

2024 Preventive Services Reference Guide for Members[‡]

In accordance with the Patient Protection and Affordable Care Act of 2010 (PPACA), many preventive services, including screening tests and immunizations, are covered by UPMC Health Plan at no cost to members. Below is a list of services that should be covered without a copayment or coinsurance and without the need to meet your deductible as long as the services are delivered by a network provider and in compliance with the terms of the preventive recommendation. Please be aware that this list may be amended from time to time to comply with federal requirements. A complete listing of recommendations and guidelines can always be found at healthcare.gov/coverage/preventive-care-benefits.

Please note: Routine preventive exams may result in specific diagnoses from your doctor or the need for follow-up care. If you require follow-up care or if you're already being treated for a condition, injury, or illness, services related to such care may not be considered preventive and may result in health care expenses, such as copayments and coinsurance. This is true even if the services are included on the list below. If you have any questions, call your Health Care Concierge team at **1-888-876-2756 (TTY: 711)**.

Under some plans that are "grandfathered" under the PPACA, you may have to pay all or part of the cost of routine preventive services. Please refer to your specific Schedule of Benefits.

Covered Preventive Services for Adults Ages 18 and Older

EXAMINATION AND COUNSELING

Clinical indicator	Ages 18-29	Ages 30-39	Ages 40-49	Ages 50-64	Ages 65+
Blood pressure	Annually as part of a physical or well-visit.				
Depression	Each visit as appropriate.				
General physical exam	Annually.				
Obesity prevention in midlife members			Annual counseling for midlife members ages 40-60 with normal or overweight body mass index (18-29.9 kg/m ²) to maintain weight or limit weight gain. Counseling may include an individualized discussion of healthy eating and physical activity.		
Screen/Counsel/Refer for tobacco use, alcohol misuse, substance use, skin cancer, healthy diet, and/or intimate partner violence	Each visit as appropriate.				
Sexually transmitted infection (STI) prevention counseling	Each visit for high-risk adults.				
Weight loss to prevent obesity-related morbidity and mortality	Offer or refer adults with a body mass index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions.				

PREVENTIVE MEASURES

Clinical indicator	Ages 18-29	Ages 30-39	Ages 40-49	Ages 50-64	Ages 65+
Abdominal aortic aneurysm screening					One-time screening with ultrasonography in men ages 65-75 years who have smoked.
Anxiety screening	Screening intervals based upon clinical judgment.				
Blood pressure monitoring	If blood pressure numbers are high, additional monitoring with home blood pressure monitoring outside of the doctor's office or clinic to confirm diagnosis of high blood pressure before starting treatment.				
BRCA screening and counseling	One-time genetic assessment for members with a personal or family history of breast, ovarian, tubal, or peritoneal cancer, as recommended by their doctor. Members with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.				
Breast cancer preventive medications			Risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, for members ages 35 or older who are at increased risk for breast cancer and at low risk for adverse medication effects.*		
Breast cancer screening				Annually.	
Cervical cancer screening	For members ages 21-29, screening every three years with cervical cytology alone.	For members ages 30-65, screening every three years with cervical cytology alone, every five years with high-risk human papillomavirus (hrHPV) testing alone, or every five years with hrHPV testing in combination with cytology (cotesting).			

[‡]This guide is intended for members with employer-sponsored and/or individual Marketplace insurance. It is not intended for members with government-sponsored insurance, such as Medicare and Medical Assistance plans.

Covered Preventive Services for Adults Ages 18 and Older (cont'd)

PREVENTIVE MEASURES

Clinical indicator	Ages 18-29	Ages 30-39	Ages 40-49	Ages 50-64	Ages 65+
Chlamydia screening	Sexually active members ages 24 and younger.	Members who are at increased risk.			
Colorectal cancer screening				Preventive screenings provided for asymptomatic members ages 45-75 who are at average risk of colorectal cancer and who do not have inflammatory bowel disease, previous adenomatous polyp(s), previous colorectal cancer, or a family history that predisposes them to a high risk of colorectal cancer. Screening procedures (fecal occult blood test, sigmoidoscopy, and colonoscopy) are subject to provider recommendation. Frequency of screening depends on recommended procedure. Bowel preparations for colonoscopy limited to two prescriptions per year.* Contact Member Services with questions.	
Contraception	Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling.* Limitations may apply for brand drugs with an available generic alternative. If your provider recommends a brand drug with an available generic, your provider may submit an exception request to have the brand drug covered without cost sharing. See Cost-Sharing Exceptions form included with this reference guide.				
Diabetes mellitus, type 2 (after pregnancy)	Screening for members with a history of gestational diabetes mellitus who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes mellitus. Members with a negative initial postpartum screening test result should be rescreened at least every three years for a minimum of 10 years after pregnancy. For members with a positive postpartum screening test result, testing to confirm the diagnosis of diabetes is indicated regardless of the initial test. Repeat testing is indicated for members who were screened with hemoglobin A1c in the first six months postpartum, regardless of the result.				
Gonorrhea screening	Sexually active members ages 24 and younger.	Members who are at increased risk.			
Fall prevention					Community-dwelling members ages 65 and older who are at increased risk for falls may receive exercise interventions to aid in fall prevention.
Hepatitis B screening	Members who are at increased risk.				
Hepatitis C virus infection screening	Recommended one-time screening for asymptomatic members ages 18-79 who are considered low risk following clinical assessment and who have not been diagnosed with liver disease. Screenings as necessary for asymptomatic members who have not been diagnosed with liver disease but who are at increased risk following clinical assessment.				
Human immunodeficiency virus (HIV) infection prevention	Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy for members who are at high risk of HIV acquisition.*				
Human immunodeficiency virus (HIV) screening	Members ages 15-65 and/or sexually active members who are younger than 15 or older than 65.				
Lung cancer screening				Members ages 50-80 who have a 20 pack per year smoking history and currently smoke or have quit within the past 15 years may receive an annual lung cancer screening at a Center of Excellence.	
Osteoporosis screening	One-time screening for osteoporosis with bone density testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.				One-time screening for osteoporosis with bone density testing to prevent osteoporotic fractures in women 65 years and older.
Prediabetes and type 2 diabetes screening	Screening for prediabetes and type 2 diabetes in adults ages 35 to 70 who are overweight or obese.				
Statin use for the prevention of cardiovascular disease (CVD)	Members ages 40-75 with no history of CVD, one or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.*				
Syphilis screening	Members who are at increased risk.				
Tobacco cessation medications ¹	Up to 180 days of pharmacotherapy per year, as prescribed by your doctor, for members age 18 and older who smoke.*				

Covered Preventive Services for Adults Ages 18 and Older (cont'd)

PREVENTIVE MEASURES

Clinical indicator	Ages 18-29	Ages 30-39	Ages 40-49	Ages 50-64	Ages 65+
Latent tuberculosis infection screening					Members who are at increased risk.
Urinary incontinence					Annually.

*Member must have pharmacy benefits through UPMC Health Plan. Prescription required. Pharmacotherapy approved by the Food and Drug Administration and identified as effective for treating tobacco dependence in nonpregnant adults.

PREVENTIVE SERVICES FOR PREGNANCIES


Clinical indicator	
Alcohol use screening	Expanded counseling and interventions for pregnant members.
Aspirin use for the prevention of pre-eclampsia	Pregnant members who are at high risk for preeclampsia after 12 weeks of gestation.*
Bacteriuria screening	Screening for asymptomatic bacteriuria using urine culture in pregnant members.
Breastfeeding	Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies for pregnant and nursing members.
Chlamydia and gonorrhea screening	Pregnant members ages 24 and younger or pregnant members 25 and older who are at increased risk.
Folic acid supplements (< 1 mg)	Members who are or may become pregnant.*
Gestational diabetes screening	Members 24-28 weeks pregnant and at first prenatal visit for those at high risk of developing gestational diabetes.
Healthy weight and weight gain in pregnancy: Behavioral counseling interventions	Behavioral counseling for interventions aimed at promoting healthy weight gain and preventing excess weight gain in pregnancy.
Hepatitis B virus infection screening	Screening for pregnant members at their first prenatal visit.
HIV screening	Screening for pregnant members.
Perinatal depression	Screen or refer members for depression counseling for all pregnant and postpartum (less than one year) members.
Pre-eclampsia screening	Screening in pregnant members with blood pressure measurements throughout pregnancy.
Rh(D) incompatibility screening	Screening for pregnant members at first prenatal visit and follow-up testing for pregnant members with increased risk.
Syphilis screening	Early screening for pregnant members.
Tdap	Each pregnancy, with timing of administration based upon clinical recommendations.‡
Tobacco use screening	Screen pregnant members for tobacco use and (if applicable) advise to stop use and provide behavioral interventions for tobacco cessation.


*Member must have pharmacy benefits through UPMC Health Plan. Prescription required. Preventive coverage of prescription drugs is limited to generics unless a medical exception is authorized. If you have questions about preventive coverage of contraceptives or other prescription drugs, please call our Health Care Concierge team at the number on your member ID card.


‡For additional information on Tdap recommendations while pregnant, please see the CDC website: upmchp.us/PSRGTdap.

Recommended Immunization Schedule for Adults

VACCINE ▼ AGE GROUP ►	18-26 years	27-49 years	50-64 years	≥ 65 years
COVID-19♦	Follow CDC guidelines			
Haemophilus influenzae type b (Hib)	1 or 3 doses depending on indication			
Hepatitis A	2 or 3 doses depending on vaccine			
Hepatitis B	2, 3, or 4 doses depending on vaccine or condition			2, 3, or 4 doses depending on vaccine or condition for those 60 years and older
Human papillomavirus (HPV) (female and male)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
Influenza (flu shot)	Annually			
Measles, mumps, rubella (MMR)*	1 or 2 doses depending on clinical indication			
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication†			
Meningococcal B (MenB)^	19 through 23 years	2 or 3 doses depending on vaccine type and per indication^		
Pneumococcal (PCV15, PCV20, PPSV23)	1 dose PCV15, followed by PPSV23 OR 1 dose PCV20			1 dose PC15, followed by PPSV23 OR 1 dose PCV20
Tetanus, diphtheria, pertussis (Td/Tdap)♦	1 dose Tdap, then Td or Tdap booster every 10 yrs or for wound management if greater than five years since last dose*			
Varicella (VAR)	2 doses (if born in 1980 or later)		2 doses	
Zoster live (ZVL)				1 dose for those 60 years and older
Zoster recombinant (RZV)	2 doses for immunocompromising conditions		2 doses	

 For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection, zoster vaccine recommended regardless of prior episode of zoster

 Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indication)

 Range of recommended ages for nonrisk groups that may receive vaccine = subject to individual clinical decision making

†Special situations for MenACWY:

- **Anatomical or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:** Two-dose series MenACWY (Menactra, Menveo) at least eight weeks apart and revaccinate every five years if risk remains.
- **Travel in countries with hyperendemic or epidemic meningococcal disease, microbiologists routinely exposed to *Neisseria meningitidis*:** One dose MenACWY (Menactra, Menveo) and revaccinate every five years if risk remains
- **First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) and military recruits:** One dose MenACWY (Menactra, Menveo)

^Shared clinical decision making for MenB:

- **Adolescents and young adults ages 16-23 years (ages 16-18 years preferred) not at increased risk for meningococcal disease:** Based on shared clinical decision making, two-dose series MenB-4C at least one month apart, or two-dose series MenB-FHbp at 0 and 6 months (if dose two was administered less than six months after dose one, administer dose three at least four months after dose two); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series).

Special situations for MenB:

- **Anatomical or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use, microbiologists routinely exposed to *Neisseria meningitidis*:** Two-dose primary series MenB-4C (Bexsero) at least one month apart, or three-dose primary series MenB-FHbp (Trumenba) at 0, 1-2, and 6 months (if dose two was administered at least six months after dose one, dose three is not needed); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series); one dose MenB booster one year after primary series and revaccinate every two to three years if risk remains.
- **Pregnancy:** Delay MenB until after pregnancy unless at increased risk and vaccination benefits outweigh potential risks.

♦For additional information on Tdap recommendations, please see the CDC website: upmchp.us/Tdap.

Covered Preventive Services for Children

SCREENINGS

Services	Infancy									
	Birth to 1 mo	2-3 mos	4-5 mos	6-8 mos	9-11 mos	12 mos	15 mos	18 mos	24 mos	30 mos
Anemia screening						✗				
Autism screening								✗	✗	
Behavioral assessments	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Body mass index (BMI) measurements									✗	✗
Critical congenital heart defect	✗									
Developmental screening					✗			✗		✗
Developmental surveillance	✗	✗	✗	✗		✗	✗		✗	
Fluoride supplements	For children ages 6 months through 16 years whose water supply is deficient in fluoride.*									
Fluoride varnish to primary teeth	All children annually beginning at first primary tooth eruption to 5 years.									
Gonorrhea (preventive medication)	✗									
Hearing	Once at birth and once before end of 2 months.									
Hearing tests	✗	✗	May be completed up to 30 months.							
Hepatitis B (HBV)	Children at increased risk as determined by clinical assessment.									
Lead screening						✗			✗	Ages 30 months to 5 years and as required by local or state law.
Newborn bilirubin	✗									
Newborn blood (including RUSP)	✗	✗								
Skin cancer behavioral counseling				Children with fair skin.						
Tuberculosis testing	As recommended by doctor and based on history and/or signs and symptoms.									
Vision	Assess through observation or health history/physical.									
Well-child, including height and weight	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗

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Covered Preventive Services for Children (cont'd)

SCREENINGS


Services	Childhood															
	3 yrs	4 yrs	5 yrs	6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs	18 yrs
Behavioral assessments	Annually.															
Blood pressure	Annually.															
Body mass index (BMI) measurements	Annually.															
Cholesterol dyslipidemia screening								X								X
Depression, anxiety, and suicide risk											Screen/Counsel for major depressive disorder (MDD), anxiety and suicide risk in adolescents through age 21.					
Developmental surveillance	Annually															
Fluoride supplements	For children ages 6 months through 16 years whose water supply is deficient in fluoride.*															
Fluoride varnish to primary teeth	All children annually beginning at first primary tooth eruption to 5 years.															
Hearing		X	X	X		X		X		X				X		Once b/t 18-21 yrs.
Hepatitis B (HBV)	Children at increased risk as determined by clinical assessment.															
Hepatitis C																X
Human immunodeficiency virus (HIV)**											Children at increased risk as determined by clinical assessment.			Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.		
Lead screening	Ages 30 months to 5 years and as required by local or state law.															
Obesity screening	Annually through 18 years.															
Screen/Counsel for alcohol and drug use, sexually transmitted infections, tobacco use, and intimate partner violence as needed	Annually.															
Sickle cell test	As indicated by history and/or symptoms.															
Skin cancer behavioral counseling	Children with fair skin.															
Sudden cardiac arrest/death	Annually or as clinically appropriate through age 21.															
Tuberculosis testing	As recommended by doctor and based on history and/or signs and symptoms.															
Vision	All children ages 3-5 should receive an amblyopia screening.			Annually.												
Well-child, including height and weight	Annually.															


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**The United States Preventive Services Task Force suggests that clinicians weigh all these factors when considering PrEP use in adolescents at high risk of HIV acquisition (jamanetwork.com/journals/jama/fullarticle/2735509).


Recommended Immunization Schedule for Children

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16-18 yrs
COVID-19 [◆]					Follow CDC guidelines											
Dengue (DEN4CYD; 9-16 yrs)														3-dose series. Seropositive in endemic areas only.*		
Diphtheria, tetanus, and acellular pertussis (DTaP: < 7 yrs)			1st dose	2nd dose	3rd dose	4th dose			5th dose							
Haemophilus influenzae type b (Hib)			1st dose	2nd dose		3rd or 4th dose										
Hepatitis A (HepA)					2-dose series [‡]											
Hepatitis B (HepB)	1st dose	2nd dose		3rd dose												
Human papillomavirus (HPV)														2-dose series		
Inactivated poliovirus (IPV) (< 18 yrs)			1st dose	2nd dose	3rd dose					4th dose						
Influenza (flu shot), (IIV) 2 doses for some					Annually											
Measles, mumps, rubella (MMR)					1st dose			2nd dose								
Meningococcal (MenACWY-D ≥ 9 mos, MenACWY-CRM ≥ 2 mos)														1st dose		2nd dose
Meningococcal B																
Pneumococcal conjugate (PCV13, PCV15)			1st dose	2nd dose	3rd dose	4th dose										
Pneumococcal polysaccharide (PPSV23)																
Rotavirus (RV) RV1 (2-dose series); RV5 (3-dose series)			1st dose	2nd dose												
Tetanus, diphtheria, and acellular pertussis (Tdap: ≥ 7 yrs)														Tdap		
Varicella (VAR)						1st dose			2nd dose							

 Range of recommended ages for all children

 Range of recommended ages for catch-up immunization

 Range of recommended ages for certain high-risk groups

 Range of recommended ages for nonrisk groups that may receive vaccine, subject to individual clinical decision making

[‡]**Hepatitis A (HepA):** Two doses should be administered six months apart. Recommended minimum age for first dose is 12 months.

***Dengue Vaccine:** Age 9–16 years living in dengue endemic areas AND have laboratory confirmation of previous dengue infection. Three doses should be administered 6 months apart at 0, 6, and 12 months.

[◆] For additional information on COVID-19 recommendations, please see the CDC website: [upmchp.us/PSRGCovid](https://www.cdc.gov/psrg/covid/).

UPMC HEALTH PLAN

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Prior authorization form

Cost-Sharing Exceptions for Contraceptives - Commercial and CHIP

Phone: 1-800-979-UPMC (8762) Fax: 412-454-7722

Providers should complete this form and submit via fax, or submit a request online at upmc.promptpa.com.

Patient name:		Prescriber name:	
UPMC member ID#:		Prescriber specialty:	
Date of birth:	Age:	Office contact:	
Drug name and strength:		NPI:	
<input type="checkbox"/> Brand	<input type="checkbox"/> Generic	Fax:	Phone:
Frequency:	Quantity dispensed (units):	If medication is ongoing, did the member show improvement while on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Generic-equivalent drugs will be substituted for brand-name drugs unless you specifically indicate otherwise.			
Place of administration (if billing medically): <input type="checkbox"/> Physician's office <input type="checkbox"/> Hospital/Facility <input type="checkbox"/> Patient home <input type="checkbox"/> Other			
Please provide hospital/facility information (if billing medically): Name: _____ Phone: _____ Address: _____		Please indicate how medication will be billed: <input type="checkbox"/> Billed directly by the provider via JCODE JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
Please indicate if an expedited review is needed by writing "urgent" on the form. An expedited review will be considered when a condition exists that places the health or safety of the person afflicted with such condition or other person(s) in serious jeopardy.			
Q1. Is this request for new or continuation of therapy? <input type="checkbox"/> New <input type="checkbox"/> Continuation			
Q2. Please provide start date of medication.			
Q3. Please provide the member's diagnosis or medical condition.			
Q4. Please provide any medications previously tried to treat the member's condition, including dosage, dates of therapy, and reason for discontinuation.			
Q5. Is this contraceptive method/medication medically necessary for the member? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Q6. Please provide the clinical rationale for why this contraceptive method/medication is medically necessary for the member.			

UPMC HEALTH PLAN

Prior authorization form

Cost-sharing exceptions for HIV PrEP - Commercial and CHIP

Phone: 1-800-979-UPMC (8762) Fax: 412-454-7722

To submit a request online, please visit upmc.promptpa.com.

Patient name:		Prescriber name:	
UPMC member ID#:		Prescriber specialty:	
Date of birth:	Age:	Office contact:	
Drug name and strength:		NPI:	
<input type="checkbox"/> Brand <input type="checkbox"/> Generic		Fax:	Phone:
Frequency:	Quantity dispensed (units):	If medication is ongoing, did the member show improvement while on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Generic-equivalent drugs will be substituted for brand-name drugs unless you specifically indicate otherwise.			
Place of administration (if billing medically): <input type="checkbox"/> Physician's office <input type="checkbox"/> Hospital/Facility <input type="checkbox"/> Patient home <input type="checkbox"/> Other			
Please provide hospital/facility information (if billing medically): Name: _____ Phone: _____ Address: _____		Please indicate how medication will be billed: <input type="checkbox"/> Billed directly by the provider via JCODE JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
Please indicate if an expedited review is needed by writing "urgent" on the form. An expedited review will be considered when a condition exists that places the health or safety of the person afflicted with such condition or other person(s) in serious jeopardy.			
Q1. Is this request for new or continuation of therapy? <input type="checkbox"/> New <input type="checkbox"/> Continuation			
Q2. Please provide start date of medication.			
Q3. Please provide the member's diagnosis.			
Q4. Is the member HIV positive? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Q5. Is the member at high risk of HIV infection?

Yes No

Q6. Has the member tried the following preferred medication for this condition?

Emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg (generic Truvada)

Please provide chart documentation that includes the duration of treatment with emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg and laboratory or other objective clinical metrics, if applicable.

Q7. For all medications previously tried to treat the member's condition, please include dosages, dates of therapy, and reasons for discontinuation.

Q8. Did the member experience side effects with emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg (generic Truvada)?

Yes No

Q9. If yes and requesting emtricitabine 200 mg/tenofovir alafenamide 25 mg (Descovy), please provide rationale for why these side effects would not be expected to occur with emtricitabine 200 mg/tenofovir alafenamide 25 mg (Descovy).

Q10. For emtricitabine 200 mg/tenofovir alafenamide 25 mg (generic Descovy) and cabotegravir (generic Apretude), please provide clinical rationale for prescribing the requested medication instead of emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg (generic Truvada). Please include why this medication would not be as effective as the requested therapy.