Status Report on Insurers' Degree of Compliance with the Oregon Reproductive Health Equity Act

As required by 2017 House Bill 3391

House Bill 3391 (2017) Report – Executive Summary

Executive Summary

Section 2 of the Reproductive Health Equity Act[1] (RHEA) requires health benefit plans in Oregon to provide a wide range of reproductive health services to their members without cost-sharing. In addition to the law's requirement to cover these services, health benefit plans are prohibited from imposing prior authorization or other utilization control techniques for FDA-approved contraceptive drugs, devices or other products.

Section 3 of RHEA requires DCBS to report to the interim committees of the Legislative Assembly related to health on the degree of compliance with section 2 of RHEA and of any actions taken to enforce compliance with the requirements of that section.

This report is necessarily a status report on compliance to date. State-regulated, large group plans have not yet had to renew their policies, so a substantial portion of the commercial market has not yet had to comply with RHEA. Health benefit plans offered by employers may be issued or renewed at any time of year. It is not uncommon for plans to have their annual renewal date in the fall. For such plans, the coverage requirements of RHEA are not yet in effect as of the time of this report, and will go into effect upon renewal. Through experience in other areas of insurance regulation, DFR estimates that up to 40% of large group plans renew in the fourth quarter.

Since January 1, 2019, DCBS has received three consumer complaints related to the coverage requirements of RHEA. However, in the case of two of these complaints, the law's requirements did not apply. In one case, the consumer was covered by a self-insured employer plan exempt from state regulation, and in the other case, the plan had not yet renewed in 2019, so the law's requirements had yet to go into effect. In the final case, the health insurance carrier's decision was overturned and coverage was made available without cost-sharing as required by the law.

Next Steps for DCBS

Issue the data call: DCBS will issue a data call Q1 2020, once all relevant plans have been modified or renewed. Carriers will have opportunities to ask questions and engage with the department through the process. While any individual results in the data call will be confidential, an aggregate report could be made available outlining the department's findings.

Work with the Oregon Health Authority to obtain APAC data. DCBS currently is a signatory to several data use agreements for APAC data, including for rate review and surprise billing

[1] 2017 Or Laws ch 721, codified at ORS 743A.067.

benchmarking. OHA is a willing and engaging partner in data sharing, and DCBS looks forward to more collaboration.

Process for provider complaints: DCBS is already in process of working with providers to ensure that their patients have the opportunity to report information to us regarding cost sharing and coverage issues. DCBS' insurance expertise will both help individual patients as well as giving the department a sense of what is occurring in the market.

Next update prior to 2021 session. DCBS commits to updating this report by Q3 2020, so as to help inform any policy conversation that may need to occur during the 2021 legislative session.

House Bill 3391 (2017) Report

Introduction

The Department of Consumer and Business Services appreciates the opportunity to report to the Legislative Assembly on the degree of compliance with Oregon's Reproductive Health Equity Act.[2] As will be discussed below, this report is necessarily a status report on compliance to date. State-regulated, large group plans have not yet had to renew their policies, so a substantial portion of the commercial market has not yet had to comply with RHEA. This report discusses what steps we have taken, and details DCBS' future plans to test compliance with RHEA once commercial carriers fully implemented the law.

1. Background

a. Commercial Health Insurance in Oregon: Individual, Small-Group and Large Group Plans

Rates and forms for individual and small group health benefit plans are required to be submitted to DCBS on an annual basis before they are offered to consumers. For example, forms for individual and small group dental plans to be offered starting in January 2020 had to be submitted for our review and approval no later than March 5, 2019. Individual medical plans had to be submitted by May 13, 2019, and small group medical plans had a submission deadline of May 1, 2019.

Individual and small group health benefit plans have a regimented timeline for review because plan renewal dates are consistent. Individual health benefit plans renew on January 1st of each year. Small group health benefit plans renew quarterly on the group's anniversary date. Large group health benefit plans, however, renew throughout the year on the groups' own schedules. While large group plans renew on a less precise timeline, those forms still are required to be reviewed and approved by DCBS before they can be sold.

b. The Oregon Reproductive Health Equity Act

Section 2 of RHEA requires health benefit plans in Oregon to provide a wide range of reproductive health services to their members without cost-sharing. In addition to the law's requirement to cover these services, health benefit plans are prohibited from imposing prior authorization or other utilization control techniques for FDA-approved contraceptive drugs, devices or other products – whether prescribed or acquired over the counter. Plans are also prohibited from imposing any other restrictions or delays on the coverage required by the law. Plans are permitted to use reasonable medical management techniques to determine the frequency, method, treatment or setting for the coverage, provided that these techniques do not amount to prohibited restrictions or to the wholesale or indiscriminate denial of coverage for a required service.

[2] 2017 Or Laws ch 721, codified at ORS 743A.067. For the rest of this report, we use RHEA to mean the Reproductive Health Equity Act.

If the services required by the law are provided by an out-of-network health care provider, health benefit plans are required to cover the required services without cost-sharing if there is no geographically accessible in-network provider available and willing to provide the service in a timely manner. Plans are required to make information about the coverage required by the law available to enrollees and potential enrollees on the insurer's website, and in writing upon request.

Section 3 of RHEA requires DCBS to report to the interim committees of the Legislative Assembly related to health on the degree of compliance with section 2 of RHEA and of any actions taken to enforce compliance with the requirements of that section.

c. Applicability of RHEA

RHEA applied to health benefit plans. Section 12 of RHEA states:

> **SECTION 12. Section 2 of this 2017 Act applies to health benefit plan policies or certificates issued, renewed, modified or extended on or after January 1, 2019.**

Non-grandfathered individual market health benefit plans sold through the Oregon Health Insurance Marketplace or purchased directly from a health insurance carrier all renew annually on January 1, so the requirements of the law have been in effect for these plans since the beginning of 2019.

However, health benefit plans offered by employers may be issued or renewed at any time of year. It is not uncommon for plans to have their annual renewal date in the fall. For such plans, the coverage requirements of RHEA are not yet in effect as of the time of this report, and will go into effect upon renewal. Through experience in other areas of insurance regulation, DFR estimates that up to 40% of large group plans renew in the fourth quarter.

RHEA's coverage requirements are limited to health benefit plans and do not apply to all health insurance plans. "Health benefit plan" is a technical term that generally applies to comprehensive state-regulated commercial health insurance plans.[3] It does not apply to self-insured employer plans, which are regulated by the federal Department of Labor. States are pre-empted from regulating self-insured employer plans under the Employee Retirement Income Security Act of 1974.[4] It also does not apply to federal programs like Medicare or

[3] *See* ORS 743B.005.
[4] 29 U.S.C. § 1144.

TRICARE, or to health insurance plans that provide more limited benefits, such as short term limited duration plans, hospital indemnity or disease-specific coverage.

Table 1. Applicability of RHEA to Different Insurance Plans

Type of Insurance	RHEA Apply?	Enrollment as of June 30, 2019	% of Insurance Market	% of Oregon Population
Individual health benefit plans	Yes	176,200	15.8%	4.2%
Small-group health benefit plans	Yes	176,211	15.8%	4.2%
Large-group health benefit plans	Yes	597,704	53.7%	14.3%
Fully-insured Associations, Trusts & MEWAs	Yes	152,643	13.7%	3.6%
Student Health Plans	Yes	10,730	1.0%	0.3%
Short-term, limited-duration insurance plans	No	2,944		0.1%
Self-insured Associations, Trusts & MEWAs	No	6,373		0.2%
Self-insured employer plans (ERISA)	No	914,583		21.8%
Hospital indemnity plans	No	N/A		N/A
Disease-specific coverage plans	No	N/A		N/A
Medicare (Traditional and Med Advantage)	No	859,388		20.5%
TRICARE	No	62,450		1.5%

Source: DCBS; Census; Centers for Medicare and Medicaid Services (CMS)

Compliance in General

DCBS's Division of Financial Regulation (DFR) employs a range of tools to ensure compliance with applicable Oregon laws and administrative rules. RHEA specifically refers to DCBS's authority to levy civil penalties for violations of the Insurance Code. While these penalties are an important tool, it is more common for DCBS to take action to ensure compliance well in advance of the need for this kind of punitive action. To ensure compliance with new coverage requirements such as RHEA, DCBS can also employ other tools, including product regulation, consumer advocacy, and market conduct regulation.

Product regulation enables DCBS to take steps to ensure compliance in advance of an insurance product entering the market. Through the form review process, DCBS's analysts have the opportunity to assess whether the provisions of health plan member contracts and other key policy documents are in compliance with all applicable legal requirements before the plan is marketed or sold. This includes evaluating whether the plan clearly indicates that it covers all of the services health benefit plans must provide without cost-sharing under RHEA.

Consumer advocacy and the complaint process enables DCBS not only to provide assistance to individual Oregonians experiencing difficulties with insurance and other financial products—it also helps regulators catch compliance problems and address them

appropriately. DCBS's consumer advocates are often able to work cooperatively with health insurance carriers to address the concerns of individuals and remedy any underlying pattern of noncompliance.

Market conduct regulation enables DCBS to conduct in-depth review of health insurers' internal policies, practices and procedures. Market conduct examinations are often initiated due to patterns of complaints. Depending on the scope and severity of the issue, an exam could take a variety of forms, from written inquiries to an extensive on-site investigation. An exam that reveals a pattern of extensive noncompliance or misconduct may lead to an enforcement action and a civil penalty, but it also often leads to remedial action by the company.

d. Front End Review: Health Insurance Rate Filings

ORS 742.003 grants the Director of the Department of Consumer and Business Services (DCBS) prior approval authority over all policy forms for individual, small group and large group health benefit plans. Although plans negotiated between large groups and commercial insurers are not required to be submitted for prior approval, they are required to fully comply with all requirements set forth in the Insurance Code.

Insurers must submit plans to DCBS for review and approval before they can be issued in this state. DCBS provides insurers with product standards intended to assist the insurers in the development of insurance products that are compliant with Oregon laws and administrative rules as well as with applicable federal law. The policies and certificates submitted for approval are specifically reviewed for compliance with the provisions of RHEA before they can be offered in Oregon. The review includes examination of the policy language, applying checklists to test the forms against legal standards in the Insurance Code, and review the construction of the forms themselves. Unlike in other lines of insurance, DCBS may disapprove health benefit plan filings that do not comply with the Insurance Code.

In order to understand how insurers were currently complying with RHEA, DCBS also made an informal request to carriers. The request collected preliminary information from insurers offering these health benefit plans to learn whether the requirements related to communication with consumers are being met.

- DCBS asked for evidence of compliance with the provision in RHEA requiring insurers to post information about reproductive health coverage to their websites. Five of the nine insurers included in the abbreviated data call appear to be compliant with the requirement to make the information readily accessible online for enrollees and potential enrollees in a consumer-friendly format. One insurer discovered the website information needs to be updated and is taking corrective action. Two of the nine

insurers did not explain how potential enrollees would be able to access this information and the other insurer did not make the information readily accessible in a consumer-friendly format.

- DCBS asked the insurers to provide information about any specific changes to policy forms or other consumer-facing plan documents made due to the coverage required by RHEA. All nine insurers explained how their forms were updated to reflect the new coverage.
- DCBS also asked the insurers to provide information about how they are communicating information to enrollees regarding reproductive health services that must be provided with no cost sharing under RHEA. The insurers generally provide this level of communication to enrollees through enrollment packets and other plan documents.

The results of this informal informational gathering exercise may be found in Exhibit A, at the end of this report.

Once the provisions of RHEA have been fully implemented, DCBS plans to issue a data call asking insurers offering these health benefit plans in Oregon to respond to a series of questions related to compliance with this law. Insurer responses to those questions should provide DCBS with insight as to the degree of compliance and whether any specific enforcement action is necessary.

In order to measure the degree of compliance relative to claims activity, DCBS plans to collect data for claims paid during the review period following implementation of RHEA that will include for each claim the:

- Incurred Date
- Type of Service
- Amount Billed
- Amount Paid
- Amount Applied to Deductible
- Amount of Copayment
- Amount of Coinsurance
- Whether services were provided in network or out of network

DCBS intends to develop questions to determine which of the insurance plans DCBS will also collect the same information for claims paid during a review period preceding the implementation of RHEA in order to be able to compare changes in how claims have been processed. A similar review will be conducted for claims denied both prior to RHEA and following full implementation of RHEA. The data we plan to collect includes:

- Incurred Date
- Type of Service
- Amount Billed
- Reason for Denial
- Whether services were provided in network or out of network.

The data call will also further inform DCBS about how insurers are communicating availability of these services to consumers on a first dollar basis. The department plans to obtain examples of written responses insurers provide to consumers who request information about coverage of contraceptives other services, drugs, devices , products and procedures described in the RHEA.

2. Compliance through Back-End Review: Claims and Complaint Data

a. Complaint data review from 2017-present

Since January 1, 2019, DCBS has received three consumer complaints related to the coverage requirements of RHEA. However, in the case of two of these complaints, the law's requirements did not apply. In one case, the consumer was covered by a self-insured employer plan exempt from state regulation, and in the other case, the plan had not yet renewed in 2019, so the law's requirements had yet to go into effect. In the final case, the health insurance carrier's decision was overturned and coverage was made available without cost-sharing as required by the law.

Given the low volume of actionable complaints received to date, there is little evidence from information available to DCBS that insurers are not currently complying with RHEA. However, many Oregonians may not know to contact our office for questions related to RHEA and cost sharing, or even that they are entitled to these benefits at no cost. Accordingly, rather than wait to collect additional complaint data until RHEA is fully implemented, DCBS plans to engage with providers to see if their experiences with RHEA are similar to what DCBS has heard so far through complaints. To that end, DCBS will explore ways to ensure that patients of providers have the means and opportunity to contact the department, should they so choose.

DCBS will continue to monitor compliance in this area closely as the law's requirements go fully into effect for all applicable health plans. One way to monitor on the back-end how insurer practices comply with RHEA is to review data from the All-Payer, All-Claims (APAC) database maintained by the Oregon Health Authority. APAC contains data elements that would be useful for future checks on the degree of compliance occurring within certain commercial insurance plans, such as co-payments, co-insurance, deductibles and other cost sharing applied to an individual claim.

3. Role of Health Savings Accounts (HSA) Eligible Plans

RHEA required health benefit plan coverage of specified health care services, drugs, devices, products and procedures related to reproductive health at no cost to the member. By requiring coverage of these services, the bill disqualified health benefit plans in Oregon from being health savings account (HSA) eligible. HSA plans typically do not provide coverage for a consumer (minus certain preventive benefits) until their deductible is met but usually have lower premiums and allow a consumer to save money in a tax-advantaged account.

In order to allow HSA plans to continue to be an option for Oregonians, SB 1549 (2018) granted DCBS the authority to approve a health benefit plan that qualifies as an HSA and does not comply with other Insurance Code provisions that require no cost-sharing for certain services that HSA plans are required to apply to the deductible. This is done to the extent that the plan would be approved notwithstanding those law requirements.

While SB 1549 granted DCBS the authority to approve these plans, the decision to offer HSA-eligible plans is still one that is made by the insurance carriers. This is because prior to the 2019 session, Oregon law only granted DCBS the authority to prescribe, by rule, the form level of coverage and benefit design for a single bronze and a single silver plan that each carrier was required to offer in the individual and small group market. Therefore, DCBS could only require carriers to offer a bronze and silver plan that complied with RHEA, disqualifying those plans from HSA-eligibility. Carriers still could offer HSA-eligible plans if they chose to do so, but faced no requirement to offer these plans. Since passage of SB 1549, DCBS has worked with carriers to encourage the development of HSA-eligible health benefit plans alongside the RHEA-compliant standard plans.

With the passage of SB 250 (2019), DCBS is allowed to require carriers to offer multiple bronze and silver plans, as long as the level of coverage is determined through rulemaking. With this authority, DCBS has the option to conduct rulemaking to require carriers to offer a bronze/silver plan that complies fully with RHEA as well as a bronze/silver plan that maintains HSA-eligibility. In this, DCBS will be able to provide consumers' reproductive health equity while maintaining options for consumers.

4. Next Steps for Division of Financial Regulation

Issue the data call: DCBS will issue a data call Q1 2020, once all relevant plans have been modified or renewed. Carriers will have opportunities to ask questions and engage with the department through the process. While any individual results in the data call will be confidential, an aggregate report could be made available outlining the department's findings.

Work with the Oregon Health Authority to obtain APAC data. DCBS currently is a signatory to several data use agreements for APAC data, including for rate review and surprise billing benchmarking. OHA is a willing and engaging partner in data sharing, and DCBS looks forward to more collaboration.

Process for provider complaints: DCBS is already in process of working with providers to ensure that their patients have the opportunity to report information to us regarding cost sharing and coverage issues. DCBS' insurance expertise will both help individual patients as well as giving the department a sense of what is occurring in the market.

Next update prior to 2021 session. DCBS commits to updating this report by Q3 2020, so as to help inform any policy conversation that may need to occur during the 2021 legislative session.

Exhibit A: Insurer Responses

Company	Info Posted to Website	Changes Made Due to HB 3391	Info to Enrollees Regarding Cost Share
Aetna	https://www.aetna.com/individuals-families/member-rights-resources/rights/disclosure-information.html under the section titled "addendums (including Arizona appeals packets)". The document is titled "Oregon Comprehensive Reproductive Addendum".	Aetna updated our large group certificate and schedule of benefits via endorsement to comply with Oregon House Bill 3391. AL OR Endorsement HB 3391 was approved on October 30, 2018 under SERFF # AETN-131668858.	As noted in the "Oregon Comprehensive Reproductive Addendum" referenced above: Coverage is generally provided with no deductible or cost sharing, unless you are covered under a qualified high deductible health plan. However, if you are covered under a group plan purchased by a religious employer, your employer may elect to not include coverage for contraceptives or abortion procedures. Please refer to your Summary of Benefits and Coverage document or health benefits booklet for a complete description of your reproductive health care coverage. Members can find specific cost share information by referring to their plan documents.
HealthNet	www.healthnet.com, www.myhealthnetoregon.com : Upon logging in, members are able to access their coverage documents that describe their benefits in detail https://ifp.healthnetoregon.com/Pharmacy_Information/drug_lists.html : Link to the Essential Drug List, shows all contraceptives as "Preventive Benefit (PV)" which indicates coverage at no cost	Our Benefit & Service Agreements have been updated to include abortion services, counseling, interventions and treatment; male sterilization; and additional covered preventive services not supported by HRSA including sexually transmitted infection screening & counseling, anemia screening, urinary tract infection screening, pregnancy screening, Rh incompatibility screening, BRCA1 or BRCA2 genetic mutation screening and counseling, and breast cancer chemoprevention counseling	Members receive enrollment packets during open enrollment. Enrollment packets contain brochures, benefit summaries, and contract change summaries (indicating contract changes from their previous contract).
Kaiser	The link below will require member sign on. Members can log on to their site, go to Women's health and there they will find information on reproductive health coverage and services. Specifically links for; • Healthy, safe sex • Birth control • Pregnancy • Just for teens	Kaiser already covered most of the Services required by HB 3391 at no cost so the EOC and benefit summary documents did not require significant changes. Here were the few changes we made for clarity: Evidence of Coverage changes: • Removed GF tagging/variability on contraceptive Services so that GF plans now all reflect contraceptives Services at $0.	Here is a link to our flier detailing the information for members. https://sites.sp.kp.org/services/infosource/mkt/mc/302257716_GEN_02-19_Contraceptive_Benefit_Flyer_r4_final_web_tj.pdf

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	Kp.org Member Information Link for Women's Health https://healthy.kaiserpermanente.org/health/mycare/!ut/p/a0/FclNDsIgEEDhq-gByEipkbprKb2AC4XdhEwKKT8NEr2-dvm-BxZeYDN-wootIlzx38ZRblTv35Iov5knjM3DEyzYbX8QVufBTKE2f1Ilt1risfaKa0IwuTCHztNhWFtwkcAMY69vA1dMyEvHONecDXN_ZYscRafEvOh-gj0lKdJ4_gF13x_f/	• Removed interrupted pregnancy and vasectomy from the outpatient surgery bullet under "Benefits for Outpatient Services" and created separate bullets for these Services as they may be covered in an office visit setting in addition to an outpatient surgery setting. • Added a vasectomy bullet under "Benefits for Inpatient Hospital Services" to clarify that these Services are also covered in an inpatient setting.	
Moda	https://www.modahealth.com/pdfs/hcr_prev_svcs_adult_or.pdf https://www.modahealth.com/members/handbooks.shtml https://www.modahealth.com/employers/samples.shtml	Individual – part of the discontinuation notice to individual enrollees Group – part of the plan change form to groups provided at renewal See attached for sample documents • A sample list of changes in 2019 individual discontinuation notices – all our individual members received a version relevant to their plans. • The small group renewal cost sharing changes that list the changes to abortion and vasectomy. • Small group plan change form – that describes the overall changes from HB 3391 • Large group plan change form – that describes the overall changes from HB 3391	Through renewal process and member handbooks. Individual – part of the discontinuation notice to individual enrollees Group – part of the plan change form to groups so groups can share with their employees

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Company	Info Posted to Website	Changes Made Due to HB 3391	Info to Enrollees Regarding Cost Share
PacificSource	A link to our webpage with the additional information is https://pacificsource.com/YourPlan/ which we added the topic "Reproductive health coverage in Oregon" towards the bottom of the page. The other documents that are available is a copy of a plan's SBC and a sample health plan document that is available for general public on our website https://pacificsource.com/oregon/individual-plan-details-2019/. Below is the language that is on our website under Reproductive health coverage in Oregon: Reproductive health coverage in Oregon The state of Oregon requires all health benefit plans to cover certain services, drugs, devices, products, and procedures relating to reproductive health and functioning. All PacificSource plans comply with these rules, which you can read at the OregonLaws.org website. Check your Member Handbook or policy for complete details on your plan's coverage of contraceptives and other reproductive health matters.	Attached are the sections of the individual policy and group member handbook that were edited due to HB 3391.	We have not created any additional communications for enrollees, other than the website, in regards to reproductive health services.
Providence	https://healthplans.providence.org/~/media/Files/Providence%20HP/pdfs/members/Documents/preventive%20health%20care.pdf	PHP made changes to our consumer handbooks to reflect coverage of voluntary sterilization services as required by HB 3391. We did not need any other changes.	Our handbooks indicate the services are covered in full when applicable (e.g. exception for HSA plans and male voluntary sterilization). Members can also check their coverage at myprovidence.com or call customer service at 503-574-7500 for benefits and coverage information.
Regence	Please see the attached "Preventive Care Services 2019" flyer. This is displayed on our website. We are updating the flyer to state that no cost		Please see the attached Oregon SOC Eff 01-1-19.

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	coverage for osteoporosis, breast cancer screening, screening and counseling for BRCA1 and BRCA2, breast cancer chemoprevention counseling, patient education and counseling on contraception and sterilization, screening for chlamydia, and screening for gonorrhea are also covered for men. We want to be clear that we have offered and provided that coverage for men since implementation of the ACA and HB 3391, as required. However, we recognize our flyer needs to declare that coverage is available for men.	Please see the attached redline documents for our Individual and Small Group form filings for 2019 products.	
Samaritan	https://www.samhealthplans.org/members/employer-group-members/health-resources https://www.samhealthplans.org/members/employer-group-members/making-the-most-of-your-benefits Certificates, Summary of Benefits and Coverage, Schedule of Benefits: https://www.samhealthplans.org/members/employer-group-members/benefits	See link above (Certificate)	See link above (Certificate)
United HealthCare	The following link takes you to UHC's public website page where we provide Oregon related notices: https://www.uhc.com/legal/required-state-notices/oregon	Any required changes were incorporated into our plan documents.	Within our plan documents, we include items such as the following: Certificate of Coverage under Preventive: With respect to individuals, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including breast cancer screening, cervical cancer screening, and all Federal Drug Administration (FDA) approved contraceptive methods. Screening mammography to include:

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			A mammogram in symptomatic of high-risk individual at any time upon referral of the woman's health care provider. A mammogram every year for individuals age 40 and over, with or without referral from the individual's health care provider. Benefits defined under the Health Resources and Services Administration (HRSA) requirement include but may be limited to the full range of FDA approved contraceptive methods without cost sharing. Benefits include at least one form of contraception in each of the methods (currently 18) that the FDA has identified in its current Birth Control Guide. These methods are including, but not limited to, hormonal methods including oral contraceptives, patches or injectables (self-administered and/or provider administered), barrier methods such as prescription diaphragms and implanted devices and oral medications for emergency contraception. Benefits include voluntary sterilization procedures, including the consultations, examinations, procedures, and necessary medical services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office. <u>Prescription Drug Schedule of Benefits:</u> A complete list of medications covered under the drug formulary, including Preventive Care Medications and tobacco use cessation medications at no cost on the Prescription Drug List, is available on our website at www.myuhc.com under Pharmacy Information or call the telephone number on your ID card for the most up-to-date Prescription Drug List information. Benefits include: Prescription Drug Products prescribed by a Physician or clinical pharmacist to prevent conception including FDA approved contraceptive methods such as diaphragms, cervical caps, contraceptive rings, contraceptive patches, oral contraceptives (including emergency contraceptive pills), injectable hormonal contraceptives (self-administered and/or provider administered) and physician prescribed over-the-counter drugs as required by law. We may use reasonable medical management techniques to control costs and promote efficient delivery of care such as covering generic drugs without cost and imposing cost sharing on equivalent Brand-name drugs. We will accommodate any person for

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			whom a particular drug would be medically appropriate. If the Brand-name contraceptive drug with the generic equivalent is Medically Necessary, it may be Pre-Authorized by us without cost sharing for the Medically Necessary Brand-name contraceptive drug.