A guide to CIGNA'S PREVENTIVE HEALTH COVERAGE for health care professionals

Introduction

Cigna's preventive care coverage complies with the Patient Protection and Affordable Care Act (PPACA). Services designated as preventive care include periodic well visits, routine immunizations and certain designated screenings for symptom-free or disease-free individuals. Preventive care services also generally include additional immunization and screening services for symptom-free or disease-free individuals at increased risk for a particular disease.

The PPACA requires that non-grandfathered health plans cover preventive care services with no cost-sharing. Most Cigna plans cover the full cost of preventive care services for individuals with Cigna coverage, including copay and coinsurance. Typically, these services must be provided by in-network health care professionals. There are some exceptions.

To determine if your patient's Cigna administered plan covers preventive care at 100%, visit the Cigna for Health Care Professionals website **(CignaforHCP.com)** to verify benefit and eligibility information, or call **1.800.88Cigna (882.4462)**. For patients with a GWH-Cigna ID card, visit the GWH-Cigna Secured Provider Portal **(GWHCignaforHCP.com)**, or call **1.866.494.2111**.

Preventive care services

The PPACA has designated specific resources that identify the preventive services required for coverage by the act.

- U.S. Preventive Services Task Force (USPSTF) A and B recommendations
- Advisory Committee on Immunization Practices (ACIP) recommendations that have been adopted by the Director of the Centers for Disease Control. Recommendations of the ACIP appear in four immunization schedules
- Comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
  - Guidelines for infants, children and adolescents appear in two charts: the periodicity schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children
  - Guidelines for women were released in August 2011 and become effective for non-grandfathered plans upon renewal date occurring on or after August 1, 2012. This guide includes details about these additional services.

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For more information regarding the preventive recommendations of these resources and implementation of the PPACA regulations, please see the federal government website: **Healthcare.gov/news/factsheets/2010/07/preventive-services-list.html**.

Coding for preventive services

Correctly coding preventive care services is key to receiving accurate payment for those services.

- Preventive care services must be submitted with an ICD-9 code that represents encounters with health services that are not for the treatment of illness or injury. The ICD-9 code must be placed in the first diagnosis position of the claim form (see the list of designated "V codes" in the following table for each preventive service). This guide will include ICD-10 codes when updated in 2013.
- If claims for preventive care services are submitted with diagnosis codes that represent treatment of illness or injury as the primary (first) diagnosis on the claim, the service will not be identified as preventive care and your patients' claims will be paid using their normal medical benefits rather than preventive care coverage.
- Use CPT coding designated as "Preventive Medicine Evaluation and Management Services" to differentiate preventive services from problem-oriented evaluation and management office visits (99381–99397, 99461, 99401–99404, S0610, S0612). Non-preventive care services incorrectly coded as "Preventive Medicine Evaluation and Management Services" will not be covered as preventive care.

When to use modifier 33: preventive service modifier

Modifier 33 was created in response to the preventive service requirements associated with the PPACA. When the primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. Preventive Services Task Force A or B rating in effect, and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending modifier 33, preventive service, to the procedure code.

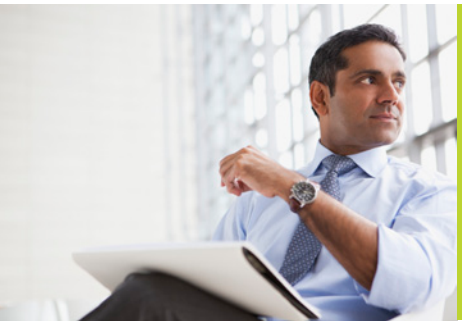
For services represented by codes which may be used for either diagnostic, therapeutic or preventive services, modifier 33 must be appended to that code on the claim when the service was used for the preventive indication.

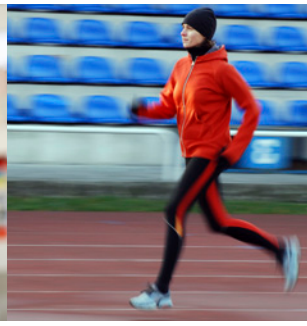
- For example, CPT code 45378, colonoscopy, may be performed for the 50-year-old asymptomatic individual as a routine screening for colorectal cancer. In this case, the colonoscopy is performed for preventive screening and modifier 33 should be appended, in addition to a well-person diagnosis code, such as V76.51.
- However, a colonoscopy, using this same code, may be performed in response to symptoms which a person exhibits. In that case, this service represents diagnostic colonoscopy. The diagnosis code would be one which would signify the symptoms exhibited and modifier 33 would not be appended.

When a separately submitted service is inherently preventive, modifier 33 is not used.

- Routine immunizations recommended for persons living in the United States to prevent communicable diseases are inherently preventive. Therefore modifier 33 would not be appended to these codes.
- Preventive medicine services (office visit services) represented by codes 99381-99387, 99391-99397, 99401-99404, and 99406-99412 are distinct from problem-oriented evaluation and management office visit codes and are inherently preventive. Therefore, modifier 33 would not be utilized with these codes.
- The CPT code for screening mammography is inherently preventive and therefore modifier 33 would not be used.

IMPORTANT NOTE: Our claim systems are not yet configured to process preventive service claims solely based on the use of modifier 33. It is required that the service also be submitted with a well-person diagnosis code as indicated earlier in this guide. We will notify health care professionals when our claim systems can accept and recognize modifer 33.





Screening versus diagnostic, monitoring or surveillance testing

A positive result on a preventive screening exam does not alter the classification of that service as a preventive service.

One example is a screening colonoscopy that is performed on an asymptomatic individual, who has not been diagnosed with the target condition of colorectal cancer or additional risk factors for colorectal cancer, such as adenomatous polyps, or inflammatory bowel disease. If the screening colonoscopy detects colorectal cancer or polyps, the purpose of the colonoscopy remains as preventive screening and is considered a screening colonoscopy, not a diagnostic colonoscopy. In order for Cigna to pay this service accurately as a preventive service, with no cost share required by your patient, the diagnosis and procedure codes submitted on the claim must represent a screening colonoscopy, as indicated on page seven of the following coding table. However, once a diagnosis of colorectal cancer or additional risk factors for colorectal cancer are identified, future colonoscopies will no longer be considered preventive screening, but are considered monitoring or surveillance of a diagnosed condition.

As another example, a bone density screening exam is performed on an asymptomatic woman who has not been diagnosed with osteoporosis. If the bone density screening exam results in a diagnosis of osteoporosis, the purpose of this initial bone density screening exam remains a screening exam, not a diagnostic test. The bone density screening exam should be submitted on the claim form with a designated diagnosis code in the first position, and procedure codes which represent bone density screening exam, as indicated on page eight of the following coding table. However, future bone density exams after the osteoporosis diagnosis is identified, will not be considered preventive screening, but are considered disease monitoring or surveillance of a diagnosed condition.

Services associated with a screening colonoscopy

Ancillary services directly related to a screening colonoscopy are considered preventive services. Therefore, the pre-procedure evaluation office visit with the physician who will perform the colonoscopy, as well as the ambulatory facility fee, anesthesiology (if necessary) and pathology services will be considered and reimbursed without cost share to your patient as preventive services providing the claim is submitted using the diagnosis and procedure codes for a preventive colonoscopy.

Payment of preventive services

Payment of preventive services by Cigna is dependent on claim submission using diagnosis and procedure codes which identify the services as preventive. The coding guidance on the following pages will assist health care professionals and their billing staff with this information.

The following pages provide guidance related to designated preventive services and the associated ICD-9, CPT and HCPCS codes. All standard correct coding practices should be observed.

Additional information about preventive care guidelines is available in the health care professionals section of Cigna's Informed on Reform website: **InformedonReform.com**.

This information does not supersede the specific terms of an individual's health coverage plan, or replace the clinical judgment of the treating physician with respect to appropriate and necessary care for a particular patient.

References
International Classification of Diseases, 9th Revision, Copyright © 2011, Practice Management Information Corporation
Current Procedural Terminology (CPT®) 2011, American Medical Association

Preventive coverage	ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)	CPT codes/ HCPCS codes (represent the services listed)
Comprehensive preventive evaluation and management services (preventive office visits for well baby, well child and well adult, including well woman) **The frequency of visits for infants, children and adolescents complies with the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule, which can be located on the Department of Health and Human Services website, accessible via InformedonReform.com.** Comprehensive preventive medicine evaluation and management of an individual includes: • An age and gender-appropriate history • Physical examination • Counseling/anticipatory guidance • Risk factor reduction interventions and • The ordering of appropriate immunization(s) and laboratory/screening procedures See the following pages for the specific preventive laboratory screenings. Lab screenings not listed in this reference guide will not be covered at the preventive benefit level of reimbursement. These preventive evaluation and management (E&M) services are represented by distinct CPT codes from those that represent problem-oriented evaluation and management services. • Preventive initial E&M (new patient) (CPT codes 99381–99387) • Preventive periodic E&M (established patient) (CPT codes 99391–99397) *Note that codes 99381–99397 include counseling, anticipatory guidance and risk factor reduction interventions that are provided at the time of the initial or periodic comprehensive preventive medicine examination.*	V20.0, V20.1, V20.2, V20.3, V20.31, V20.32 V65.11 V70.0, V70.8, V70.9, V72.3, V72.31, V79.0, V79.1, V79.3, V79.8, V79.9	99381–99387 (new patient) 99391–99397 (established patient) 99461 (initial newborn care) S0610, S0612, S0613 } annual GYN exam 99420 (administration of HRA) G0402, G0438, G0439 (Medicare only)

Preventive coverage	ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)	CPT codes/ HCPCS codes (represent the services listed)
Comprehensive preventive evaluation and management services *(continued)* Typically, the examination component of the preventive evaluation and management service includes, but is not limited to: • Age and gender-appropriate review of physical condition, including vital signs such as blood pressure, height/weight/BMI calculation (utilized to screen for obesity) • Review of family and personal health risks • Screening (not examination) of vision and hearing status • Screening for growth and development milestones and developmental surveillance • Autism screening • Psychosocial/behavioral assessment • Screening for depression in adolescents and adults • Screening for alcohol and substance misuse/abuse • Screening for tobacco use Typically, the counseling/anticipatory guidance/risk factor reduction component of the preventive evaluation and management service includes, but is not limited to: • Oral health (including water fluoridation discussion and referral to dental home) • Counseling regarding obesity, weight loss, healthy diet and exercise • Breast-feeding counseling and support • Counseling and evaluation for BRCA testing (genetic counseling only – BRCA testing is not included) • Discussion of chemoprevention with women at high risk for breast cancer • Counseling related to sexual behavior/STD/STI prevention • Aspirin prophylaxis for cardiovascular risk • Guidance and counseling regarding substance abuse, alcohol misuse, tobacco use, obesity, exercise and healthy diet/nutritional counseling as indicated, • Behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related disease • Screening procedure recommendations (such as breast cancer, colorectal cancer, osteoporosis) • Review of laboratory test results available at the time of the encounter • Counseling regarding minimizing exposure to ultraviolet radiation in persons 10–24 years of age • Screening and counseling for domestic and interpersonal violence • Counseling and education regarding FDA-approved contraception methods for women with reproductive capacity		If counseling services are required beyond what is described as included in the preventive medicine E&M visit codes, see specific counseling codes in the following section, as well as the following codes: 96110 (developmental testing , limited (such as developmental screening test II) S0302 – early periodic screening, diagnosis and treatment (EPSDT) 96040, S0265 (genetic counseling, each 30 minutes or 15 minutes respectively) such as for BRCA counseling: up to three visits for a preventive indication 97802–04, S9470 (medical nutrition therapy services) up to three visits for a preventive indication G0442, G0443, G0444, G0445, G0446, G0447, G0449, G0450, G0451

Preventive coverage	ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)	CPT codes/ HCPCS codes (represent the services listed)
Preventive medicine, individual counseling CPT codes 99401–99404 are designated to report services provided to individuals at a face-to-face encounter for the purpose of promoting health and preventing illness or injury. Preventive medicine counseling and risk factor reduction interventions will vary with age and should address such issues as: • Diet and exercise (such as related to obesity, hyperlipidemia) • Substance misuse/abuse • Tobacco use and cessation • Sexual practices, and STD/STI prevention • Screening procedures and laboratory test results available at the time of the encounter • Breast-feeding counseling and support • Domestic and interpersonal violence • FDA-approved contraception methods for women with reproductive capacity Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment. These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. For counseling individual patients with symptoms or established illness, use the appropriate office, hospital, consultation or other evaluation and management codes.	V65.3, V65.42, V65.44, V65.45	99401–99404 If behavior change interventions are required beyond what is described in the preventive medicine counseling code descriptions here, see specific codes in the following section which represent smoking and tobacco cessation counseling, alcohol or substance abuse screening and counseling G0443, G0445, G0446, G0447
Behavior change interventions CPT codes 99406–99412 are designated to report services provided to individuals at a face-to-face encounter and are utilized for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse or obesity. Behavior change services may be reported when performed as part of the treatment of conditions related to or potentially exacerbated by the behavior or when performed to change the harmful behavior that has not yet resulted in illness. Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up.	V65.42, V79.1	99406–99412 G0446, G0447

Preventive coverage	ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)	CPT codes/ HCPCS codes (represent the services listed)
Routine immunizations and administration of vaccines **Please note that immunizations that are administered solely for the purpose of travel or occupation are typically excluded from coverage in most Cigna plans.** There are four immunization schedules on the website of the Centers for Disease Control (CDC). These represent the routine immunization services that are currently designated as preventive care by the PPACA regulations. The URLs for those schedules are listed here for your convenience. The schedules are: • Childhood: ages zero through six years, and • Childhood : ages seven through 18 years • Childhood: catch-up schedule • Adult schedule www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#hcp www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm#hcp Diphtheria, tetanus toxoids and acellular pertussis (DTaP) (Tdap) (Td) Haemophilus influenzae type b conjugate (Hib) Hepatitis A (HepA) Hepatitis B (HepB) Human papillomavirus (HPV) Influenza vaccine Measles, mumps and rubella (MMR) Meningococcal (MCV) Pneumococcal (pneumonia) Poliovirus (IPV) Rotavirus Varicella (chickenpox) Zoster	V20.2, V70.0, V03.5, V03.6, V03.7, V03.81, V03.82, V03.89, V04.0, V04.2, V04.3, V04.6, V04.8, V04.81, V04.89, V05.3, V05.4, V06.1, V06.2, V06.3, V06.4, V06.5, V06.6, V06.8, V06.9	**Administration codes:** 90465–90468 (to be replaced 1/1/2011 with CPT codes 90460, 90461) 90471–90474, G0008, G0009, G0010, J3530 **Vaccine codes:** 90696, 90698, 90700–90703, 90714, 90715, 90718, 90719, 90720, 90721, 90723, 90647, 90648 90632–90634, 90636, 90740, 90743, 90744, 90746, 90747, 90748 90649, 90650 90654–90658, 90660–90662, 90704, 90705, 90706, 90707, 90708, 90710 90732, 90733, 90734, 90644 90669, 90670, 90732, S0195 90712, 90713, 90680, 90681 90716, 90736 Q2034, Q2035, Q2036, Q2037, Q2038, Q2039 (Medicare only)
Screenings The following laboratory and imaging screening procedures are the designated preventive services that are allowed without cost sharing to the patient. Additional laboratory or procedural services if ordered, will be subject to standard medical plan provisions of deductible, coinsurance or copay by the patient.		
Abdominal aortic aneurysm screening by ultrasonography: men, age 65–75 who have ever smoked	V70.0, V70.8	76700, 76705, 76770, 76775, G0389

Preventive coverage	ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)	CPT codes/ HCPCS codes (represent the services listed)
Screenings *(continued)* Anemia screening, iron deficiency: pregnant women	Covered as preventive only when submitted with a maternity diagnosis code	85013, 85014, 85018, 85025, 85027, 85041, G0306, G0307
Bacteriuria screening with urine culture: pregnant women at 12–16 weeks gestation or at the first prenatal visit, if later	Covered as preventive only when submitted with a maternity diagnosis code	87086, 87088
Breast cancer screening: women 40 and older: screening mammography with or without clinical breast exam, every one to two years	V76.10, V76.11, V76.12, V76.19, V16.3	77055, 77056, 77057, 77051, 77052, G0202, G0204, G0206
Cervical cancer screening: • Pap smear, women 21–65 every three years • HPV DNA test in combination with Pap smear, women age 30–65, every five years	V76.2, V72.32	87620–22, 88141–43, 88147–48, 88150, 88152, 88153, 88154, 88164–67, 88174–75, G0101, G0123–24, G0141, G0143–45, G0147–48, P3000, P3001, Q0091
Chlamydial infection screening: all sexually active women age 24 and younger, and older women at increased risk	V73.88, V73.98: or a maternity diagnosis code	86631–32, 87110, 87270, 87320, 87490–92, 87810, G0450
Cholesterol screening (dyslipidemia): children at risk due to known family history, when family history is unknown, or with personal risk factors such as obesity, high blood pressure or diabetes, after age two but by age 10 (periodicity schedule/Bright Futures)	V 77.91	80061, 82465, 83718, 83719, 83721, 84478
Cholesterol screening (dyslipidemia) in adults: • Men age 35 and older: or age 20–35 if risk factors for coronary heart disease are present • Women age 45 and older: or age 20–45 if risk factors for coronary heart disease are present	V77.91	80061, 82465, 83718, 83719, 83721, 84478
Colorectal cancer screening: beginning at age 50 by any of the following methods: • Fecal occult blood testing (FOBT)/fecal immunochemical test (FIT), annually; or • Sigmoidoscopy every five years; or • Colonoscopy every 10 years; or • Computed tomographic colonography[1] (virtual colonoscopy) every five years; or • Double contrast barium enema (DCBE) every five years	V76.41, V76.50, V76.51, V76.52, V16.0, V18.51	82270, 82274, G0328, 45330, 45331, 45338, 45339, G0104, 45378, 45380, 45381, 45383, 45384, 45385, G0105, G0121 74263[1] 74270, 74280, G0106, G0120, G0122 00810, 88305
Congenital hypothyroidism screening: newborns	V77.0, V20.2	84436, 84437, 84443

Preventive coverage	ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)	CPT codes/ HCPCS codes (represent the services listed)
Screenings *(continued)* Diabetes screening: adults with sustained blood pressure greater than 135/80 (whether treated or untreated)	V77.1	82947, 82948, 83036
Gestational diabetes: pregnant women at first prenatal visit for those at risk; all pregnant women at 24 to 28 weeks gestation	Covered as preventive only when submitted with a maternity diagnosis code	82950, 82951, 82952
Gonorrhea screening: sexually active women including pregnant women if they are at increased risk for infection	V74.5: or a maternity diagnosis code	87850, 87590, 87591, G0450
Gonorrhea: prophylactic ocular medication for all newborns to prevent blindness (typically instilled at birth)	V20.2	No specific code; typically included on hospital billing, miscellaneous charge
Hearing screening: infants, children through age 10 (not a full hearing examination)	V20.2	May be a component of the preventive E&M visit service or 92551, 92552, 92553, 92568, 92583, 92586, 92587
Hemoglobin or hematocrit: infants, children (see anemia screening for pregnant women, above)	V20.2	85013, 85014, 85018, 85025, 85027, 85041, G0306, G0307
Hemoglobinopathy screening for sickle cell disease: newborns	V78.2	85660
Hepatitis B screening: pregnant women, first prenatal visit	Covered as preventive only when submitted with a maternity diagnosis code	87340, 87341, G0450
HIV screening: pregnant women, adolescents and men at risk ; annually for sexually active women	V73.89: or a maternity diagnosis code	86701, 86703, 87390, G0432, G0433, G0435, S3645
Hypothyroidism, congenital: newborns	V77.0	84436, 84437, 84443
Lead screening for children at risk for lead exposure (periodicity schedule/Bright Futures)	V20.2	83655
Newborn metabolic screening panel (specific combination of tests will vary according to state law): there are not designated codes for all heritable diseases which are identified for screening in this recommendation	V20.2, V78.3	S3620
Nutrition counseling for adults with hyperlipidemia, and other known risk factors for cardiovascular and diet-related chronic disease; nutrition counseling and behavioral interventions to promote sustained weight loss for obese adults and children age six years and older	V65.3, V77.8	97802, 97803, 97804, S9470 May also be performed as component of preventive E&M visit or in context of preventive counseling visit (99401–99404)
Osteoporosis screening: women age 65 or older (or younger women at risk)[2]	V82.81, V17.81	76977, 77078,[2] 77079,[2] 77080, 77081, G0130
Ovarian cancer/breast cancer risk: referral/counseling for women whose family history is associated with increased risk for BRCA1 and BRCA2 gene mutations (does not include BRCA test)	V26.33, V16.3, V16.41	96040, S0265

Preventive coverage	ICD-9 codes (represent services that are NOT for treatment of illness or injury and should be submitted as the primary diagnosis for preventive services)	CPT codes/ HCPCS codes (represent the services listed)
Screenings *(continued)* Phenylketonuria (PKU) screening: newborns	V20.2, V77.3	84030
Rh incompatibility screening: Rh (D) blood typing and antibody testing for all pregnant women at first visit and repeat for unsensitized Rh negative women at 24–28 weeks	Covered as preventive only when submitted with a maternity diagnosis code	86900, 86901
Prostate cancer screening: PSA age 50 and older or age 40 with risk factors	V76.44, V16.42	84152, 84153, 84154, G0103
Syphilis screening: all pregnant women and persons at increased risk of syphilis infection	V74.5; or a maternity diagnosis code	86592, 86593, G0450
Tobacco use: counseling and interventions for tobacco cessation in adults who smoke	Any diagnosis code	99406, 99407; HCPCS codes C9801, C9802 will be replaced with G0436, G0437 effective 1/1/2011
Tuberculin testing: children and adolescents at high risk	V20.2, V74.1	86580
Visual impairment screening: age three through age 18 (USPSTF and periodicity schedule/Bright Futures)	V20.2	Preventive E&M visit component or 99173

[1.] CPT code 74263 (computerized tomographic colonography) requires precertification

[2.] CPT codes 77078 and 77079 (computed tomography, bone density studies) require precertification

Medication	Examples	Recommended for this population
After completing an analysis of the current PPACA guidance, Cigna has determined there are four instances in which the regulations recommend the use of a prescription medication or an over-the-counter (OTC) medication. These medications and OTCs will be administered under our pharmacy benefits and will require a prescription – even for the OTCs. This section does not apply to customers who do not have Cigna pharmacy benefit plans.		
Aspirin to prevent cardiovascular disease (OTC)	Ascriptin, Bufferin, Halfprin	Men ages 45–79, Women ages 55–79
Iron supplementation (OTC) (for children at increased risk for iron-deficiency anemia)	Fer-In-Sol®, Vitafol®, ICAR, Fer-Gen-Sol	Children ages six–12 months
Folic acid supplementation (for women planning or capable of pregnancy)	Prenatal, Natalcare, Optinate, folic acid	Women of childbearing age
Oral fluoride supplementation (where water source does not contain fluoride)	Poly-Vi-Flor, Fluor-A-Day®, Luride, Fluoritab	Children ages six months to preschool
Note: Ocular topical medication for newborns is also referenced in the regulations; however, this medication is typically administered at birth and covered under the hospital charges.		

Breast-feeding equipment and supplies	Examples	HCPCS codes
Provision of breast pumps and supplies for postpartum women to ensure successful breast-feeding. Requires a prescription and must be ordered through CareCentrix, Cigna's national durable medical equipment vendor.	Breast pump, manual (purchase only)	E0602
	Breast pump, electric (rental)	E0603
	Breast pump, hospital grade	E0604[3]
	Supplies	A4281–A4286

[3] HCPCS code E0604 requires precertification

Contraceptive services for women

The following contraceptive methods are covered for women with reproductive capacity.[4]

Method/type	Examples	CPT/HCPCS codes
Services for insertion/removal of intrauterine devices, implants; fitting diaphragm or cervical cap		58300–58301, 11976, 11981–11983, 57170, S4981
Surgical sterilization procedures for women		58565, 58600, 58605, 58611, 58615, 58670, 58671, A4264
Contraceptive products covered at no cost share:		
Generic oral contraceptives	Ameithia, Apri, Camila, Jolessa, Levora, Low-Ogestrel, Nortrel, Solia	
Diaphragms and cervical caps	Femcap, Ortho All-flex	A4266, A4261
Spermacides (OTC)[5]	VCF (foam), Gynol II (jelly), Encare (suppository)	A4269
Sponge (OTC)[5]	Today	
Female condom (OTC)[5]	Aimsco, Fantasy, Kimono, Trustex	A4268
IUD devices	Mirena, ParaGard	J7302, J7300
Injection	Depot medroxyprogesterone acetate	J1055 (Use J1055 when physician administration is required)
Implants	Implanon, Nexplanon	J7307
Patch	Ortho Evra	J7304
Vaginal ring	Nuvaring	J7303
Emergency contraception (originally FDA approved Plan B) generic and OTC[5] forms	Ella, Levonorgestrel, Next Choice (two pill regimen of .75 mg of levonorgestrel)	

Contraceptive products that require customer cost share:		
Brand oral contraceptives[6]	Brands with generic therapeutic equivalents: Seasonique, Ortho-Novum 7/7/7, Yaz Brands that have therapeutic oral contraceptive alternatives: BeYaz, LoLoestrin FE, LoSeasonique, Ovcon-50, Natazia, Safyral	
Injection	Depo-Provera (brand only versions)	J1055 (Use J1055 when physician administration is required)
Emergency contraception (originally FDA approved Plan B) brand only versions	Plan B One-Step 1.5 mg (one pill regimen)	

4. The most recent recommendations released by the Department of Health and Human Services (HHS) for preventive care services for women become effective for non-grandfathered plans upon renewal date occurring on or after August 1, 2012, unless exemptions apply.

5. For coverage of any OTC product under the pharmacy benefit, a written order from a prescribing health care professional is required. Should the OTC product be obtained in customer-directed care/purchase (without a prescription at point of sale), pharmacy benefit coverage is not extended at point of sale.

6. Brand oral contraceptives have preferred and non-preferred products available. Customers should refer to their specific drug list on **myCigna.com** or **myCignaforHealth.com** to determine preferred or non-preferred brand status.