



Waterstone Benefit Administrators Affordable Care Act Frequently Asked Questions

Under the new Adult Dependent provision, is the age up to 26 or through 26?

Section 2714 (a) Extension of Dependent Coverage states “dependent coverage of children shall continue to make such coverage available for an adult child (who is not married) **until the child turns 26 years of age**”. However, under the Reconciliation Bill, Section 2301 (b) states “Section 2714(a) of the Public Health Service Act, as added by section 1001(5) of the Patient Protection and Affordable Care Act, is **amended by striking “(who is not married)”**”. Therefore, a “married or unmarried” adult dependent should be covered up to age 26. Grandfathered Plans can stipulate the dependent child cannot be eligible for an employer sponsored health plan. An affidavit should be obtained from the employee verifying the dependent child is/is not eligible for an employer health plan.

Regulations and Guidance, along with Model Notices, regarding Dependent Coverage for Children up to age 26, Lifetime Limits, Patient Protection and Grandfathered Status can be reviewed at www.dol.gov/ebsa/healthreform including guidance regarding the Internal/External Review process.

www.dol.gov/ebsa/dependentsmodelnotice.doc
www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc
www.dol.gov/ebsa/patientprotectionmodelnotice.doc
www.dol.gov/ebsa/grandfatherregmodelnotice.doc

What is the difference between a “grandfathered” plan and “non-grandfathered” plan?

“Grandfathered” plan is a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment (March 23, 2010).

The following provisions are *not applicable* to “Grandfathered” plans:

- Preventive coverage without cost-sharing, (PPACA, Section 2713)
- Designation of OB/GYN and pediatrician as Primary Care Provider (PPACA, Section 2719A)
- Clinical Trials (PPACA, Section 2709)
- Internal/External Reviews (PPACA, Section 2719)
- Essential Health Benefits (PPACA, Section 1302)

Grandfathered plans **are** subject only to the following requirements:

- Uniform explanation of coverage (Summary of Coverage)
- Cost reporting and rebates
- Notification of availability of the exchange and subsidies
- Limitation on lifetime and annual limits
- Limitation on pre-existing condition exclusions
- Prohibition on rescissions
- Limitation on waiting periods
- Coverage of adult children

(Plan’s claim of grandfathered status must be communicated to participants and beneficiaries in plan materials)

With the change to no exclusions for pre-existing conditions, will it change the need to obtain Creditable Coverage documentation from employees?

The “Pre-existing” Exclusion Provision applies to members under the age of 19. A Letter of Creditable Coverage will not be required in order to waive pre-existing for those members under age 19. However, the provision will apply to all members effective 2014.

What is the definition of “Plan Year” and when will the provisions begin?

The Provisions will begin the first “Plan Year” six months after the date of enactment (September 24, 2010). The “Plan Year” is different for each group and the definition of “Plan Year” is outlined in the plan document. Normally it is the date the group is required to file Form 5500. For example, if a group has October 1 as the “Plan Year”, the provisions will be effective October 1, 2010. If the “Plan Year” is January 1, the provisions will be effective January 1, 2011.

What would be the projected increase in costs, should we adopt the no pre-existing for ALL enrollees on our plan year January 2011?

Waterstone estimates a 3-5% additional increase (in addition to normal increases). We suggest each Group contact Waterstone directly for cost information.

What is the “comparative effectiveness fee”?

Section 4376 in Law: "Imposition of Fee - In the case of any applicable self-insured health plan for each plan year ending after September 30, 2012, there is hereby imposed a fee equal to \$2 (\$1 in the case of plan years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan". (Applies to Large group health plan (including self-insured). The assessed fee is to contribute to the Patient-Centered Research Outcomes Trust Fund that will be responsible for comparative effectiveness research. Fees will cease to be collected after 2019.)

When does the \$2500 cap for Health Flexible Spending Account begin and will Dental and Vision apply to the Health Flexible Spending Account?

Section 9005 page 736-737: \$2500 cap on contributions effective to taxable years beginning after Dec. 31, 2010. However, this was amended by the Reconciliation under Sec. 1403 page 95, to strike "2010" and inserted "December 31 2012". Therefore, the effective date is January 1, 2013. We believe it will allow dental and vision, however the Law does not define. The law does not limit what FSAs may be used for; it simply places the \$2,500 yearly contribution cap on them. Multiple family member employees with separate FSA elections can each elect \$2,500.00.

“Essential Health Benefit Requirements”, does this provision apply to both “grandfathered” and “non-grandfathered” plans?

The required coverage of essential health benefits does not apply to Grandfathered plans. (Please refer to Sec. 1302 in the PPACA)

What constitutes number of hours worked to be full-time employee?

The term "full-time employee" means an employee who is employed on average at least 30 hours of service per week". (Please refer to Sec. 4980H (4)(A) in the PPACA) The definition of a "full-time employee" applies only to the calculation of fees and penalties. Groups do not have to change the Plan's definition of a full-time employee.

Is the government supplying “opt-out” forms?

The law is silent on whether there will be a universal employee opt-out form. Unless there is guidance to the contrary in the future, it is our interpretation that as long as employers offer the ability of opting-out, they are in compliance of the provision.

What advantages do you see for wellness programs? The increase on the cap went from 20% to 30%.

All non-grandfathered self-insured plans (and all other non-grandfathered group health plans) must comply with provisions relating to prevention and wellness programs. Plans may offer wellness programs that do not require an individual to satisfy a standard related to a health factor as a condition for obtaining a premium discount, rebate or other reward, if it does so to all similarly situated beneficiaries. Such programs include:

- A partial or full subsidy for membership in a fitness center
- A diagnostic testing program
- Programs that encourage preventive care through the waiving of a copayment or deductible
- Smoking cessation programs
- Health education seminars

Plans may offer discounts, rebates or rewards for participants of a wellness program based on achieving a change in health status, but only under certain conditions:

- If the premium discount is less than 30%
- The program has a reasonable chance of improving the health of, or preventing disease in, participating individuals
- The program is offered at least once a year

*Section 10408 in the base text deals with grants for small businesses to provide wellness programs. To be eligible, an employer has to have less than 100 employees and have not had a wellness program in effect of 3/23/10.

In regards to the insurers requirement on how the money collected for premiums is spent and maintain a medical/loss ratio of at least 85%. Do you have a general idea of what we would be comparing so we can get a general idea of where we are and how we can control the ratios? Also if we have to pay a rebate b/c we go above 85% is that something paid annually or monthly.

This provision applies to all group health plans, *excluding self-insured health plans.*

Is the government actually going to come up with an outline of what a four page uniform summary of benefits looks like? (Effective date – Plan years beginning after 9/23/12)

Yes. According to the Law under Section 2715 "not later than 12 months after the date of enactment the Secretary shall develop standards for use by a group health plan".

All self-insured health plans (and all other health plans) will be required to provide to their enrollees and applicants a summary of benefits and coverage explanations that accurately describes the benefits and coverage under the plan.

The standards to be developed will include:

- A summary of benefits and coverage presented in uniform format that does not exceed 4 pages and has a font of at least 12 point
- A summary written in a culturally and linguistically appropriate manner using terminology understandable by the average plan enrollee
- The summary of benefits will be required to include:
 1. Uniform definitions of insurance terms
 2. A description of the coverage including cost-sharing for each of the categories of the essential health benefits
 3. Other benefits
 4. The exceptions reductions and limitations on coverage
 5. Cost-sharing provisions, including deductible, coinsurance and co-payment obligations
 6. The renewability and continuation of coverage provisions
 7. Examples of common benefits scenarios including; pregnancy and chronic medical conditions and cost-sharing scenarios for each
 8. Whether the plan provides minimum essential coverage and provides a cost-share of at least 60%
 9. A statement that the summary should be consulted to determine the governing contractual provisions
 10. Contact information for the beneficiary to contact with questions and an Internet address for the beneficiary where a certificate of insurance can be reviewed.

The summary will be presented to the enrollee at the time of their application for the plan and prior to their reenrollment. The summary is to be in paper or electronic form.

If the plan makes any material modification not reflected in the most recent summary, it will provide notice to enrollees no later than 60 days prior to the effective date of such modification.

UPDATE FEBRUARY 9, 2012: Final Regulations have been issued. The Summary of Benefit and Change (SBC) is effective for Plan Years beginning on or after September 23, 2012.

<http://www.dol.gov/ebsa/pdf/SBCfinalreg.pdf>

<http://www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf>

Will the 90 day Waiting Period begin at the date of hire? Can we no longer have eligibility at the first of the month after a 90 day waiting period?

The law is silent on whether a plan may wait until the first of the month after 90 days or does it simply have to start by the 90th day. The law simply states "plans can not apply a waiting period longer than 90 days". Our interpretation would be that the first of the month after the 90th day would most likely violate the spirit of this provision.

If an employee "opts out" of employer coverage at time of hire or open enrollment, then they get sick, can they enroll at any time?

If an employee "opts-out" of the employer based insurance, the employee will not be able to enroll until open enrollment or if he/she has a qualifying event.

If a Group that is "grandfathered" and decides to make changes to the Plan will we lose "grandfather" status?

Yes. Basically if you change your plan design to help control costs, your plan will no longer be considered a grandfathered plan and all healthcare reform provisions will now apply to your plan. Most of the provisions, plans already comply with. The other provision will not have that big of an impact. Below are guidelines from the Department of Labor regarding this issue:

Grandfathered health plans will be able to make routine changes to their policies and maintain their status. These routine changes include cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law, or making changes to comply with State or other Federal laws. Premium changes are not taken into account when determining whether or not a plan is

grandfathered.

Plans will lose their grandfathered status if they choose to make significant changes that reduce benefits or increase costs to consumers. If a plan loses its grandfathered status, then consumers in these plans will gain additional new benefits including:

- Coverage of recommended prevention services with no cost sharing; and
- Patient protections such as guaranteed access to OB-GYNs and pediatricians.

Under the Affordable Care Act, these requirements are applicable to all new plans, and existing plans that choose to make the following changes that would cause them to lose their grandfathered status.

Compared to their policies in effect on March 23, 2010, grandfathered plans:

- **Cannot Significantly Cut or Reduce Benefits.** For example, if a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.
- **Cannot Raise Co-Insurance Charges.** Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20% of a hospital bill). Grandfathered plans cannot increase this percentage.
- **Cannot Significantly Raise Co-Payment Charges.** Frequently, plans require patients to pay a fixed-dollar amount for doctor's office visits and other services. Compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next 2 years, it will lose its grandfathered status.
- **Cannot Significantly Raise Deductibles.** Many plans require patients to pay the first bills they receive each year (for example, the first \$500, \$1,000, or \$1,500 a year). Compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points. In recent years, medical costs have risen an average of 4-to-5% so this formula would allow deductibles to go up, for example, by 19-20% between 2010 and 2011, or by 23-25% between 2010 and 2012. For a family with a \$1,000 annual deductible, this would mean if they had a hike of \$190 or \$200 from 2010 to 2011, their plan could then increase the deductible again by another \$50 the following year.
- **Cannot Significantly Lower Employer Contributions.** Many employers pay a portion of their employees' premium for insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers' share of premium from 15% to 25%).
- **Cannot Add or Tighten an Annual Limit on What the Insurer Pays.** Some insurers cap the amount that they will pay for covered services each year. If they want to retain their status as grandfathered plans, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).
- **Cannot Change Insurance Companies.** If an employer decides to buy insurance for its workers from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when employers that provide their own insurance to their workers switch plan administrators or to collective bargaining agreements.

SUMMARY OF HEALTHCARE PROVISIONS THAT WILL APPLY

Effective 2011:

1. Preventive Care/Screenings: must be provided without cost-sharing for in-network providers
2. Emergency Services: Must be provided without prior authorization or out-of-network cost sharing
3. Access: Plan that requires a PCP must allow individuals to designate any PCP; must provide direct access to OB/BYN
4. Clinical Trials: Cannot deny coverage that would otherwise be provided on grounds of clinical trial. Network restrictions permitted.
5. Internal/External Reviews: Plans must provide both in accordance with regulations of Secretary.

Effective 2012:

1. Annual Reports: Required annual reports to Secretary and participants regarding health care quality, wellness initiatives

"Clinical Trials", does that mean the "experimental treatment" is covered?

Section 2709 – Coverage for individuals participating in Approved Clinical Trials – States under section (B) Exclusions...routine costs does not include – (i) the investigational item, device, or service itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

We are inclined to say that it would be difficult to deny experimental services, however it appears that any clinical trial has to be approved by the federal government. If it is not approved by the Federal Government then you might be able to deny it. There will be a lot more clarification and "testing" of this law in the next few

Does the first dollar coverage for preventative and immunizations and screening apply to out of network providers also? In other words, will we have to pay the full bill to a competitor if our female employees want to go to a competing physician for annual exam, PAP, and Mammogram... or a male employee wants Labcorp to run his PSA, etc.?

Coverage of Preventive Services applies to Non-Grandfathered plans. With respect to a plan or health insurance coverage that has a network of providers, the plan *is not required* to provide coverage for recommended preventive services delivered by an out-of-network provider. Such a plan or issuer may also impose cost-sharing requirements for recommended preventive services delivered by an out-of-network provider.

Does the prohibition of different handling for emergency care mean that we will need to add emergency care for foreign travel?

While the Law doesn't say anything specifically about coverage of emergency services during foreign travel, our interpretation would be that it appears like the plan *would be responsible for payment*. The regulation states, the plan must cover without prior authorization, without regard whether the service is furnished by a participating provider, without imposing limitations more restrictive than for out-of-network services than in-network, in compliance with cost-sharing requirements and (maybe most significant to the question) without regard to any other term or condition other than an exclusion for benefits, coordination of benefits, waiting periods or applicable cost-sharing.

For a plan or health insurance coverage with a network of providers that provides benefits for emergency services, the plan or issuer may not impose any administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services.

What are the guidelines on the Prohibition of Annual and Lifetime Maximums?

Background on Prohibition of Annual and Lifetime Limits:

The PPACA prohibits all group health plans and plans offering individual coverage from maintaining annual and lifetime limits on the dollar value of health benefits. The PPACA prohibits annual limits on the dollar value of benefits generally, but allows "restricted annual limits" with respect to essential health benefits (as defined in section 1302(b) of the Affordable Care Act) for plan years beginning before January 1, 2014. ***With respect to benefits that are not "essential health benefits", a plan or issuer may impose annual or lifetime per-individual dollar limits on specific covered benefits.*** For plan years beginning before the issuance of regulations defining "essential health benefits", for purposes of enforcement, plans are expected to make good faith efforts to comply with a reasonable interpretation of the term "essential health benefits".

Final Interim Rule on Prohibition of Annual and Lifetime Limits:

These interim final regulations adopt a three-year phased approach for restricted annual limits. Under these interim final regulations, annual limits on the dollar value of benefits that are essential health benefits may not be less than the following amounts for plan years (in the individual market, policy years) beginning before January 1, 2014:

- * For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, \$750,000;
- * For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, \$1.25 million; and
- * For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, \$2 million

Plans or issuers may use higher annual limits or impose no limits.

These interim final regulations clarify that the prohibition **under PHS Act section 2711 does not prevent a plan or issuer from excluding all benefits for a condition**, but if any benefits are provided for a condition, then the requirements of the rule apply. Therefore, an exclusion of all benefits for a condition is not considered to be an annual or lifetime dollar limit.

The minimum annual limits for plan or policy years beginning before 2014 apply on an individual-by-individual basis.

Under these interim final regulations, individuals who reached a lifetime limit under a plan or health insurance coverage prior to the applicability date of these interim final regulations and are otherwise still eligible under the plan or health insurance coverage must be provided with a notice that the lifetime limit no longer applies.

These interim final regulations provide that the prohibition on limits does not apply to CDHPs.

What services are considered "Essential Health Benefits"?

The Act sets forth a general list of "Essential Health Benefits" which will be required under certain plans. However, the final regulations have not yet been issued. The "Essential Health Benefits" listed as of now are:

- Ambulatory patient services
- Emergency services
- Hospitalization

- Maternity and newborn care
- Mental health and substance use disorders including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventative and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Update – ESSENTIAL HEALTH BENEFITS: On December 16th, 2011, the Center for Consumer Information and Insurance Oversight proposed a benchmark standard to define essential health benefits. Under the proposal, states would choose a benchmark plan from:

- The largest plan by enrollment in any of the three largest small group insurance products in the state;
- Any of the largest three state employee benefit plans;
- Any of the largest three national Federal Employee Health Benefits program plans; or
- The largest commercial HMO in the state.

If a state failed to choose a benchmark, the default plan would be the largest plan by enrollment in the small group market. Of course, any benchmark plan would need to include the 10 statutorily-required areas of essential health benefits.

<http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>

When making plan changes, this there a specific timeframe on notifying members of the plan changes?

Yes. PPACA Section 2715 states the “the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective”. “Failure to provide such notice shall be subject to a fine of not more than \$1,000.00 for each such failure”. This notice will be effective for plan years beginning after September 23, 2012.

Form W-2, Reporting the Value of Health Coverage, what date does the reporting begin?

Originally reporting was to begin for calendar year 2011, reported in January 2012. However, the IRS has delayed the provision of the Affordable Care Act which requires employers to report the aggregate value of coverage for each employee and dependent by the end of January 2013 for the 2012 calendar year. (Reporting the cost of coverage will be optional with respect to 2011.)

<http://www.irs.gov/newsroom/article/0,,id=228881,00.html>

To view IRS FAQ's on the Form W-2 Reporting provision click the below link

<http://www.irs.gov/pub/irs-drop/n-12-09.pdf>

What amount must be included when reporting the Form W-2?

The COBRA rate minus the 2% administrative charge is used for reporting.

<http://www.irs.gov/pub/irs-drop/n-12-09.pdf>

What benefit amounts are not included in the Form W-2 reported amount?

Certain “excepted benefits” are not subject to the reporting requirements :

- Coverage only for accident, or disability income insurance, or any combination thereof;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits

<http://www.irs.gov/pub/irs-drop/n-12-09.pdf>

PREVENTIVE BENEFITS FOR NON-GRANDFATHERED HEALTH PLANS

What are the new regulations regarding Coverage of Preventive Health Services without Cost-Sharing?

Under the regulations, plans must cover without copay, coinsurance or deductible – certain preventive services that have “strong scientific evidence of their health benefits.”

Interim final rule, which means final rules, may eventually differ, but these are final in the interim.

There is a positive impact of 100% Preventive coverage. Chronic diseases, such as heart disease, cancer, and diabetes are responsible for seven of ten deaths among Americans each year and account for 70% of the nation’s health spending. In many cases, chronic diseases are preventable. However, health plans with cost-sharing for preventive care have been found to reduce the likelihood that these services will be used. By eliminating cost-sharing for in-network preventive care, employers can expect higher enrollee utilization of these important, possibly life-saving services.

General highlights of the new regulations:

- Grandfathered plans are exempt for as long as they remain grandfathered
- Non-grandfathered plan (i.e. plans either not in effect on 3/23/10 or that made changes since then resulting in loss of grandfathered status) must comply with the no-cost-sharing requirement beginning with the first plan year on or after September 23,2010
- Preventive services are to be covered without any cost-sharing requirement when delivered by a network provider. Plans are not required to provide coverage for recommended preventive services delivered by an out-of-network provider or may impose cost-sharing for recommended preventive services delivered by an out-of-network provider.
- Employers and insurers are not required to provide coverage for recommended preventive services delivered by an out-of-network provider or may impose cost-sharing for recommended preventive services delivered by an out-of-network provider.
- If a guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the service, the plan or issuer may use “reasonable medical management techniques” to determine any coverage limitations on the service.
- Plans that cover preventive services in addition to those required may apply cost-sharing requirements for the additional services.
- The regulation references preventive care services outlined by the United States Preventive Services Task Force with an A or B rating. They are listed below and can be found at: <http://www.healthcare.gov/center/regulations/prevention/taskforce.html>

General list of services to be offered without cost-sharing:

Evidence-based preventive services: This list of items is taken from the current recommendations of the United States Preventive Services. They are included only if they have a rating of A or B. This broad list generally includes:

- Breast cancer and cervical cancer screenings
- Colon cancer screenings
- Screening for vitamin deficiencies during pregnancy
- Screenings for diabetes, high cholesterol and high blood pressure

Breast cancer screening: The most recent recommendations issued in November 2009 should be disregarded and the prior recommendations issued in 2002 should be used until new recommendations are issued. This means that until further notice all women age 40 and over should have an annual mammogram and clinical breast exam.

Routine vaccinations: A list of immunizations – recommended by the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention. They are considered routine for use with children, adolescents, and adults and range from childhood immunizations to periodic tetanus shots for adults.

Prevention for children: From birth to age 21, guidelines developed by the Health Resources and Services Administration with the American Academy of Pediatrics. Services include regular pediatrician visits, vision and hearing screening, developmental assessments, immunizations, and screening and counseling to address obesity.

Prevention for women: Certain preventive care measures for women. These recommendations will be in place until new requirements for prevention for women are issued by the United States Preventive Services task Force or appear in comprehensive guidelines supported by the Health Resources and Services Administration.

Billing and Office Visits

If a recommended preventive item or service is billed separately from an office visit, then cost-sharing may be applied to the office visit.

If a recommended preventive item or service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of such item or service, then cost-sharing requirements may not be imposed with respect to the office visit.

If a recommended preventive item or service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of the preventive item or service, then cost-sharing may be applied to the office visit.

List of Covered Preventive Care Services	
Children and Adolescents	Childhood/Adolescent Immunizations
<p><u>Newborns</u></p> <ul style="list-style-type: none"> ▪ Screening all newborns for <ul style="list-style-type: none"> • Hearing loss • Hypothyroidism • Sickle cell disease • Phenylketonuria (PKU) ▪ Gonorrhea preventive medication for eyes of all newborns 	<ul style="list-style-type: none"> ▪ Diphtheria, Tetanus, Pertussis ▪ Haemophilus influenza type B ▪ Hepatitis A and B ▪ Human Papillomavirus (HPV) ▪ Influenza (Flu) ▪ Measles, Mumps, Rubella ▪ Meningococcal ▪ Pneumococcal (pneumonia) ▪ Inactivated Poliovirus ▪ Rotavirus ▪ Varicella (chickenpox)
<p><u>Childhood Screenings</u></p> <ul style="list-style-type: none"> ▪ Medical history for all children throughout development ▪ Height, weight and Body Mass Index measurements ▪ Developmental screening for children throughout childhood ▪ Autism screening for children at 18 and 24 months ▪ Behavioral assessment for children of all ages ▪ Vision screening ▪ Oral health risk assessment for young children ▪ Hematocrit or Hemoglobin screening ▪ Obesity screening and weight management counseling for children age 6 or older ▪ Iron supplements for children 6 to 12 months who are at higher risk for anemia ▪ Fluoride supplements for children without fluoride in their water ▪ Lead screening for children at risk of exposure ▪ Dyslipidemia screening for children at higher risk of lipid disorders ▪ Tuberculin testing for children at higher risk of tuberculosis 	
<p><u>Additional Screening for Adolescents</u></p> <ul style="list-style-type: none"> ▪ Depression screening ▪ Alcohol and drug use assessment ▪ Counseling to prevent sexually transmitted infections for sexually active adolescents ▪ Cervical dysplasia screening for sexually active young women ▪ HIV screening for adolescents at higher risk 	
<p><u>Health Screening for Adults</u></p> <ul style="list-style-type: none"> ▪ Blood pressure screening for all adults ▪ Cholesterol screening for men age 35 and older, women age 45 and older, and younger adults at higher risk ▪ Diabetes screening for type 2 diabetes for adults with high blood pressure ▪ HIV and sexually transmitted infection screenings for adults at higher risk 	
<p><u>Cancer Screenings</u></p> <ul style="list-style-type: none"> ▪ Breast cancer mammography every 1 to 2 years for women over age 40 ▪ Breast cancer chemoprevention counseling for women at high risk for breast cancer ▪ Cervical cancer pap test for women ▪ Colorectal cancer screenings including fecal occult blood testing, sigmoidoscopy or colonoscopy from age 50 to 75 ▪ Prostate cancer (PSA) screening for men 	
<p><u>Health Counseling</u></p> <ul style="list-style-type: none"> ▪ Doctors are encouraged to counsel patients about these health issues and refer them to appropriate resources as needed: <ul style="list-style-type: none"> • Healthy diet • Weight Loss • Tobacco use • Alcohol misuse • Depression • Prevention of sexually transmitted infections • Use of aspirin to prevent cardiovascular disease 	
<p><u>Adult Immunizations</u></p> <ul style="list-style-type: none"> • Hepatitis A and B • Herpes Zoster • Human Papillomavirus (HPV) • Influenza (Flu) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Tetanus, Diphtheria, Pertussis 	

<ul style="list-style-type: none"> • Varicella (chickenpox)
<p>Screenings for Men</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm one-time screening for men age 65 to 75 who have smoked
<p>Screenings for Women</p> <ul style="list-style-type: none"> • Osteoporosis screening for women age 60 and older, depending on the risk factors • Chlamydia infection screening for sexually active women age 24 and younger and other women at higher risk • Gonorrhea and syphilis screening for sexually active women at higher risk • BRCA counseling about genetic testing for women at higher risk
<p>Specifically for Pregnant Women</p> <ul style="list-style-type: none"> • Folic acid supplements for women who may become pregnant • Anemia screening for iron deficiency • Tobacco cessation counseling for all pregnant women who smoke • Syphilis screening for all pregnant women • Hepatitis B screening during the first prenatal visit • Rh incompatibility blood type testing at first prenatal visit and at 24-28 weeks • Bacteriuria urinary tract infection screening at 12 to 16 weeks • Breastfeeding education to promote breastfeeding

*HR 3590 "The Patient Protection and Affordable Care Act" (PPACA)

* HR 4872 "Health Care and Education Reconciliation Act of 2010"

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