# Fact Sheet - Plan First Program

***What is Plan First?***

The Plan First Program is a program designed to extend family planning and birth control services to expanded eligibility groups in Alabama.

Approved in June 2000, the Plan First Program operates under a federally-approved Demonstration Waiver granted by the Centers for Medicare and Medicaid Services (CMS).

***Who is eligible for Plan First?***

To qualify for the Plan First Program, a woman must be between the ages of 19 through 55 and a man must be age 21 or older (desiring a vasectomy) with an income which does not exceed 141% of the Federal Poverty Level (FPL). A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income. Maternity Care eligible women who lose Medicaid coverage after their Medicaid Maternity eligibility ends, become automatically eligible for the Plan First Program.

Women who are not automatically enrolled, who wish to apply for family planning services may obtain an application from the Alabama Department of Public Health, outstationed Medicaid workers, providers of services to pregnant women and children, or the Alabama Medicaid Agency. An application can also be downloaded from the Medicaid web site and submitted by mail. Women may also apply for the Plan First Program online at www.insurealabama.org.

Men may apply for the Plan First Program by obtaining an application from the Alabama Department of Public Health, outstationed Medicaid workers, the Alabama Medicaid Agency, downloading an application from the Medicaid web site and submitting it by mail or apply online at www.insurealabama.org.

***What is covered under this program?***

For women, the Plan First Program is limited to birth control services and supplies, and smoking cessation counseling and products. This includes all currently available family planning methods, outpatient tubal ligation, doctor/clinic visits (for family planning only), certain screening tests, such as the STD/HIV tests and embedded IUDs in an office or outpatient hospital setting.

For men, coverage is limited to doctor/clinic visits (for family planning only), vasectomy in a doctor's office or outpatient hospital setting and postoperative semen analysis. Plan First does not pay for any other medical services. Women and men who have been previously sterilized are not eligible for this program.

***How will the Plan First program work?***

Eligible women ages 19 through 55 will be required to go to an enrolled Plan First doctor or clinic for all birth control services. Women have an option of obtaining oral contraceptives, the contraceptive ring, the contraceptive patch and diaphragms, at a Medicaid-enrolled community/outpatient pharmacy. In order to fill a prescription at a community/outpatient pharmacy, the Plan First recipient must have received the prescription from a private provider. A 30-day supply is the maximum that may be dispensed at one time**.** Plan First recipients seeing providers at a Federally Qualified Health Center (FQHC) or the health department will continue to receive the oral contraceptives, contraceptive patch or vaginal ring from the FQHC or health department provider. A 12-month supply of contraceptives may be dispensed at one time. Recipients can also receive Depo-Provera injections, implants or IUDs from private providers, FQHCs or health departments. Tubal ligations are performed in an outpatient setting. Women with special birth control-related needs or barriers to access may be referred to a care coordinator for follow-up.

Eligible men age 21 or older can go to either an enrolled Plan First doctor or clinic or non-enrolled provider for sterilizations only. Sterilizations for men are performed in an office or outpatient hospital setting. There are no co-payments for Plan First recipients.

***How do I know which program a Medicaid recipient is eligible for?***

In order to determine what type of eligibility a recipient has, it is the responsibility of the provider to verify a recipient's eligibility for the date(s) of service. Failure to check eligibility may result in a recipient receiving non-covered services. Claims for non-covered services will be denied. To verify eligibility, providers will need to use the Web Portal, Provider Electronic Solutions (PES) or Automated Voice Response System (AVRS). For more information on verifying eligibility, contact Hewlett Packard (HPES) at (800) 688-7989.

**10/29/2015**