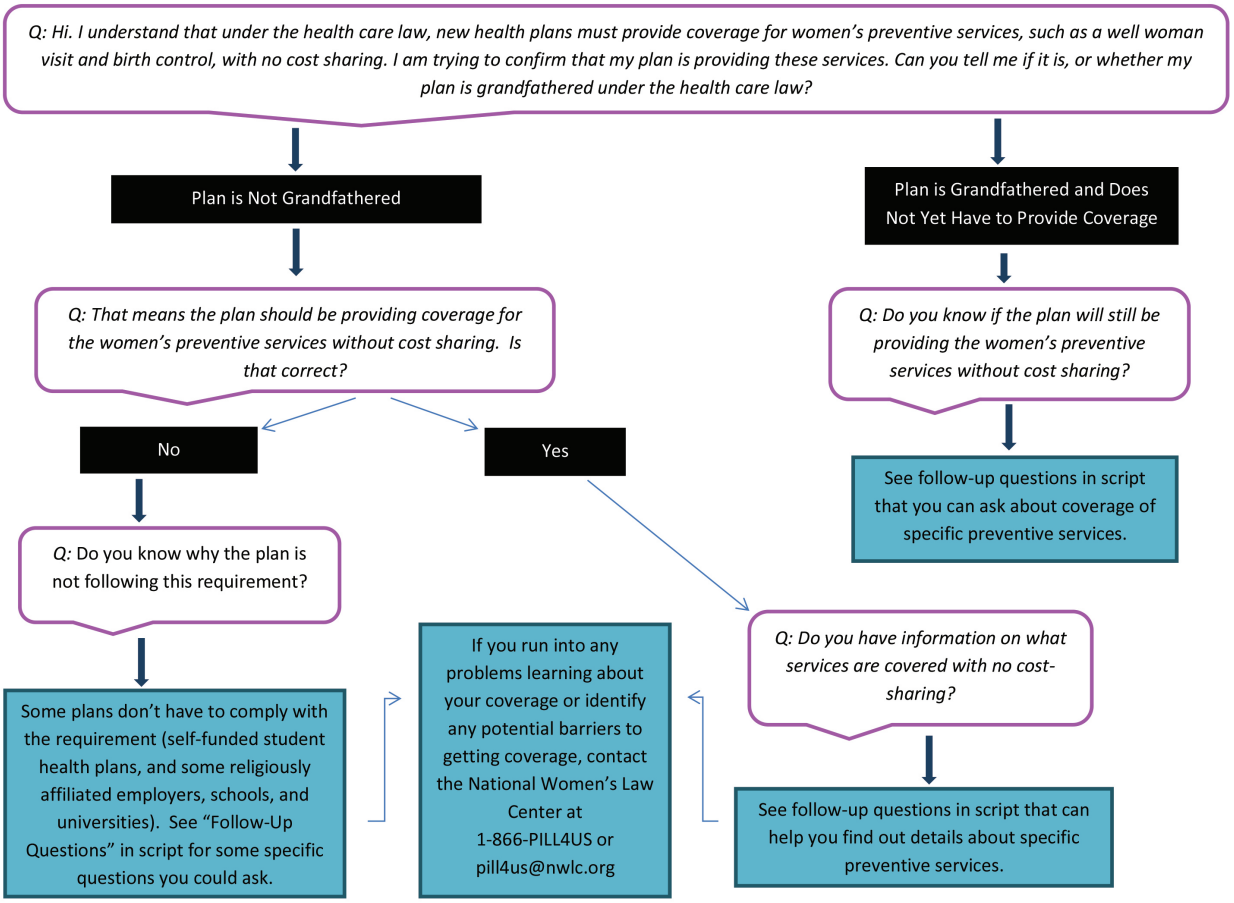
Potential follow up questions you could ask on how services will be covered:

Is it possible to find out if a specific birth control pill will be covered without a co-pay? Can I see the formulary to know if prescriptions I use will be covered?

Can you tell me if all costs associated with the placement of an IUD are covered without co-pays, including doctor visits and the cost of the procedure?

Do you have details on how breastfeeding support and supplies will be covered?

Coverage of the Women's Preventive Health Services: Script for Calling Your Health Insurance Plan



* Churches and other houses of worship do not have to provide contraceptive coverage. Additionally, non-profit organizations with a religious objection to providing contraception or sterilization services have an additional year to come into compliance. If your employer or school falls into one of these categories, then your plan still must provide the seven other women's preventive services.

If you feel you are not receiving the women's preventive health services benefits to which you are entitled, contact the National Women's Law Center at 1-866-PILL4US or pill4us@nwlc.org.

Appeal: Instructions and Draft Letters to Insurance Companies

pages 18-39

Instructions For Sending An Appeal Letter: General Preventive Services

ADDRESSING THE LETTER

- Contact your insurer to find out to whom you should send your appeal.
- If you are given an appeal form, it will include the address for the person to whom you should send your appeal.
- In addition, if you are in an employer-based plan, you can send a copy of the appeal letter and form to your insurance plan's Plan Administrator.
  - The contact information for your Plan Administrator can be found in the Summary Plan Description.
  - If you are in an employer-sponsored plan and you are comfortable doing so, you should give a copy to the person who manages employee benefits in your HR department.

COMPLETING THE LETTER

- Complete every field of the form letter that appears in capital letters with the information specific to your situation (for example, YOUR NAME, POLICY NUMBER, etc.) For a Word version of the letter, please visit: www.nwlc.org/preventiveservices.
- Make sure you have documentation of the costs you've incurred for the preventive service (such as receipts from the pharmacy or an explanation of benefits from your insurer) and attach copies of the documentation.
- Be sure to attach a copy of the "Frequently Asked Questions" to the letter – you can print a copy here: http://www.dol.gov/ebsa/pdf/faq-aca12.pdf.

CREATING A RECORD OF YOUR LETTER

- Make a copy of the letter and keep it in your files.

AFTER YOU SEND YOUR LETTER

- Continue to keep copies of receipts or other documents that show when you have had to pay a co-payment, co-insurance or deductible for the preventive services.
- Please let us know if you receive a reply from your insurance company. We are keeping track of how insurers respond.

For a Word version of the letter, please visit: **www.nwlc.org/preventiveservices**

IF YOU HAVE ANY QUESTIONS, CONTACT THE NATIONAL WOMEN'S LAW CENTER AT 1-866-PILL4US or PILL4US@NWLC.ORG.

Sample Letter: General Preventive Services

[NAME]

[ADDRESS]

[DATE]

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. I recently visited [NAME OF PROVIDER] for [NAME OF PREVENTIVE SERVICE]. The Patient Protection and Affordable Care Act requires that my insurance coverage of this preventive service be with no cost sharing, however I was required to pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] to obtain this service.

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Service Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall provide coverage of certain preventive services with no cost sharing requirements. (42 U.S.C. § 300gg-13) [NAME OF PREVENTIVE SERVICE] is one of the preventive services that must be covered without cost sharing requirements. My health insurance plan is non-grandfathered. Thus, the plan must comply with the preventive services provision and provide coverage of [NAME OF PREVENTIVE SERVICE] without cost sharing.

The Affordable Care Act defines "cost-sharing" to include "deductibles, coinsurance, copayments, or similar charges." (42 U.S.C. § 18022(c)(3)(A)(i)) Furthermore, the regulations implementing § 2713 state, "a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide coverage for all of the [preventive services], and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services." (45 C.F.R. 147.130) Thus, both the statute and the regulations implementing it explicitly state that a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] is a form of cost sharing and should not be imposed on the preventive services. However, [NAME OF INSURANCE COMPANY]'s current policy requires that I pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] for [NAME OF PREVENTIVE SERVICE]. This policy is in violation of the Affordable Care Act's preventive services provision.

I have spent [TOTAL AMOUNT] out of pocket on [NAME OF PREVENTIVE SERVICE], despite the fact that it should have been covered without cost sharing. I have attached copies of receipts which document these out of pocket expenses. I expect that [COMPANY NAME] will rectify this situation by ensuring that [NAME OF PREVENTIVE SERVICE] is covered by my plan without cost sharing in the future, reimbursing me for the out of pocket costs I have incurred during the period it was not covered without cost sharing, and changing any corporate policies that do not comply with the Affordable Care Act.

Sincerely,

[YOUR SIGNATURE]

Encl: Copies of Receipts Documenting Out of Pocket Costs

Instructions For Sending An Appeal Letter: Birth Control

ADDRESSING THE LETTER

- Contact your insurer to find out to whom you should send your appeal.
- If you are given an appeal form, it will include the address for the person to whom you should send your appeal.
- In addition, if you are in an employer-based plan, you can send a copy of the appeal letter and form to your insurance plan's Plan Administrator.
  - The contact information for your Plan Administrator can be found in the Summary Plan Description.
  - If you are in an employer-sponsored plan and you are comfortable doing so, you should give a copy to the person who manages employee benefits in your HR department.

COMPLETING THE LETTER

- Complete every field of the form letter that appears in capital letters with the information specific to your situation (for example, YOUR NAME, POLICY NUMBER, etc.) For a Word version of the letter, please visit: www.nwlc.org/preventiveservices.
- Make sure you have documentation of the costs you've incurred for your birth control (such as receipts from the pharmacy) and attach copies of the documentation.
- Be sure to attach a copy of the FDA's "Birth Control Guide" to the letter – a copy appears on the last page of this toolkit and you can print a copy here: http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf
- Be sure to attach a copy of the "Frequently Asked Questions" to the letter – you can print a copy here: http://www.dol.gov/ebsa/pdf/faq-aca12.pdf.

CREATING A RECORD OF YOUR LETTER

- Make a copy of the letter and keep it in your files.

AFTER YOU SEND YOUR LETTER

- Continue to keep copies of receipts or other documents that show when you have had to pay out-of-pocket for your birth control.
- Please let us know if you receive a reply from your insurance company. We are keeping track of how insurers respond.

For a Word version of the letter, please visit: **www.nwlc.org/preventiveservices**

IF YOU HAVE ANY QUESTIONS, CONTACT THE NATIONAL WOMEN'S LAW CENTER AT 1-866-PILL4US or PILL4US@NWLC.ORG.

Sample Letter: Birth Control

[NAME]

[ADDRESS]

[DATE]

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. My health care provider has prescribed the contraceptive [NAME OF CONTRACEPTIVE]. The Patient Protection and Affordable Care Act requires that my insurance provide coverage of this contraceptive with no cost sharing, however I have been asked to pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] to obtain my contraception.

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Services Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall provide coverage of and not impose cost sharing for certain preventive services for women. The list of women's preventive services which must be covered in plan years starting after Aug. 1, 2012 includes "all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity." (http://www.hrsa.gov/womensguidelines/) These methods are listed in the Food and Drug Administration's "Birth Control Guide." (Attached) My health insurance plan is non-grandfathered. Thus, the plan must comply with the women's preventive services.

I have spent [TOTAL AMOUNT] out of pocket on [NAME OF CONTRACEPTIVE], despite the fact that it should have been covered without cost sharing. I have attached copies of receipts which document these out of pocket expenses. I expect that [COMPANY NAME] will rectify this situation by ensuring that [NAME OF CONTRACEPTIVE] is covered by my plan without cost sharing in the future, reimbursing me for the out of pocket costs I have incurred during the period it was not covered without cost sharing, and changing any corporate policies that do not comply with the Affordable Care Act.

Sincerely,

[YOUR SIGNATURE]

Encl:

FDA Birth Control Guide (available at:
http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf)

Frequently Asked Questions about the Affordable Care Act (Part XII)
(available at http://www.dol.gov/ebsa/faqs/faq-aca12.html)

Copies of Receipts Documenting Out of Pocket Costs.

Instructions For Sending An Appeal Letter: NuvaRing® or OrthoEvra® Patch

ADDRESSING THE LETTER

- Contact your insurer to find out to whom you should send your appeal.
- If you are given an appeal form, it will include the address for the person to whom you should send your appeal.
- In addition, if you are in an employer-based plan, you can send a copy of the appeal letter and form to your insurance plan's Plan Administrator.
  - The contact information for your Plan Administrator can be found in the Summary Plan Description.
  - If you are in an employer-sponsored plan and you are comfortable doing so, you should give a copy to the person who manages employee benefits in your HR department.

COMPLETING THE LETTER

- Complete every field of the form letter that appears in capital letters with the information specific to your situation (for example, YOUR NAME, POLICY NUMBER, etc.) For a Word version of the letter, please visit: www.nwlc.org/preventiveservices.
- Make sure you have documentation of the costs you've incurred for your birth control (such as receipts from the pharmacy) and attach copies of the documentation.
- Be sure to attach a copy of the FDA's "Birth Control Guide" to the letter - a copy appears on the last page of this toolkit and you can print a copy here: http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf
- Be sure to attach a copy of the "Frequently Asked Questions" to the letter – you can print a copy here: http://www.dol.gov/ebsa/pdf/faq-aca12.pdf.

CREATING A RECORD OF YOUR LETTER

- Make a copy of the letter and keep it in your files.

AFTER YOU SEND YOUR LETTER

- Continue to keep copies of receipts or other documents that show when you have had to pay out-of-pocket for your birth control.
- Please let us know if you receive a reply from your insurance company. We are keeping track of how insurers respond.

For a Word version of the letter, please visit: **www.nwlc.org/preventiveservices**

IF YOU HAVE ANY QUESTIONS, CONTACT THE NATIONAL WOMEN'S LAW CENTER AT 1-866-PILL4US or PILL4US@NWLC.ORG.

Sample Letter: NuvaRing®

[INSURANCE COMPAY NAME]

[COMPANY ADDRESS]

[DATE]

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. My health care provider has prescribed the contraceptive NuvaRing to me. The Patient Protection and Affordable Care Act (ACA) requires that my insurance coverage of this contraceptive be without cost sharing, however I have been required to pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] when getting coverage for NuvaRing.

The Patient Protection and Affordable Care Act requires that all non-grandfathered group health plans and health insurance issuers offering group or individual coverage provide coverage of and not impose cost sharing for certain preventive services for women. (ACA § 1001, amending § 2713 of Public Health Service Act.) The list of women's preventive services which must be covered in plan years starting after Aug. 1, 2012 includes "all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity." (http://www.hrsa.gov/womensguidelines/) These methods are listed in the Food and Drug Administration's "Birth Control Guide." (Attached) My health insurance plan is non-grandfathered. Thus, the plan must comply with the women's preventive services requirement.

Specifically, the plan must provide coverage without cost sharing of the NuvaRing which has been prescribed to me. The ACA requires plans to provide coverage without cost sharing of all FDA approved contraceptive methods. The Food and Drug Administration's "Birth Control Guide" indicates that the Vaginal Contraceptive Ring is a unique contraceptive method. Therefore, the Vaginal Contraceptive Ring is one of the methods which plans must cover without cost sharing. Furthermore, on Feb. 20, 2013, the Departments of Labor and Health and Human Services and the Treasury released a set of "Frequently Asked Questions" which affirmed that the ACA's women's preventive services requirement requires plans to provide coverage of all brand-name forms of contraception that do not have a generic equivalent. The FAQ says, "If, however, a generic version is not available,…then a plan or issuer must provide coverage for the brand name drug in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management)." (see Question 14 in enclosed FAQ.) The NuvaRing is a brand name drug without a generic equivalent, thus my plan must provide coverage of the NuvaRing without cost sharing. Additionally, the FAQ says that the HRSA Guidelines ensure women have access to "the full range of FDA-approved contraceptive methods…as prescribed by a health care provider." My health care provider, [PROVIDER'S NAME], prescribed the NuvaRing as my contraceptive method, and therefore it must be covered without cost sharing.

I have spent [TOTAL AMOUNT] out of pocket on NuvaRing, while it should have been covered without cost sharing. I have attached copies of receipts which document these out of pocket expenses. I expect that [COMPANY NAME] will rectify this situation by ensuring that NuvaRing is covered by my plan without cost sharing in the future, reimbursing me for the out of pocket costs I have incurred during the period it was not covered without cost sharing, and changing any policies that do not comply with the Affordable Care Act.

Sincerely,

[YOUR SIGNATURE]

Encl:

FDA Birth Control Guide (available at: http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf)

Frequently Asked Questions about the Affordable Care Act (Part XII) (available at http://www.dol.gov/ebsa/faqs/faq-aca12.html)

Copies of Receipts Documenting Out of Pocket Costs

Sample Letter: OrthoEvra® Patch

[NAME]

[ADDRESS]

[DATE]

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. My health care provider has prescribed the contraceptive OrthoEvra, the contraceptive patch. The Patient Protection and Affordable Care Act requires that my insurance provide coverage of this contraceptive with no cost sharing, however I have been asked to pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] to obtain my contraception.

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Services Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall provide coverage of and not impose cost sharing for certain preventive services for women. The list of women's preventive services which must be covered in plan years starting after Aug. 1, 2012 includes "all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity." (http://www.hrsa.gov/womensguidelines/) These methods are listed in the Food and Drug Administration's "Birth Control Guide." (Attached) My health insurance plan is non-grandfathered. Thus, the plan must comply with the women's preventive services.

Specifically, the plan must provide coverage without cost sharing of the OrthoEvra patch which has been prescribed to me. The ACA requires plans to provide coverage without cost sharing of all FDA approved contraceptive methods. The Food and Drug Administration's "Birth Control Guide" indicates that the Vaginal Contraceptive Ring is a unique contraceptive method. Therefore, the Vaginal Contraceptive Ring is one of the methods which plans must cover without cost sharing. Furthermore, on Feb. 20, 2013, the Departments of Labor and Health and Human Services and the Treasury released a set of "Frequently Asked Questions" which affirmed that the ACA's women's preventive services requirement requires plans to provide coverage of all brand-name forms of contraception that do not have a generic equivalent. The FAQ says, "If, however, a generic version is not available,…then a plan or issuer must provide coverage for the brand name drug in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management)." (see Question 14 in enclosed FAQ.) The OrthoEvra patch is a brand name drug without a generic equivalent, thus my plan must provide coverage of the OrthoEvra patch without cost sharing. Additionally, the FAQ says that the HRSA Guidelines ensure women have access to "the full range of FDA-approved contraceptive methods…as prescribed by a health care provider." My health care provider, [PROVIDER'S NAME], prescribed the OrthoEvra patch as my contraceptive method, and therefore it must be covered without cost sharing.

I have spent [TOTAL AMOUNT] out of pocket on the OrthoEvra patch, despite the fact that it should have been covered without cost sharing. I have attached copies of receipts which document these out of pocket expenses. I expect that [COMPANY NAME] will rectify this situation by ensuring that [NAME OF CONTRACEPTIVE] is covered by my plan without cost sharing in the future, reimbursing me for the out of pocket costs I have incurred during the period it was not covered without cost sharing, and changing any corporate policies that do not comply with the Affordable Care Act.

Sincerely,

[YOUR SIGNATURE]

Encl:

FDA Birth Control Guide (available at: http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf)

Frequently Asked Questions about the Affordable Care Act (Part XII) (available at http://www.dol.gov/ebsa/faqs/faq-aca12.html)

Copies of Receipts Documenting Out of Pocket Costs

Instructions For Sending An Appeal Letter: IUD

ADDRESSING THE LETTER

- Contact your insurer to find out to whom you should send your appeal.
- If you are given an appeal form, it will include the address for the person to whom you should send your appeal.
- In addition, if you are in an employer-based plan, you can send a copy of the appeal letter and form to your insurance plan's Plan Administrator.
    - The contact information for your Plan Administrator can be found in the Summary Plan Description.
    - If you are in an employer-sponsored plan and you are comfortable doing so, you should give a copy to the person who manages employee benefits in your HR department.

COMPLETING THE LETTER

- Complete every field of the form letter that appears in capital letters with the information specific to your situation (for example, YOUR NAME, POLICY NUMBER, etc.) For a Word version of the letter, please visit: www.nwlc.org/preventiveservices.
- If you have already had your IUD inserted, use Last Paragraph Option (1). Also, make sure you have documentation of the costs you've incurred (such as receipts or an explanation of benefits from your insurer) and attach copies of the documentation.
- If your plan did not cover without co-pays any part of your visit for insertion or your follow-up visit, include information about that visit.
- If you have not yet had your IUD inserted, use Last Paragraph Option (2).
- Be sure to attach a copy of the FDA's "Birth Control Guide" to the letter - a copy appears on the last page of this toolkit and you can print a copy here: http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf
- Be sure to attach a copy of the "Frequently Asked Questions" to the letter – you can print a copy here: http://www.dol.gov/ebsa/pdf/faq-aca12.pdf.

CREATING A RECORD OF YOUR LETTER

- Make a copy of the letter and keep it in your files.

AFTER YOU SEND YOUR LETTER

- Continue to keep copies of receipts or other documents that show when you have had to pay out-of-pocket for your IUD or related services.
- Please let us know if you receive a reply from your insurance company. We are keeping track of how insurers respond.

For a Word version of the letter, please visit: **www.nwlc.org/preventiveservices**

IF YOU HAVE ANY QUESTIONS, CONTACT THE NATIONAL WOMEN'S LAW CENTER AT 1-866-PILL4US or PILL4US@NWLC.ORG.

Sample Letter: IUD

[NAME]

[ADDRESS]

[DATE]

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. My health care provider has prescribed the contraceptive [MIRENA/SKYLA/PARAGARD], an intrauterine device (IUD). The Patient Protection and Affordable Care Act requires that my insurance provide coverage of this contraceptive with no cost sharing, however [I have been asked to pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] to obtain my contraception] OR [I have been told that [COMPANY NAME] will not provide coverage of this IUD without cost sharing].

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Services Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall provide coverage of and not impose cost sharing for certain preventive services for women. The list of women's preventive services which must be covered in plan years starting after Aug. 1, 2012 includes "all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity." (http://www.hrsa.gov/womensguidelines/) These methods are listed in the Food and Drug Administration's "Birth Control Guide." (Attached) My health insurance plan is non-grandfathered. Thus, the plan must comply with the women's preventive services.

Specifically, the plan must provide coverage without cost sharing of the IUD which has been prescribed to me. The ACA requires plans to provide coverage without cost sharing of all FDA approved contraceptive methods. The Food and Drug Administration's "Birth Control Guide" indicates that the [IUD WITH PROGESTIN/COPPER IUD] is a unique contraceptive method. Therefore, the [IUD WITH PROGESTIN/COPPER IUD] is one of the methods which plans must cover without cost sharing. Furthermore, on Feb. 20, 2013, the Departments of Labor and Health and Human Services and the Treasury released a set of "Frequently Asked Questions" which affirmed that the ACA's women's preventive services requirement requires plans to provide coverage of IUDs. The FAQ says. "Are intrauterine devices and implants contraceptive methods under the HRSA Guidelines and therefore required to be
covered without cost sharing? Yes." (see Question 17 in enclosed FAQ) [MIRENA/SKYLA/PARAGARD] is an IUD and a contraceptive method under the HRSA Guidelines, and therefore must be covered without cost sharing.

Furthermore, the FAQ affirmed that the women's preventive services requirement requires plans to provide coverage of all brand-name forms of contraception that do not have a generic equivalent. The FAQ says, "If, however, a generic version is not available,…then a plan or issuer must provide coverage for the brand name drug in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management)." (see Question 14 in enclosed FAQ.) According to the Food and Drug Administration, there is currently no generic equivalent available for [MIRENA/SKYLA/PARAGARD]. Therefore, the plan must provide coverage of [MIRENA/SKYLA/PARAGARD] without cost sharing.

Additionally, the FAQ affirmed that the HRSA Guidelines include "services related to follow-up and management of side effects, counseling for continued adherence, and for device removal" and therefore these services must be covered without cost sharing. Therefore the plan must provide coverage of [TYPE OF VISIT] that [OCCURRED/WILL OCCUR] at the office of [PROVIDER'S NAME] on [DATE]. I spent [DOLLAR AMOUNT] out-of-pocket in relation to that visit and documentation of those fees are attached to this letter.

LAST PARAGRAPH OPTIONS:

(1)

I have spent [TOTAL AMOUNT] out of pocket on [MIRENA/SKYLA/PARAGARD], despite the fact that it should have been covered without cost sharing. I have attached copies of receipts which document these out of pocket expenses. I expect that [COMPANY NAME] will rectify this situation by ensuring that [MIRENA/SKYLA/PARAGARD] is covered by my plan without cost sharing in the future, reimbursing me for the out of pocket costs I have incurred during the period it was not covered without cost sharing, and changing any corporate policies that do not comply with the Affordable Care Act.

(2)

My health care provider is prepared to insert the IUD when [COMPANY NAME] assures that I have coverage without cost sharing. I expect that [COMPANY NAME] will rectify this situation and notify me within 30 days of receipt of this letter that [MIRENA/SKYLA/PARAGARD] will be covered without cost sharing.

Sincerely,

[YOUR SIGNATURE]

Encl:

FDA Birth Control Guide (available at: http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf)

Frequently Asked Questions about the Affordable Care Act (Part XII) (available at http://www.dol.gov/ebsa/faqs/faq-aca12.html)

Copies of Receipts Documenting Out of Pocket Costs

Instructions For Sending An Appeal Letter: Female Sterilization

ADDRESSING THE LETTER

- Contact your insurer to find out to whom you should send your appeal.
- If you are given an appeal form, it will include the address for the person to whom you should send your appeal.
- In addition, if you are in an employer-based plan, you can send a copy of the appeal letter and form to your insurance plan's Plan Administrator.
  - The contact information for your Plan Administrator can be found in the Summary Plan Description.
  - If you are in an employer-sponsored plan and you are comfortable doing so, you should give a copy to the person who manages employee benefits in your HR department.

COMPLETING THE LETTER

- Complete every field of the form letter that appears in capital letters with the information specific to your situation (for example, YOUR NAME, POLICY NUMBER, etc.)
- If you have already had your sterilization procedure, use Last Paragraph Option (1). Also, make sure you have documentation of the costs you've incurred (such as receipts or an explanation of benefits from your insurer) and attach copies of the documentation.
- If your plan did not cover without co-pays any part of your follow-up visit, include information about that visit.
- If you have not yet had your sterilization procedure, use Last Paragraph Option (2).
- Be sure to attach a copy of the FDA's "Birth Control Guide" to the letter – a copy appears on the last page of this toolkit and you can print a copy here: http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf
- Be sure to attach a copy of the "Frequently Asked Questions" to the letter – you can print a copy here: http://www.dol.gov/ebsa/pdf/faq-aca12.pdf.

CREATING A RECORD OF YOUR LETTER

- Make a copy of the letter and keep it in your files.

AFTER YOU SEND YOUR LETTER

- Continue to keep copies of receipts or other documents that show when you have had to pay out-of-pocket for your sterilization procedure or related services.
- Please let us know if you receive a reply from your insurance company. We are keeping track of how insurers respond.

For a Word version of the letter, please visit: **www.nwlc.org/preventiveservices**

IF YOU HAVE ANY QUESTIONS, CONTACT THE NATIONAL WOMEN'S LAW CENTER AT 1-866-PILL4US or PILL4US@NWLC.ORG.

Sample Letter: Female Sterilization

[NAME]

[ADDRESS]

[DATE]

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. My health care provider [HAS PERFORMED/ WILL PERFORM] a [STERILIZATION SURGERY FOR WOMEN/SURGICAL STERILIZATION IMPLANT FOR WOMEN (ESSURE)] on [DATE]. The Patient Protection and Affordable Care Act requires that my insurance provide coverage of this sterilization procedure with no cost sharing, however [I have been asked to pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] for this procedure] OR [I have been told that [COMPANY NAME] will not provide coverage of this this procedure without cost sharing].

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Services Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall provide coverage of and not impose cost sharing for certain preventive services for women. The list of women's preventive services which must be covered in plan years starting after Aug. 1, 2012 includes "all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity." (http://www.hrsa.gov/womensguidelines/) These methods are listed in the Food and Drug Administration's "Birth Control Guide." (Attached) My health insurance plan is non-grandfathered. Thus, the plan must comply with the women's preventive services.

Specifically, the plan must provide coverage without cost sharing of the sterilization procedure which my provider [HAS PERFORMED/WILL PERFORM]. The ACA requires plans to provide coverage without cost sharing of all FDA approved contraceptive methods and sterilization procedures. Furthermore, the Food and Drug Administration's "Birth Control Guide" indicates that the [STERILIZATION SURGERY FOR WOMEN/ SURGICAL STERILIZATION IMPLANT FOR WOMEN (ESSURE)] is a unique contraceptive method. Therefore, the [STERILIZATION SURGERY FOR WOMEN/SURGICAL STERILIZATION IMPLANT FOR WOMEN (ESSURE)] is one of the methods which plans must cover without cost sharing.

On Feb. 20, 2013, the Departments of Labor and Health and Human Services and the Treasury released a set of "Frequently Asked Questions" which affirmed that the HRSA Guidelines include "services related to follow-up and management of side effects, counseling for continued adherence, and for device removal" and therefore these services must be covered without cost sharing. Therefore the plan must provide coverage of [TYPE OF VISIT] that [OCCURRED/WILL OCCUR] at the office of [PROVIDER'S NAME] on [DATE]. I spent [DOLLAR AMOUNT] out-of-pocket in relation to that visit and documentation of those fees are attached to this letter.

LAST PARAGRAPH OPTIONS:

(1)

I have spent [TOTAL AMOUNT] out of pocket on [STERILIZATION SURGERY FOR WOMEN/SURGICAL STERILIZATION IMPLANT FOR WOMEN (ESSURE)], despite the fact that it should have been covered without cost sharing. I have attached copies of receipts which document these out of pocket expenses. I expect that [COMPANY NAME] will rectify this situation by ensuring that [STERILIZATION SURGERY FOR WOMEN/SURGICAL STERILIZATION IMPLANT FOR WOMEN (ESSURE)] is covered by my plan without cost sharing in the future, reimbursing me for the out of pocket costs I have incurred during the period it was not covered without cost sharing, and changing any corporate policies that do not comply with the Affordable Care Act.

(2)

My health care provider is prepared to perform the [STERILIZATION SURGERY FOR WOMEN/SURGICAL STERILIZATION IMPLANT FOR WOMEN (ESSURE)] when [COMPANY NAME] assures that I have coverage without cost sharing. I expect that [COMPANY NAME] will rectify this situation and notify me within 30 days of receipt of this letter that [STERILIZATION SURGERY FOR WOMEN/SURGICAL STERILIZATION IMPLANT FOR WOMEN (ESSURE)] will be covered without cost sharing.

Sincerely,

[YOUR SIGNATURE]

Encl:

FDA Birth Control Guide (available at: http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf)

Frequently Asked Questions about the Affordable Care Act (Part XII) (available at http://www.dol.gov/ebsa/faqs/faq-aca12.html)

Copies of Receipts Documenting Out of Pocket Costs

Instructions For Sending An Appeal Letter: Generics

ADDRESSING THE LETTER

- Contact your insurer to find out to whom you should send your appeal.
- If you are given an appeal form, it will include the address for the person to whom you should send your appeal.
- In addition, if you are in an employer-based plan, you can send a copy of the appeal letter and form to your insurance plan's Plan Administrator.
  - The contact information for your Plan Administrator can be found in the Summary Plan Description.
  - If you are in an employer-sponsored plan and you are comfortable doing so, you should give a copy to the person who manages employee benefits in your HR department.

COMPLETING THE LETTER

- Complete every field of the form letter that appears in capital letters with the information specific to your situation (for example, YOUR NAME, POLICY NUMBER, etc.) For a Word version of the letter, please visit: www.nwlc.org/preventiveservices.
- Make sure you have documentation of the costs you've incurred for your birth control (such as receipts from the pharmacy) and attach copies of the documentation.
- If the birth control that you are on has no generic equivalent, include the paragraph in the letter which begins "Furthermore, the FAQs affirmed that the ACA's women's preventive services requirement…"
- Be sure to attach a copy of the FDA's "Birth Control Guide" to the letter - a copy appears on the last page of this toolkit and you can print a copy here: http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf
- Be sure to attach a copy of the "Frequently Asked Questions" to the letter – you can print a copy here: http://www.dol.gov/ebsa/pdf/faq-aca12.pdf.

CREATING A RECORD OF YOUR LETTER

- Make a copy of the letter and keep it in your files.

AFTER YOU SEND YOUR LETTER

- Continue to keep copies of receipts or other documents that show when you have had to pay out-of-pocket for your birth control.
- Please let us know if you receive a reply from your insurance company. We are keeping track of how insurers respond.

For a Word version of the letter, please visit: **www.nwlc.org/preventiveservices**

IF YOU HAVE ANY QUESTIONS, CONTACT THE NATIONAL WOMEN'S LAW CENTER AT 1-866-PILL4US or PILL4US@NWLC.ORG.

Sample Letter: Generics

[NAME]

[ADDRESS]

[DATE]

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. My health care provider has prescribed the contraceptive [NAME OF CONTRACEPTIVE]. The Patient Protection and Affordable Care Act requires that my insurance provide coverage of this contraceptive with no cost sharing, however I have been asked to pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] to obtain my contraception.

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Services Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall provide coverage of and not impose cost sharing for certain preventive services for women. The list of women's preventive services which must be covered in plan years starting after Aug. 1, 2012 includes "all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity." (http://www.hrsa.gov/womensguidelines/) These methods are listed in the Food and Drug Administration's "Birth Control Guide." (Attached) My health insurance plan is non-grandfathered. Thus, the plan must comply with the women's preventive services.

Specifically, the plan must provide coverage without cost sharing of [NAME OF CONTRACEPTIVE] which has been prescribed to me. On Feb. 20, 2013, the Departments of Labor and Health and Human Services and the Treasury released a set of "Frequently Asked Questions" which affirmed that under the ACA's women's preventives services, plans cannot limit their coverage of contraceptives to only oral contraceptives. In response to the question, "May a plan or issuer cover only oral contraceptives?" the FAQs unequivocally answer, "No." The FAQs go on to state, "The HRSA Guidelines ensure women's access to the full range of FDA-approved contraceptive methods including, but not limited to, barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider." (emphasis added, see Question 14 in enclosed FAQ.) [INSURANCE COMPANY NAME]'s current policy of only providing coverage of [GENERIC ORAL CONTRACEPTIVES/ORAL CONTRACEPTIVES] is in violation of the clear statement in the FAQs that the full range of FDA-approved contraceptives must be covered. Additionally, the FAQs emphasize that plans must cover contraceptive methods as prescribed by a health care provider. My health care provider, [PROVIDER'S NAME], prescribed [NAME OF CONTRACEPTIVE] as my contraceptive method, and therefore it must be covered without cost sharing.

[ADD THIS PARAGRAPH IF YOUR METHOD HAS NO GENERIC EQUIVALENT]

Furthermore, the FAQs affirmed that the ACA's women's preventive services requirement requires plans to provide coverage of all brand-name forms of contraception that do not have a generic equivalent. The FAQ says, "If, however, a generic version is not available,…then a plan or issuer must provide coverage for the brand name drug in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management)." (see Question 14 in enclosed FAQ.) [NAME OF CONTRACEPTIVE] is a brand name drug without a generic equivalent, thus my plan must provide coverage of [NAME OF CONTRACEPTIVE] without cost sharing.

I have spent [TOTAL AMOUNT] out of pocket on [NAME OF CONTRACEPTIVE], despite the fact that it should have been covered without cost sharing. I have attached copies of receipts which document these out of pocket expenses. I expect that [COMPANY NAME] will rectify this situation by ensuring that [NAME OF CONTRACEPTIVE] is covered by my plan without cost sharing in the future, reimbursing me for the out of pocket costs I have incurred during the period it was not covered without cost sharing, and changing any corporate policies that do not comply with the Affordable Care Act.

Sincerely,

[YOUR SIGNATURE]

Encl:

FDA Birth Control Guide (available at: http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf)

Frequently Asked Questions about the Affordable Care Act (Part XII) (available at http://www.dol.gov/ebsa/faqs/faq-aca12.html)

Copies of Receipts Documenting Out of Pocket Costs

Instructions For Sending An Appeal Letter: Breastfeeding Supports and Supplies

ADDRESSING THE LETTER

- Contact your insurer to find out to whom you should send your appeal.
- If you are given an appeal form, it will include the address for the person to whom you should send your appeal.
- In addition, if you are in an employer-based plan, you can send a copy of the appeal letter and form to your insurance plan's Plan Administrator.
  - The contact information for your Plan Administrator can be found in the Summary Plan Description.
  - If you are in an employer-sponsored plan and you are comfortable doing so, you should give a copy to the person who manages employee benefits in your HR department.

COMPLETING THE LETTER

- Complete every field of the form letter that appears in capital letters with the information specific to your situation (for example, YOUR NAME, POLICY NUMBER, etc.) For a Word version of the letter, please visit: www.nwlc.org/preventiveservices.
- If your insurance plan does not have a clear process in pace to get a breast pump, such as working with a durable medical equipment (DME) supplier or ordering through your mail-order pharmacy benefits, include the paragraph beginning "My physician has prescribed…" in your letter.
- If you have already purchased your breast pump, use Last Paragraph Option (1). Also, make sure you have documentation of the costs you've incurred (such as receipts or an explanation of benefits from your insurer) and attach copies of the documentation.
- If you have not yet purchased your breast pump, use Last Paragraph Option (2).
- Be sure to attach a copy of the "Frequently Asked Questions" to the letter – you can print a copy here: http://www.dol.gov/ebsa/pdf/faq-aca12.pdf.

CREATING A RECORD OF YOUR LETTER

- Make a copy of the letter and keep it in your files.

AFTER YOU SEND YOUR LETTER

- Continue to keep copies of receipts or other documents that show when you have had to pay out-of-pocket for your breast pump or related services.
- Please let us know if you receive a reply from your insurance company. We are keeping track of how insurers respond.

For a Word version of the letter, please visit: **www.nwlc.org/preventiveservices**

IF YOU HAVE ANY QUESTIONS, CONTACT THE NATIONAL WOMEN'S LAW CENTER AT 1-866-PILL4US or PILL4US@NWLC.ORG.

Sample Letter: Breastfeeding Supports and Supplies

[NAME]
[ADDRESS]
[DATE]

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. I recently tried to purchase a breast pump through my health insurance. The Patient Protection and Affordable Care Act requires that my insurance coverage of this preventive service be with no cost sharing. However, when I contacted [INSURANCE COMPANY NAME] about the coverage, I was told I could not get coverage of [BREAST PUMP REQUESTED].

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Services Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall provide coverage of certain preventive services for women with no cost sharing. The list of women's preventive services which must be covered in plan years starting after Aug. 1, 2012 includes "comprehensive lactation support and counseling and costs of renting or purchasing breastfeeding equipment [] for the duration of breastfeeding"." (http://www.dol.gov/ebsa/pdf/faq-aca12.pdf) My health insurance plan is non-grandfathered. Thus, the plan must comply with the women's preventive services provision.

[INCLUDE THIS PARAGRAPH IF YOUR PLAN DOES NOT HAVE A CLEAR PROCESS TO GET A PUMP] My physician has prescribed that I use [BREAST PUMP REQUESTED]. The insurance plan has not established a process for me to obtain a pump, such as through a durable medical equipment supplier, and thus it remains an over-the-counter product for the purposes of my plan. As the FAQs on the preventive services (dated February 20, 2013) state, "OTC recommended items and services must be covered without cost-sharing…when prescribed by a health care provider." Accordingly, [INSURANCE COMPANY] must cover [BREAST PUMP REQUESTED] as required under the Affordable Care Act.

LAST PARAGRAPH OPTIONS:

(1)

I have spent [TOTAL AMOUNT] out of pocket on [NAME OF PREVENTIVE SERVICE], despite the fact that it should have been covered. I have attached copies of receipts which document these out of pocket expenses. I expect that [COMPANY NAME] will rectify this situation by ensuring that [NAME OF PREVENTIVE SERVICE] is covered by my plan without cost sharing in the future, reimbursing me for the out of pocket costs I have incurred during the period it was not covered without cost sharing, and changing any corporate policies that do not comply with the Affordable Care Act.

(2)

I am prepared to order [BREAST PUMP REQUESTED] when [COMPANY NAME] assures that I have coverage without cost sharing. I expect that [COMPANY NAME] will rectify this situation and notify me within 30 days of receipt of this letter that [BREAST PUMP REQUESTED] will be covered without cost sharing.

Sincerely,

[YOUR SIGNATURE]

Encl:

Frequently Asked Questions about the Affordable Care Act (Part XII) (available at http://www.dol.gov/ebsa/faqs/faq-aca12.html)

Copies of Receipts Documenting Out of Pocket Costs

Instructions For Sending An Appeal Letter: BRCA Testing

ADDRESSING THE LETTER

- Contact your insurer to find out to whom you should send your appeal.
- If you are given an appeal form, it will include the address for the person to whom you should send your appeal.
- In addition, if you are in an employer-based plan, you can send a copy of the appeal letter and form to your insurance plan's Plan Administrator.
  - The contact information for your Plan Administrator can be found in the Summary Plan Description.
  - If you are in an employer-sponsored plan and you are comfortable doing so, you should give a copy to the person who manages employee benefits in your HR department.

COMPLETING THE LETTER

- Complete every field of the form letter that appears in capital letters with the information specific to your situation (for example, YOUR NAME, POLICY NUMBER, etc.) For a Word version of the letter, please visit: www.nwlc.org/preventiveservices.
- Make sure you have documentation of the costs you've incurred for your BRCA testing (such as an explanation of benefits from your insurance company) and attach copies of the documentation.
- Be sure to attach a copy of the "Frequently Asked Questions" to the letter – you can print a copy here: http://www.dol.gov/ebsa/pdf/faq-aca12.pdf.

CREATING A RECORD OF YOUR LETTER

- Make a copy of the letter and keep it in your files.

AFTER YOU SEND YOUR LETTER

- Continue to keep copies of any other documents that show you had to pay out-of-pocket for your BRCA testing.
- Please let us know if you receive a reply from your insurance company. We are keeping track of how insurers respond.

For a Word version of the letter, please visit: **www.nwlc.org/preventiveservices**

IF YOU HAVE ANY QUESTIONS, CONTACT THE NATIONAL WOMEN'S LAW CENTER AT 1-866-PILL4US or PILL4US@NWLC.ORG.

Sample Letter: BRCA Testing

[NAME]

[ADDRESS]

[DATE]

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. I recently visited [NAME OF PROVIDER] for [NAME OF PREVENTIVE SERVICE]. The Patient Protection and Affordable Care Act requires that my insurance coverage of this preventive service be with no cost sharing, however I have been asked to pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] to obtain this service.

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Services Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall cover certain preventive services with no cost sharing. My health insurance plan is non-grandfathered. Thus, the plan must comply with the preventive services provision. Covered services include evidence-based items or services that are rated "A" or "B" by the United States Preventive Services Task Force (USPSTF) and, for women, evidence-informed preventive care and screening provided in guidelines supported by the Health Resources and Services Administration, to the extent not already included in the USPSTF's recommendations.

More specifically, the plan must cover genetic counseling and testing for the breast cancer susceptibility gene (BRCA), including the BRCA test itself, for women with a family history associated with an increased risk for deleterious mutations in the BRCA1 and BRCA2 genes. The USPSTF issued a "B" recommendation for genetic counseling and evaluation for BRCA testing for high-risk women in 2005, while the HRSA guidelines from 2011 include "referral for genetic counseling and BRCA testing, if appropriate." In addition, HHS has determined that clinical experts are responsible for determining which individuals are "high risk." Therefore if my physician determines that I am part of a high-risk population and should receive a preventive service identified for patients at high-risk, my plan is required to cover this service without cost sharing.

I have spent [TOTAL AMOUNT] out-of-pocket on [NAME OF PREVENTIVE SERVICE], despite the fact that it should have been covered without cost sharing. I have attached copies of receipts which document these out-of-pocket expenses. I expect that [COMPANY NAME] will rectify this situation by reimbursing me for the out-of-pocket costs I have incurred during the period [NAME OF PREVENTIVE SERVICE] was not covered without cost sharing and changing any corporate policies that do not comply with the Affordable Care Act.

Sincerely,

[YOUR SIGNATURE]

Encl:

Frequently Asked Questions about the Affordable Care Act (Part XII) (available at http://www.dol.gov/ebsa/faqs/faq-aca12.html)

Copies of Receipts Documenting Out of Pocket Costs

Instructions For Sending An Appeal Letter: Colonoscopy

ADDRESSING THE LETTER

- Contact your insurer to find out to whom you should send your appeal.
- If you are given an appeal form, it will include the address for the person to whom you should send your appeal.
- In addition, if you are in an employer-based plan, you can send a copy of the appeal letter and form to your insurance plan's Plan Administrator.
  - The contact information for your Plan Administrator can be found in the Summary Plan Description.
  - If you are in an employer-sponsored plan and you are comfortable doing so, you should give a copy to the person who manages employee benefits in your HR department.

COMPLETING THE LETTER

- Complete every field of the form letter that appears in capital letters with the information specific to your situation (for example, YOUR NAME, POLICY NUMBER, etc.) For a Word version of the letter, please visit: |www.nwlc.org/preventiveservices.
- Make sure you have documentation of the costs you've incurred for the colonoscopy (such as an explanation of benefits from your insurer) and attach copies of the documentation.
- Be sure to attach a copy of the "Frequently Asked Questions" to the letter – you can print a copy here: http://www.dol.gov/ebsa/pdf/faq-aca12.pdf.

CREATING A RECORD OF YOUR LETTER

- Make a copy of the letter and keep it in your files.

AFTER YOU SEND YOUR LETTER

- Continue to keep copies of receipts or other documents that show when you have had to pay out-of-pocket for the colonoscopy.
- Please let us know if you receive a reply from your insurance company. We are keeping track of how insurers respond.

For a Word version of the letter, please visit: **www.nwlc.org/preventiveservices**

IF YOU HAVE ANY QUESTIONS, CONTACT THE NATIONAL WOMEN'S LAW CENTER AT 1-866-PILL4US or PILL4US@NWLC.ORG.

Sample Letter: Colonoscopy

[NAME]

[ADDRESS]

[DATE]

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. I recently visited [NAME OF PROVIDER] for a colonoscopy. The Patient Protection and Affordable Care Act requires that my insurance coverage of this preventive service be with no cost sharing, however I have been asked to pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] to obtain this service.

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Services Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall provide coverage of certain preventive services with no cost sharing. My health insurance plan is non-grandfathered. Thus, the plan must comply with the preventive services provision. Covered services include evidence-based items or services that are rated "A" or "B" by the United States Preventive Services Task Force (USPSTF).

More specifically, the plan must cover colonoscopy, including polyp removal, with no cost-sharing if the colonoscopy is scheduled and performed as a screening procedure, per the USPSTF recommendations. USPSTF has issued an "A" recommendation for colorectal cancer screening for adults between the ages of 50 and 75; for individuals who undergo screening colonoscopy, USPSTF recommends screening at 10-year intervals. In addition, the Department of Health and Human Services has determined that polyp removal is an integral part of screening colonoscopy, and cannot therefore be subject to cost sharing requirements. (See Question 5 of attached FAQs)

I have spent [TOTAL AMOUNT] out-of-pocket on a colonoscopy, despite the fact that it should have been covered without cost sharing. I have attached copies of receipts which document these out-of-pocket expenses. I expect that [COMPANY NAME] will rectify this situation by ensuring that a colonoscopy is covered by my plan without cost sharing in the future, reimbursing me for the out-of-pocket costs I have incurred during the period it was not covered without cost sharing, and changing any corporate policies that do not comply with the Affordable Care Act.

Sincerely,

[YOUR SIGNATURE]

Encl:

Frequently Asked Questions about the Affordable Care Act (Part XII) (available at http://www.dol.gov/ebsa/faqs/faq-aca12.html)

Copies of Receipts Documenting Out of Pocket Costs

Instructions For Sending An Appeal Letter: Well-Woman Visit

ADDRESSING THE LETTER

- Contact your insurer to find out to whom you should send your appeal.
- If you are given an appeal form, it will include the address for the person to whom you should send your appeal.
- In addition, if you are in an employer-based plan, you can send a copy of the appeal letter and form to your insurance plan's Plan Administrator.
  - The contact information for your Plan Administrator can be found in the Summary Plan Description.
  - If you are in an employer-sponsored plan and you are comfortable doing so, you should give a copy to the person who manages employee benefits in your HR department.

COMPLETING THE LETTER

- Complete every field of the form letter that appears in capital letters with the information specific to your situation (for example, YOUR NAME, POLICY NUMBER, etc.) For a Word version of the letter, please visit: www.nwlc.org/preventiveservices.
- Make sure you have documentation of the costs you've incurred for your well-woman visit (such as an explanation of benefits from your insurance company) and attach copies of the documentation.
- Be sure to attach a copy of the "Frequently Asked Questions" to the letter – you can print a copy here: http://www.dol.gov/ebsa/pdf/faq-aca12.pdf.

CREATING A RECORD OF YOUR LETTER

- Make a copy of the letter and keep it in your files.

AFTER YOU SEND YOUR LETTER

- Continue to keep copies of receipts or other documents that show when you have had to pay out-of-pocket for the well-woman visit.
- Please let us know if you receive a reply from your insurance company. We are keeping track of how insurers respond.

For a Word version of the letter, please visit: **www.nwlc.org/preventiveservices**

IF YOU HAVE ANY QUESTIONS, CONTACT THE NATIONAL WOMEN'S LAW CENTER AT 1-866-PILL4US OR PILL4US@NWLC.ORG.

Sample Letter: Well-Woman Visit

[NAME]

[ADDRESS]

[DATE]

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. I recently visited [NAME OF PROVIDER] for a well-woman visit. The Patient Protection and Affordable Care Act requires that my insurance coverage of this preventive service be with no cost sharing, however I was asked to pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] to obtain this service.

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Service Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall provide coverage of certain preventive services with no cost sharing requirements. (42 U.S.C. § 300gg-13) The list of women's preventive services which must be covered in plan years starting after Aug. 1, 2012 includes well-women preventive care visits (http://www.hrsa.gov/womensguidelines/) My health insurance plan is non-grandfathered. Thus, the plan must comply with the women's preventive services.

The Affordable Care Act defines "cost-sharing" to include "deductibles, coinsurance, copayments, or similar charges." (42 U.S.C. § 18022(c)(3)(A)(i)) Furthermore, the regulations implementing § 2713 state, "a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide coverage for all of the [preventive services], and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services." (45 C.F.R. 147.130) Thus, both the statute and the regulations implementing it explicitly state that a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] is a form of cost sharing and should not be imposed on preventive services. However, [NAME OF INSURANCE COMPANY]'s current policy requires that I pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] for a well-woman visit. This policy is in violation of the Affordable Care Act's preventive services provision.

I have spent [TOTAL AMOUNT] out of pocket on well-woman visits, despite the fact that it should have been covered without cost sharing. I have attached copies of receipts which document these out of pocket expenses. I expect that [COMPANY NAME] will rectify this situation by ensuring that well-woman visits are covered by my plan without cost sharing in the future, reimbursing me for the out of pocket costs I have incurred during the period it was not covered without cost sharing, and changing any corporate policies that do not comply with the Affordable Care Act.

Sincerely,

[YOUR SIGNATURE]

Encl: Copies of Receipts Documenting Out of Pocket Costs

Sample Letter: Multiple Well-Woman Visits

[NAME]

[ADDRESS]

[DATE]

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. I recently visited [NAME OF PROVIDER] for a well-woman visit. The Patient Protection and Affordable Care Act requires that my insurance coverage of this preventive service be with no cost sharing, however I was asked to pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] to obtain this service.

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Service Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall provide coverage of certain preventive services with no cost sharing requirements. (42 U.S.C. § 300gg-13) The list of women's preventive services which must be covered in plan years starting after Aug. 1, 2012 includes well-women preventive care visits (http://www.hrsa.gov/womensguidelines/) My health insurance plan is non-grandfathered. Thus, the plan must comply with the women's preventive services.

Specifically, the plan must provide coverage for multiple well-woman visits if they are necessary to obtain all appropriate services. On Feb. 20, 2013, the Departments of Labor and Health and Human Services and the Treasury released a set of "Frequently Asked Questions" which affirmed that under the ACA's women's preventives services, multiple well-woman visits must be covered without cost-sharing if indicated by the clinician. In response to the question, "What is included in a well-woman visit?" the FAQs states, "HHS understands that additional well-woman visits, provided without cost-sharing, may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors. If the clinician determines that a patient requires additional well-woman visits for this purpose, then the additional visits must be provided in accordance with the requirements of the interim final regulations." [INSURANCE COMPANY NAME]'s current policy of only providing coverage for one well-woman visit a year is in violation of the clear statement in the FAQs.

I have spent [TOTAL AMOUNT] out of pocket on well-woman visits, despite the fact that these visits should have been covered without cost sharing. I have attached copies of receipts which document my out of pocket expenses. I expect that [COMPANY NAME] will rectify this situation by ensuring that multiple well-woman visits are covered by my plan without cost sharing in the future, reimbursing me for the out of pocket costs I have incurred during the period it was not covered without cost sharing, and changing any corporate policies that do not comply with the Affordable Care Act.

Sincerely,

[YOUR SIGNATURE]

Encl: Copies of Receipts Documenting Out of Pocket Costs

Sample Letter:
Well-Woman Visit - Prenatal Care

[NAME]

[ADDRESS]

[DATE]

To Whom It May Concern:

I am enrolled in a [INSURANCE COMPANY NAME] plan, policy number [POLICY NUMBER]. I recently visited [NAME OF PROVIDER] for a prenatal care visit. The Patient Protection and Affordable Care Act requires that my insurance coverage of this preventive service be with no cost sharing, however I was asked to pay a [CO-PAY/DEDUCTIBLE/CO-INSURANCE] to obtain this service.

Under § 1001 of the Patient Protection and Affordable Care Act (ACA), which amends § 2713 of the Public Health Service Act, all non-grandfathered group health plans and health insurance issuers offering group or individual coverage shall provide coverage of certain preventive services with no cost sharing requirements. (42 U.S.C. § 300gg-13) The list of women's preventive services which must be covered in plan years starting after Aug. 1, 2012 includes well-women preventive care visits (http://www.hrsa.gov/womensguidelines/) My health insurance plan is non-grandfathered. Thus, the plan must comply with the women's preventive services.

Specifically, the plan must provide coverage without cost sharing for prenatal care visits. On Feb. 20, 2013, the Departments of Labor and Health and Human Services and the Treasury released a set of "Frequently Asked Questions" which affirmed that under the ACA's women's preventives services, prenatal care is considered part of a well-woman visit and prenatal visits should be covered without cost-sharing. In response to the question, "What is included in a well-woman visit?" the FAQs states, "The HRSA Guidelines recommend at least one annual well-woman preventive care visit for adult women to obtain the recommended preventive services that are age- and developmentally-appropriate, including preconception and prenatal care." The FAQ also recognizes the need for multiple visits, stating, "additional well-woman visits, provided without cost-sharing, may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors. If the clinician determines that a patient requires additional well-woman visits for this purpose, then the additional visits must be provided in accordance with the requirements of the interim final regulations." [INSURANCE COMPANY NAME]'s current policy of not covering all necessary prenatal care visits without cost-sharing is in violation of the clear statement in the FAQs.

I have spent [TOTAL AMOUNT] out of pocket on prenatal care visits, despite the fact that it should have been covered without cost sharing. I have attached copies of receipts which document these out of pocket expenses. I expect that [COMPANY NAME] will rectify this situation by ensuring that multiple well-woman visits are covered by my plan without cost sharing in the future, reimbursing me for the out of pocket costs I have incurred during the period it was not covered without cost sharing, and changing any corporate policies that do not comply with the Affordable Care Act.

Sincerely,

[YOUR SIGNATURE]

Encl: Copies of Receipts Documenting Out of Pocket Costs

Medicines To Help You

BIRTH CONTROL GUIDE

Most Effective

Methods	Number of pregnancies expected per 100 women*	Use	Some Risks
Sterilization Surgery for Women	less than 1	Onetime procedure Permanent	• Pain • Bleeding • Infection or other complications after surgery • Ectopic (tubal) pregnancy
Surgical Sterilization Implant for Women	less than 1	Onetime procedure Waiting period before it works Permanent	• Mild to moderate pain after insertion • Ectopic (tubal) pregnancy
Sterilization Surgery for Men	less than 1	Onetime procedure Waiting period before it works Permanent	• Pain • Bleeding • Infection
Implantable Rod	less than 1	Inserted by a healthcare provider Lasts up to 3 years	• Changes in bleeding patterns • Weight gain • Breast and abdominal pain
IUD Copper	less than 1	Inserted by a healthcare provider Lasts up to 10 years	• Cramps • Bleeding • Pelvic inflammatory disease • Infertility • Tear or hole in the uterus
IUD w/ Progestin	less than 1	Inserted by a healthcare provider Lasts up to 3-5 years, depending on the type	• Irregular bleeding • No periods • Abdominal/pelvic pain • Ovarian cysts
Shot/Injection	6	Need a shot every 3 months	• Bone loss • Bleeding between periods • Weight gain • Nervousness • Abdominal discomfort • Headaches
Oral Contraceptives (Combined Pill) "The Pill"	9	Must swallow a pill every day	• Nausea • Breast Tenderness • Headache • Rare: high blood pressure, blood clots, heart attack, stroke
Oral Contraceptives (Progestin only) "The MiniPill"	9	Must swallow a pill every day	• Irregular bleeding • Headache • Breast tenderness • Nausea • Dizziness
Oral Contraceptives Extended/Continuous Use "The Pill"	9	Must swallow a pill every day.	• Risks are similar to other oral contraceptives (combined) • Light bleeding or spotting between periods
Patch	9	Put on a new patch each week for 3 weeks (21 total days). Don't put on a patch during the fourth week.	• Exposure to higher average levels of estrogen than most oral contraceptives
Vaginal Contraceptive Ring	9	Put the ring into the vagina yourself. Keep the ring in your vagina for 3 weeks and then take it out for one week.	• Vaginal discharge • Discomfort in the vagina • Mild irritation • Risks are similar to oral contraceptives (combined)
Diaphragm with Spermicide	12	Must use every time you have sex.	• Irritation • Allergic reactions • Urinary tract infection • Toxic shock
Sponge with Spermicide	12-24	Must use every time you have sex.	• Irritation • Allergic reactions • Hard time removing • Toxic shock
Cervical Cap with Spermicide	17-23	Must use every time you have sex.	• Irritation • Allergic reactions • Abnormal Pap test • Toxic shock
Male Condom	18	Must use every time you have sex. Except for abstinence, latex condoms are the best protection against HIV/AIDS and other STIs.	• Allergic reactions
Female Condom	21	Must use every time you have sex. May give some protection against STIs.	• Irritation • Allergic reactions
Spermicide Alone	28	Must use every time you have sex.	• Irritation • Allergic reactions • Urinary tract infection
Emergency Contraception — If your primary method of birth control fails			
Plan B Plan B One Step Next Choice	7 out of every 8 women who would have gotten pregnant will not become pregnant after taking Plan B, Plan B One-Step, or Next Choice	Swallow the pills within 3 days after having unprotected sex.	• Nausea • Vomiting • Abdominal pain • Fatigue • Headache
Ella	6 or 7 out of every 10 women who would have gotten pregnant will not become pregnant after taking Ella.	Swallow the pill within 5 days after having unprotected sex.	• Headache • Nausea • Abdominal pain • Menstrual pain • Tiredness • Dizziness

Least Effective

*effectiveness of the different methods during typical/actual use (including sometimes using a method in a way that is not correct or not consistent) http://www.fda.gov/birthcontrol

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

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