

Getting the most from your health plan



MIChild Handbook
and Certificate of Coverage

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For hearing-impaired TDD/TTY:

Call 888 551-6761

No English? ¿No hable inglés?

*Comunicarse a el 888 389-6645 y pedir
un traductor*

Priority Health Government Programs, Inc.

P.O BOX 269

Grand Rapids, MI 49501-0269

616 464-8102

888 975-8102

Walk-in hours:

Mon-Thu, 8:30 a.m.-5 p.m.

Fri, 9 a.m.-5 p.m.

Other Priority Health locations

Holland

Farmington Hills

Jackson

Kalamazoo

Traverse City

Welcome

Thank you for choosing Priority Health Government Programs, Inc. (PHGP). As a member of MIChild, your child can get covered services and benefits with no deductibles or copays. Your child's health is important.

Please read this handbook carefully. You should keep it in a safe place. It will help explain your child's plan benefits. It will also answer many questions you may have.

If you have any questions or want to talk with someone about your child's benefits, please call us at 888 975-8102.

At PHGP, it is our job to help your child receive quality health care. We have many doctors, specialists, and other resources on our team to serve your child.

We look forward to being your child's health care partner.

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Why is this handbook important?

- It will guide you through services that are available to your child.
- It will give you information to get the care your child needs.
- It will make getting services easier.
- When we use the words “us”, “we”, “health plan”, “Priority Health,” or “PHGP” we mean Priority Health Government Programs, Inc.

Remember these important points:

- Work with your child’s doctor and Priority Health Government Programs, Inc.
- Share in every medical decision.
- Make and keep your child’s doctor appointments.
- When your child needs medical services, use this handbook.
- Call us at 888 975-8102 if you have any questions.

Important phone numbers

PHGP Customer Service (available 24 hours a day) _____ 616 464-8102
Toll-free _____ 888 975-8102

Hearing impaired, TDD _____ 616-464-8485
Toll-free _____ 888 551-6761

MICChild Hotline _____ 888 988-6300
Dental services and other non-plan benefits

Michigan Enrolls _____ 888 367-6557
To change plans
Enrollment questions
Premium questions

Add your own numbers

The name and phone number of your **child's primary care provider**:

The name and phone number of your **child's pharmacy**:

The phone number of the nearest **urgent care center**:

Other important numbers:

Be smart about your child's health!

Good health starts with you. Taking good care of your child's health will improve the quality of your child's life. This means you should:

- Actively share in making treatment decisions with your child's doctor.
- Ask questions and share concerns with your child's doctor.
- Work to build a strong relationship with your child's doctor.
- Become aware of health problems before they become serious.

By working with your child's doctor, you can improve the quality of care your child receives. At the first sign of health problems you should:

- Keep written notes about the problem.
- Write down anything unusual that might be related to the problem.
- Call your child's doctor if the problems do not go away.
- Ask your child's doctor any questions you have about the problem.
- Make an appointment if necessary.

Member rights

You and your child have the right to:

- Receive prompt medical care for medical conditions, including emergency care if necessary.
- Talk to your child's doctor or nurse about your child's care. This can help you decide what is best for your child.
- Talk to your child's doctor about all treatment options for your child's condition, regardless of the cost or benefit coverage.
- Receive information about PHGP, our services, our providers and member rights and responsibilities.
- Be treated with respect.
- Have your child's privacy protected.
- Have your child's medical records kept private.
- Look at your child's medical records to the extent permitted by law.
- Approve or deny the release of your child's personal information. We do not need approval to release information when required by law.
- Be notified in a timely manner if we release personal information in response to a court order.
- Call us to discuss concerns about the quality of care your child received from doctors or a hospital.
- Go to federally qualified health centers (FQHC), Tribal Health Centers and child and adolescent health centers.
- File a complaint with us, or the State, if you have a problem with us, or a provider.
- File a lawsuit if you have a problem with us, or a provider.
- Expect our staff and our participating providers to meet all requirements concerning member rights.
- Review a summary of PHGP's Annual Report
- Look at the full PHGP Annual Report on file with the Michigan Department of Community Health or the Office of Financial and Insurance Regulation.

Member responsibilities

As a member you and your child also have the responsibility to:

- Read this handbook, the Certificate of Coverage and other member materials.
- Follow the instructions given in all member materials.
- Always go to your child's primary care provider (PCP) or another participating provider for care when it is not an emergency.
- Get a well child physical exam for your child. Call his or her PCP or another participating provider to make an appointment. This should be done within one year of joining the plan.
- Keep your child's appointment. If you cannot make it, call your child's PCP at least 24 hours ahead of time to cancel.
- Get prior approval for services as noted in the Certificate of Coverage.
- Follow the limits of any approval of services.
- Show your child's ID card to the provider before your child receives a service.
- Go to participating providers for all services and equipment not requiring prior approval, unless we tell you otherwise in this handbook or the Certificate of Coverage.
- Follow our instructions.
- Follow any instructions agreed to by you and your child's provider.
- Provide all information your child's doctor or PHGP asks for. This will help your child get proper care.
- Tell your providers and us if your child has other health insurance coverage.
- Tell us as soon as possible about any change in address or family size.
- Tell us as soon as possible if your child's ID card is lost or stolen.
- Treat providers and their staff with respect.
- Call us with questions.

Our nurses may work with you and your child's doctor to help meet your child's health needs.

Commonly asked questions

1. How do I use my child's PHGP ID Card?

When your child enrolls with PHGP your child will receive a PHGP ID card. This card has the name and phone number of your child's primary care provider (PCP). This is the doctor you should call when you have questions about your child's health. Show this card when your child needs any care. When you get the ID card, make sure your child's name and PCP are correct. If you lose your child's ID card, it is stolen, you have a problem with it, or want to change the PCP listed on the card, call our Customer Service department at 888 975-8102.

Take your PHGP ID card with you every time your child:

- Goes to his or her PCP
- Has a medical appointment or
- Gets medical care.



You also need to show your child's PHGP ID card:

- At the hospital
- At the emergency room
- At the urgent care center
- At the pharmacy

2. My child is in the plan, now what do I do?

Here is what you need to do to get the most from the plan:

- Make sure the PCP you chose is listed on your child's ID card.
- If you did not choose a PCP for your child, one was chosen for you. You may make a change by calling our Customer Service department at 616 464-8102 or 888 975-8102. (If you change your child's PCP to a pediatrician, that change will take effect the day that we receive the request.)
- Make an appointment with your child's PCP.
- Transfer records from your child's old doctor if your appointment is with a new PCP.
- For children 2 and older, make an appointment once each year with your child's PCP. You should make this appointment even if your child is not sick. This "well child visit" will help you and your child's doctor stay ahead of any health problems. Children under the age of 2 will need "well child visits" more often to stay up to date on shots.
- Call your child's PCP first when you have a medical problem or concern. If you do not call your child's PCP before getting services, you may have to pay for the services yourself.

3. How do I choose a doctor for my child?

We will help you find a doctor. We will ask you questions about:

- What doctor your child has seen before,
- Where you live, and
- Which hospital you want to use.

You may also ask for a copy of our Provider Directory by calling our Customer Service department. You can also see it online at priorityhealth.com. The Provider Directory lists all of PHGP's participating providers.

It is important that you build a good relationship with your child's PCP and other health professionals. If you cannot keep a good relationship with your child's doctors, we can ask you to choose another PCP for your child. Your child's PCP can also refer your child to another participating provider.

You can call our Customer Service department at 888 975-8102 for help with picking a PCP. You can also write to the address on page 2 of this handbook.

4. How do I change my child's PCP?

You can change your child's PCP by calling our Customer Service department at 888 975-8102. You can also write to us. The address is on page 2 of this handbook.

The primary care provider change will take effect within 30 days of your request. If you are changing your child's PCP to a pediatrician, the change will take effect the day that we receive the request. You will receive a new PHGP ID card with the name of your child's new PCP.

5. How do I change my child's health plan?

If we are not the right plan for your child, please call the MICHild Customer Service at 888 988-6300. You will get information about enrolling your child with a different plan. Your child must keep seeing his or her PHGP doctor. You must follow PHGP's rules until your child is enrolled in another health plan.

6. How can I be sure about quality?

We work hard to make sure that your child gets the best service possible. Here are some examples of what we have done:

- We check the training and experience of every doctor.
- We test how easy it is for you to get an appointment with every doctor.
- Our Customer Service staff is trained to make sure that your needs are met.
- The State of Michigan reviews the services we give. They tell us when to change or improve services.
- You can file a complaint anytime by calling our Customer Service department at 888 975-8102. If you want, we will help you to report any problem you see with your child's doctor or our services.
- We give you materials to help you stay healthy. Just call us! We can give you information in pamphlets, by telephone, and in person. If you want, someone can come to your home.

7. What if my child needs to see a specialist or have medical tests?

You should talk to your child's primary care provider first. Your child's PCP will work hard to keep your child healthy. If your child needs care or special tests, your child's doctor will help him or her see a specialist who is a PHGP provider. Do not take your child to see a nonparticipating provider without the okay of your child's PCP. You may also need our prior approval. If you do not get prior approval when it is required, you may have to pay the bill. We must approve a referral to a provider such as a physical therapist who is outside our network.

If your child is a new PHGP member and he or she is receiving medical treatment, call the PCP listed on your child's ID card to have his or her care re-approved. Your child does not need approval to be treated by a participating provider for these services:

- OB/GYN (having babies or a routine female examination)
- Vision (for the name of an eye doctor, call us)
- Routine pediatric services from a participating pediatrician

8. When should I take my child to the emergency room?

For most problems, call your child's PCP. You can even call at night, on weekends or holidays. Only go to the emergency room when it is an emergency. The emergency room is for problems that can seriously harm your child's health or problems that are a matter of life or death. You should take your child to his or her PCP when emergency care is not needed.

Urgent care

When your child has a problem that is serious (but is not as bad as an emergency) such as cuts, bumps or sprains, call your child's PCP. Remember, you can call at night, on weekends or holidays. Your child's PCP will give you instructions on what to do, or where to go for treatment. You should try to contact your child's PCP before you visit an urgent care center. If you take your child without trying to contact his or her PCP, you may have to pay for the visit.

Emergency care

An emergency is any condition that may cause death or injury if not treated right away. For an emergency, go to an emergency room or call 911 immediately. Examples of emergencies (call 911 or seek care immediately):

- Chest pain
- Severe burns
- Convulsions
- Stroke
- Drug overdose
- Severe bleeding
- Heart attack
- Unconsciousness

Examples that are not emergencies (call your child's PCP):

- Colds or flu
- Sore throat
- Earache
- Sprains or strain
- Headache
- Stomachache
- Low back pain
- Vaginal discharge
- Minor cuts or bruises

When the problem is not an emergency, call your child's PCP's office, anytime day or night.

When your child needs an ambulance

In an emergency, dial 911. If your child has a very serious illness or injury, an ambulance will take your child to the hospital.

9. What if my child is out of town when he or she gets sick?

If your child needs care right away, but it is not a life-threatening situation, you should call your child's PCP first. Remember, you can call at night, on weekends or holidays. If you cannot reach your child's PCP and your child needs emergency or urgent care:

- Go to the nearest medical facility for medical care.
- Show your child's PHGP ID card.
- Call your child's PCP for follow-up care. Tell your child's PCP about the medical care your child needed.

Do not get routine medical care when your child is out of town without getting approval from your child's PCP and us first.

If your child needs emergency care, go to the nearest medical facility. You do NOT need prior approval from your child's PCP to seek emergency care.

10. What if our family moves?

If you and your child move, call our Customer Service department at 888 975-8102. We want to update your child's address. If necessary, we will also be happy to help you find a new PCP for your child that is closer to your house.

If your family moves outside of our service area, you should contact Michigan Enrolls. They will help you choose a new MIChild plan for your child.

11. What if my child's MIChild coverage ends?

MIChild enrollment is usually guaranteed for one year. However, there are some reasons that your child may lose his or her MIChild coverage mid-year, including:

- Failure to pay premiums
- If you move out of the State of Michigan
- If your child dies
- If your child becomes eligible for Medicaid
- If your child is no longer eligible because of admission to a public institution

At the time of annual re-determination, your child may be disenrolled from MIChild due to:

- Eligibility for other programs (e.g. Medicaid)
- Eligibility for other insurance coverage
- Changes in income
- Change in family size or
- Change in job status

If your child loses MIChild eligibility for any reason, we will no longer pay for services beginning on the date of disenrollment. If your child is a hospital inpatient on the date of disenrollment, we will pay for all covered services until your child is discharged.

12. What if I get a bill?

You should not get a bill for services that your child received from his or her PCP or another participating provider. If you get a bill, write to us at the address on page 2. You may also call our Customer Service department at 888 975-8102.

Using Priority Health Government Programs MIChild plan

Healthy children start with you

Children need to see a doctor even when they are well! Before your child gets sick, see the doctor. Children (especially those under age two) need many checkups. At least once each year you should make an appointment for your child to see his or her PCP. This visit is important. Your child's PCP will use the time to get to know him or her when your child is healthy.

Your child's PCP will:

- Check how much your child is growing
- Make sure your child is eating right
- Give immunizations (or shots)

Checkups help keep your child well! Call our Customer Service department at 888 975-8102 if you have questions or need help finding a PCP for your child.

Healthy pregnancy

If your daughter is a MIChild member and becomes pregnant, make an appointment with your child's PCP. It is important to start pre-natal care as soon as possible. Early pre-natal care improves the chances of a healthy baby.

We want to help. That's why we offer **HealthyEncounters**SM Maternity Care program.

This program will give you and your daughter information during the pregnancy and after the baby arrives. Your daughter will get free information on caring for her newborn, breastfeeding and postpartum depression.

Your daughter may be eligible for Medicaid benefits during and after her pregnancy.

Contact the Department of Human Services in your area. Medicaid will usually cover both the expecting mother and her child. If your daughter is enrolled in Medicaid during her pregnancy, she will be disenrolled from the MIChild program.

If your daughter has MiChild coverage when she delivers, contact MiChild to learn if the baby will be eligible for either MiChild or Healthy Kids. The State of Michigan rules for MiChild do not allow a newborn to automatically be covered under the MiChild program.

Appointments with your child's doctor

We can help

Your child's PCP is listed on the PHGP ID card. A good relationship with your child's PCP will help your child stay healthy and happy. If you need help picking a PCP for your child, call us.

Make an appointment

When your child is sick or needs a well child checkup, call your child's PCP's office. The phone number is listed on your child's PHGP ID card.

Call to change or cancel

Call the PCP's office as soon as possible if you are not able to keep your appointment. They will help you to change the appointment to a different day or time. Calling to cancel an appointment is sometimes hard to remember, but it is important to do. It lets others get appointments they need.

Make your wishes known

You have the right to make decisions about your child's medical care. You have a right to accept or refuse medical or surgical treatment for your child. You also have the right to plan and decide the types of health care your child gets in the future if you become unable to express your wishes.

What services are covered?

The following services are covered when the providers are contracted with us and the services are determined to be medically necessary and appropriate:

- Inpatient and outpatient hospital services
- Emergency services

- Primary care provider visits
- Well child check-ups
- Immunizations (shots)
- Blood lead testing
- Allergy testing
- OB/GYN and Certified Nurse Midwife services (A child may seek obstetrician/gynecologist and Hospital services out of network if she is pregnant at the time of enrollment)
- Prenatal and post-partum care
- Family planning
- Abortions to save the life of the mother or in cases of rape or incest
- Vision services
- Limited oral surgery
- Fluoride varnish treatments (covered four times in a 12 month period for children ages 0-3 years)
- Communicable disease services
- Dermatology services
- Specialty provider visits
- Second surgical opinions
- Chiropractic services
- Transplant services
- Prosthetics and orthotics
- Durable medical equipment and supplies
- Hospice services
- Pain management
- Ambulance and other emergency medical transportation

- Hearing and speech services, including hearing aids
- Therapies (speech, language, physical and occupational)
- Chelation therapy
- Diagnostic lab, x-ray and other imaging services
- Home health services
- Skilled nursing care
- Weight loss counseling
- Acupuncture
- End stage renal disease services, including hemodialysis and peritoneal dialysis
- Out of state services (if authorized by us)
- Pharmacy

These services are covered when they are medically necessary and appropriate. Except in a life-threatening emergency, we recommend that you talk with your child's PCP before receiving services. Certain services need prior approval from your child's PCP and us. There may be a limit to the number of visits approved based upon medical necessity. The Certificate of Coverage (COC) describes these limitations in more detail. Your child's PCP will help you arrange these services or you may call our Customer Service department at 888 975-8102 if you have questions.

What services are covered by MiChild but NOT by PHGP?

This plan does not cover all services that your child may be eligible for as a member of MiChild. Certain services are covered by other organizations. Those services include:

Mental health and substance abuse services

If your child needs mental or emotional care, call Community Mental Health (CMH) in your area. They will talk with you and provide any services your child may need. The CMH agency can help refer you to the right local agency when your child has problems with drugs or alcohol. If you have questions about your child's mental health or substance abuse benefits, you can call the CMH agency in your area, the MiChild Customer Service line at 888 988-6300 or PHGP for help.

Routine dental services

Certain dental services are covered by PHGP. You can find more information about what services we cover in the COC. Contact your dental plan, MIChild or PHGP for help with questions about your child's dental benefits or for help in locating a dental provider.

Services provided by a school district and billed through the Intermediate School District

Contact your local Intermediate School District for more information about available services.

What services are NOT covered by MIChild?

Some services are not covered by MIChild. You will have to pay for any non-covered services that your child receives. Also, we have the right to limit services to those that are medically necessary and covered by the State of Michigan MIChild program. Services that are not covered, or those that have limits are listed in the Certificate of Coverage. If you have any questions about what services are not covered, call our Customer Service department at 888 975-8102.

Vision services

As a PHGP member your child can receive:

- Annual vision exam
- Annual glaucoma testing
- Eye glasses once every 24 months or once every 12 months with a prescription change
- Contact lenses when medically necessary or therapeutic, to correct visual impairment when glasses are insufficient to correct a visual impairment

When you visit the office, show your child's PHGP ID card. If you have questions about these services, you can also call our Customer Service department at 888 975-8102.

Prescription drug program

Your child has prescription drug coverage with us. We use a formulary. This is list of approved drugs. Doctors use it when deciding on medicines for members. The formulary

includes many kinds of drugs. This plan does not cover every medicine. Some drugs that are not covered are:

- Brand name drugs when the Food and Drug Administration (FDA) has approved a generic medicine that can be used instead. Brand name drugs may be used if you get prior approval from PHGP.
- Appetite control drugs.
- Drugs that are not prescribed by a doctor.

If you would like to know more about the PHGP medication formulary, call or write the Customer Service department. You can also visit us at priorityhealth.com and get the answers to questions, including:

- Which drugs are on the formulary?
- How can I get a copy of the formulary?
- How can I get a copy of PHGP's pharmacy policies and procedures?
- What if my child needs a drug that is not on the formulary?
- What if my child needs a drug that requires prior approval?
- What is a generic drug?
- Are generic drugs safe?

Your child's doctor will usually order a 30-day supply of medicine. It is important to know about the medicine your child takes. Always:

- Talk with and listen to your child's doctor and pharmacist about your child's medicine.
- Make sure that all of your child's doctors know about all over-the-counter medicines your child is taking.
- Make sure that all of your child's doctors know about all vitamins and supplements that your child is taking.
- Make sure that your child's doctors know about any allergies and reactions to any medicine that your child has had.
- Understand what the medicine is for, how to use it, and where to store it.

- Understand what side effects (if any) you might expect.
- Make sure that you can read the prescriptions your child gets from his or her doctor.
- Some questions you should ask the doctor and pharmacist about your child's medicine are:
 - What are the brand and generic names of the medicine?
 - What does the medicine look like?
 - How should it be taken?
 - How long should your child take it?
 - What should you do if your child misses a dose?
 - What should you do if side effects occur?

When you pick up the medicine, ask the pharmacist if this is the medicine that was prescribed. Make sure you understand the instructions on the label.

Patient safety

You can make a difference. We are working with other local health plans to educate all of our members about patient safety. Here is what you can do to improve the safety of your child's medical care:

- Give your child's doctors a complete health history.
- Be an active member of your child's health care team.
- Take part in every decision about your child's health care.
- Speak up – ask questions.
- Ask for test results. Don't assume that no news is good news.
- Tell your child's doctor about any changes in his or her health.
- Follow your child's doctor's advice and the instructions for care that you and your child's doctor have agreed on.

It is always important that you play an active role in decisions about your child's health and your child's health care. Take responsibility – you can make a difference!

Other insurance

If you have MIChild coverage and other insurance, call the Customer Service department at 888 975-8102 to tell us what the other plan is. The other insurance must always be billed before PHGP. Examples of other insurance might include:

- Insurance from a new job
- Insurance from a non-custodial parent
- Insurance coverage through another driver due to an auto accident

If your child is injured, someone else's insurance may have to pay your child's medical costs. For example, if your child is injured in an automobile accident, the driver's auto insurance may be responsible for your medical costs. We will not pay any expenses that are covered by the other insurance.

Additional information

Physician incentive plan disclosure

You may ask if we have special financial arrangements with our doctors that can affect the use of referrals and other services that your child might need. If you have any questions about this, please call Customer Service at 888 975-8102.

Inquiry and review procedures

We hope that you are always happy with the service your child receives from us. We know, however, that sometimes you may have a problem or concern that you want us to know about. If you have a question, concerns or complaints about us, please call our Customer Service department at 888 975-8102 or 616 464-8102. Our Customer Service representatives will try to resolve your problem as soon as possible.

If you are not happy with the answers that our representative has provided, you or someone acting on your child's behalf can send us a formal complaint. You may contact our Customer Service department for assistance drafting a formal complaint. This formal complaint is handled through our review process. Below is a summary of the steps you can take:

1. Tell Customer Service that you want to file a Level 1 Review. Our Level 1 Internal Review Committee will look at your complaint and make a decision. They will send the decision to you in writing. You have 90 days from the date you learn of a problem to file a complaint with us.
2. If you are not happy with this decision, you can send your complaint to our Level 2 Internal Review Committee. They will review the complaint. They will also send you their decision in writing. You have 3 days after you receive your Level 1 Review decision to request a Level 2 Review.

If your child has not yet received the services: Steps 1 and 2 combined, including a final decision, must be completed within a total of 30 calendar days after we receive your request for review. Up to 10 business days can be added to receive information from health professionals or others with information necessary to resolve your concern if it would be to your benefit.

If your child has already received the services: Steps 1 and 2 combined, including a final decision, must be completed within a total of 35 calendar days after we receive

your request for review Up to 10 business days can be added to receive information from health professionals or others with information necessary to resolve your concern if it would be to your benefit.

3. If you are not happy with the outcome of the Level 2 Review, you can have your complaint reviewed by the Office of Financial and Insurance Regulation in Lansing, Michigan. You or your child's authorized representative may request this review by filling out the External Review form. The form will be included with the decision from the Level 2 Internal Review Committee. Your request for an external review must be made within 60 days of our final decision. You may also send your complaint to the following address:

Office of Financial and Insurance Regulation
Health Plans Division
611 West Ottawa, Third Floor
P. O. Box 30220
Lansing, MI 48909-7720
877 999-6442
michigan.gov/ofir

Expedited Review procedure

If your child's doctor tells us that the time it takes to resolve your complaint may put your child's life in danger, interfere with your child's full recovery or delay treatment for severe pain, we will follow our emergency timeline. This is our "Expedited Review" procedure. Steps 1 and 2 in an "Expedited Review" procedure must be completed within 72-hours (3 days) of receipt of your request. If you are not happy with our decision, you have 10 days to appeal to the Office of Financial and Insurance Regulation, who also has an expedited review process. You may file a request for an "Expedited Review" with the Office of Financial and Insurance Regulation only after you have filed a request for an "Expedited Review" with us. If you are not happy with PHGP's decision, you may appeal within 10 days of our final decision to the Office of Financial and Insurance Regulation.

Obtaining information about the review or "Expedited Review" procedure

To obtain a complete copy of our Level 1 Review or "Expedited Review" Procedures and Level 1 Review Form, or to find out more about your Level 2 review rights, please contact our Customer Service Department. You can also find more information in Section 12 of your Certificate of Coverage.

Filing a lawsuit against Priority Health Government Programs, Inc.

You have the right to bring an action for benefits under Section 500.3422 of the Michigan Insurance Code. However, before filing a lawsuit against us, you must complete our Grievance Procedure as described in Section 12 of your Certificate of Coverage. In addition, no action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of (3) three years after the time written proof of loss is required to be furnished.

For additional information about Priority Health Government Programs, Inc., please visit our website at priorityhealth.com.

Filed in Michigan: 2011

Doc _2525

Certificate of Coverage

Agreement Filed in: Michigan 2011

Read this entire Certificate carefully. It is a contract. It describes the rights and obligations of Members and Priority Health Government Programs, Inc. (PHGP). It is your responsibility to understand the terms and conditions of your child's health benefits contained in this Certificate. In some circumstances certain medical services are not Covered or may require prior approval by PHGP.

Section 1 About this Certificate

This Certificate sets the terms and conditions of Coverage as required by the agreement between PHGP and the State of Michigan. This Certificate describes the health care services that are Covered for Members.

This Certificate only Covers Medically/Clinically Necessary services or supplies that are furnished while a person is a Member. It replaces and takes the place of any Certificate we might have issued in the past.

Words that are capitalized in this Certificate are special terms that are defined in Section 16. The terms "we", "us", "our" and "PHGP" refer to Priority Health Government Programs, Inc. The terms "you", "your" and "yourself" refer to the parent or guardian of children enrolled in this plan. If you have any questions about Coverage, contact our Customer Service department at:

Priority Health Government Programs, Inc.
Customer Service Department, MS 1105
PO Box 269
Grand Rapids, MI 49501-0269
616 464-8102 or 888 975-8102

Section 2 Obtaining Covered Services

A. Primary Care Provider (PCP)

Your child's PCP arranges your child's medical care. He or she provides your child with basic health care, and refers your child to and consults with Specialist Providers, including Participating Providers and Non-Participating Providers when necessary. Your child's PCP provides or coordinates such services as ordering of lab tests and x-rays, prescribing medicines or therapies, and arranging hospitalization. We recommend you talk with your child's PCP about any issues concerning your child's medical care, and you must contact your child's PCP before your child receives medical services, except in a Medical Emergency or unless we tell you otherwise in this Certificate.

All referrals or services received from Non-Participating Providers (providers not listed in our Provider Directory) must be prior approved by us, as well as by your child's PCP. If you do not receive written approval from us prior to obtaining services from a Non-Participating Provider, you will be responsible for payment unless we tell you otherwise in this Certificate. A copy of the Priority Health Government Programs, Inc. Provider Directory is available by calling our Customer Service department or online at priorityhealth.com. When your child is enrolled with us, we will

give you a list of PCPs to choose from. You must choose a PCP for your child from that list. Each child in your family may have a different PCP, if you desire. If you need help choosing a PCP, call our Customer Service department at 888 975- 8102 or 616 464-8102. If you do not choose a PCP for your child, we will select one for your child. You may change your child's PCP as described below. When you change your child's PCP, all medical treatment your child is currently receiving must be re-approved by the new PCP.

You can change your child's PCP at any time. To do this, fill out and turn in a Change form to us. If you need a form, or you need help filling it out, contact our Customer Service department. You can also change your child's PCP by calling our Customer Service department. The change will take effect on the first day of the month after we receive your request. If you are changing your child's PCP to a pediatrician, the change will take effect the day that we receive the request. A PCP change cannot be made while your child is in the Hospital unless the child's health or safety is in jeopardy. We will send you a new ID card with the new PCP's name. If you don't receive a new ID card, please call our Customer Service department to be sure the change was properly processed.

B. Establishing and Maintaining a Provider-Patient Relationship

It is important that you establish and maintain a good relationship with your child's PCP and

other Health Professionals. We require your child's PCP and other Participating Providers to discuss with you all treatment options available to your child, regardless of benefit Coverage limitations.

If you do not choose a PCP for your child, or if you cannot maintain a satisfactory provider-patient relationship with Participating Physicians, we can request that your child be disenrolled from PHGP "for cause." Disenrollment for cause is explained in Section 11.C. If you cannot maintain a good relationship with a Participating Provider, we can do any of the following:

1. Ask you to choose another PCP for your child;
2. Select a PCP for your child;
3. Arrange for your child's PCP to refer your child to another Participating Provider
4. Request that your child be disenrolled from PHGP.

C. Referrals

At times your child may need services from another Participating Provider, including a Specialist Provider, or a Non-Participating Provider. Participating Providers are those listed in the Priority Health Government Programs, Inc. Provider Directory; a provider is a Non-Participating provider if he or she is not listed in the directory.

You, your child and your child's PCP do not need approval from us to refer to a Participating Provider, except for a few specific services that are listed at the end of this subsection. Except for federally qualified health centers (FQHCs), Tribal Health Centers and child and adolescent health centers, all referrals and services received from a Non-Participating Provider must be pre-approved by us. Do not go to a Non-Participating Provider unless your child's PCP has referred your child and we have approved the referral

first. Otherwise, you must pay for the services. You also must pay for services your child receives in excess of the services that we approved.

A child may seek obstetrician/gynecologist and Hospital services out of network if she is pregnant at the time of enrollment. Your child may seek an annual well-woman examination or routine obstetrical services from a participating obstetrician/gynecologist or routine pediatric services from a participating pediatrician without referral from his or her PCP or us.

You may call our Customer Service department at 888-975-8102 or 616 464-8102 to find out if a provider is participating or non-participating. You may also call to find out if we have approved a referral to a Non-Participating Provider.

NOTE: Sometimes your child's PCP or another Participating Provider may refer or suggest a service for your child that we do not Cover. Just because your child's PCP or another Participating Provider refers or suggests the service for your child does not mean your child will have Coverage for that service. Remember – if your child receives services that we do not Cover, you must pay for the services.

A second medical opinion from a Specialist may be appropriate for certain health conditions and proposed surgeries. Requests for second opinions from Non-Participating Providers must come from your child's PCP or the child, parent, guardian or authorized representative (not a Specialist Provider) and be approved by us before you see the second doctor. We will Cover second medical opinions from Participating Providers having skills and training substantially similar to those of the doctor making the original treatment recommendation. If no Participating Provider is available and your child's PCP tells us about the need for a second opinion, we may

Cover a second medical opinion from a Non-Participating Provider. Any tests, procedures, treatments or surgeries recommended by the consulting provider must be performed by a Participating Provider, unless we approve the services in advance.

Certain services and supplies that Health Professionals recommend or provide to you must receive prior approval from us before they can be Covered. Services for which our prior approval is required:

1. Consultations and procedures for:
 - a. Enteral feeding
 - b. Neuropsychological testing
 - c. Cosmetic and reconstructive surgery
 - d. Septoplasty
 - e. Uvulopalatopharyngoplasty
 - f. Orthognathic surgery (jaw reconstruction)
 - g. Transplant and evaluations for transplant
 - h. Comprehensive pain and headache programs
2. Inpatient Care
 - a. Elective admissions
 - b. Inpatient skilled nursing, subacute, long-term acute and rehabilitation care
3. Referrals to Non-Participating Providers (Participating Providers are those listed in the Priority Health Government Programs, Inc. Provider Directory; a provider is Non-Participating if he or she is not listed in the Provider Directory)
4. Home health care
5. Hospice Care
6. Home infusion services
7. Durable Medical Equipment over \$500
8. Prosthetics and orthotics over \$500

D. Termination of Provider's Participation

A Participating Provider, or we, can terminate a Participating Provider's contract or limit the number of Members the Participating Provider will accept as patients. We do not promise that your child will be able to receive services from a specific Participating Provider the whole time your child is covered by us. We will notify you if your child's PCP or Specialty Care Physician is no longer a Participating Provider. You agree to choose another PCP for your child with our help if needed. If you choose or are assigned another PCP for your child, you must have the medical treatment your child is currently receiving re-approved by your child's new PCP.

If your child is being actively treated (or is hospitalized) at the time a Participating Provider's contract with us is terminated, and the provider is able to continue to treat your child, your child may continue to be treated by the terminated provider until treatment is completed or until we have made arrangements for another provider to provide the services. In addition, if, at the time of termination, your child is undergoing treatment for a chronic or disabling condition, or if your daughter is in the second or third trimester of pregnancy, your child may continue to see the terminated provider for up to 90 days, or through the completion of postpartum care. This paragraph does not apply if the Participating Provider's contract with us has been terminated for quality of care reasons.

Any provider you use in addition to your child's PCP may also stop being a Participating Provider. If that happens, we recommend you contact your child's PCP for another referral. Otherwise, we may not Cover any services your child receives from the provider.

We will assist you in finding another Participating Provider and in receiving care during the transition if the Participating Provider's contract with us is terminated.

If you have any questions please call our Customer Service department at 888 975-8102 or 616 464-8102.

E. Care After Regular Office Hours

Your child's PCP must have telephone coverage 24 hours a day, 7 days a week. If your child becomes Ill or is Injured after regular office hours, we recommend you call your child's PCP and tell them your child is a Member of PHGP. Your child's PCP or a Participating Provider who is covering for your child's PCP may give advice over the phone, prescribe medicine or therapy, ask you to bring your child into the office, or refer your child to an urgent care center, emergency room or another Participating Provider to receive help.

F. Medical Emergency or Urgent Care

Your child has Coverage for Medical Emergency care and Urgent Care services. The rules for that Coverage depend on whether your child receives care inside or outside of the Service Area and whether the care is for a Medical Emergency or an Urgent Care situation.

1. Inside the Service Area

If your child has a Medical Emergency, seek help immediately. Call 911 or your county's emergency telephone number for emergency assistance and emergency transportation. Your child can receive emergency room Coverage in any Medical Emergency. But if you use an emergency room for care your child's PCP could have given, or for something that is not a Medical Emergency, we will not Cover the cost.

When your child needs Urgent Care services, we recommend that you try to contact your child's PCP before your child obtains those services. Otherwise, you may be responsible for any of the services your child receives. Your child's PCP will tell

you either to go to his or her office or to another Participating Provider's office. If you are unable to reach your child's PCP and your child's problem requires Urgent Care, go to a participating Urgent Care Center or Participating Hospital emergency room. Present your child's ID Card when your child receives care. Afterward, contact your child's PCP for follow-up care.

Remember, if you use an emergency room or an Urgent Care Center for care that is not for a Medical Emergency or Urgent Care or that could have been provided by your PCP, you must pay for the services.

NOTE: *If your child is confined in a Hospital after a Medical Emergency, we recommend that you (or someone on your behalf) let your child's PCP know about your child's confinement as soon as it is reasonably possible to provide that notice. Notifying your child's PCP will ensure that the proper follow-up care is provided by the PCP or another Participating Provider.*

The following are Covered Services within the Service Area:

- a. Services and supplies that your child receives for a Medical Emergency (see the definition in Section 16).
- b. Services and supplies that your child receives for any condition that, following our review of the proper medical records, we determine to have required Urgent Care at the time your child received the services and supplies.
- c. Hospitalization for a Medical Emergency in a facility that is a Non-Participating Provider, until, in our determination, it is appropriate for your child to be transferred to a Participating Provider.

We will not Cover services or supplies your child receives from a Non-Participating Provider for a situation that is not a Medical Emergency or does not require Urgent Care unless we have given approval for those services or supplies. This includes follow-up care after a Covered emergency.

If your child receives Medical Emergency or Urgent Care services, we recommend that you contact the PCP's office as soon as you can after your child receives the services to allow the PCP to arrange follow up care. Follow-up care must be provided by your child's PCP or another Participating Provider. Except for emergency services, out of network services must be prior approved by us, and your child's PCP, or you will be financially responsible for the services unless we tell you otherwise in this Certificate.

2. Outside the Service Area

- a. If your child is out of the Service Area temporarily or for an extended period of time

If your child becomes Ill or is Injured while away from the Service Area, we will Cover care for Medical Emergencies and Urgent Care. All other out of network services must be prior approved by us, and your child's PCP, or you will be financially responsible for the services.

Services and supplies for Medical Emergencies, Urgent Care situations, and other Covered Services that your child receives outside the Service Area are Covered, if:

- i. You could not reasonably have expected, before your child left the Service Area, to need the services and supplies; and

- ii. It would be hazardous to your child's health to wait for those services and supplies until your child could reasonably return to receive them from a Participating Provider; or
- iii. The Urgent Care or other services that your child receives outside the Service Area are approved by a referral from the child's PCP and prior approved by us.

If you have a Medical Emergency, seek help immediately. You can receive emergency room Coverage in any Medical Emergency, including emergency transportation.

If your child needs Urgent Care services outside the Service Area, we recommend that you try to contact your child's PCP before you obtain those services. Otherwise, you may be responsible for any of the services your child receives. If you are unable to reach your child's PCP and your child's problem requires Urgent Care, go to an Urgent Care Center or a Hospital emergency room.

We will not Cover services and supplies your child receives during travel outside the Service Area if the only reason for the travel is to obtain medical services or supplies, unless we approve them in writing first.

If your child receives Medical Emergency or Urgent Care services, we recommend that you contact your child's PCP as soon as reasonably possible after your child receives the services to allow your child's PCP to arrange follow up treatment. Out of network services (other than emergency services) must be prior approved by us, as well as by your child's PCP. The PCP will assist you with finding a Non-Participating Provider, if necessary, for follow up care and obtaining our approval for your child to visit that provider.

Remember, your child's PCP must provide or arrange all follow up and continuing care received outside the Service Area. A prior approval from us must also be obtained before your child visits a Non-Participating Provider. Otherwise, your child will not have Coverage for the services your child receives.

- b. If your child lives outside the Service Area

We will request to disenroll your child from this plan if he or she permanently lives outside the Service Area. We are responsible for Covered Services until the date of disenrollment.

3. Ambulance Services

"Ambulance" includes a motor vehicle or rotary aircraft that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support, or advanced life support.

- a. In the case of a Medical Emergency, we will Cover ambulance service to the nearest medical facility that can provide Medical Emergency care.
- b. We will Cover ambulance transfers between facilities that are approved by your child's PCP or us as Medically/Clinically Necessary.

G. Prior Approval of Certain Health Care Services and Supplies

As stated in Section 2.C above, certain services and supplies that Health Professionals recommend or provide to your child must receive prior approval from us before they can be Covered. In most cases, we will approve, deny or partially approve or deny a request for prior approval within 14 days of receipt. However, in urgent cases, the determination period is reduced to 72 hours. In some cases we may ask you for additional information

or additional time in which to make our determination. If we decide that the services and supplies are not Covered, we will let you know. In the case that your child's PCP is requesting services from a Non-Participating Provider, you and your child's PCP will receive a letter from us indicating whether or not the services will be Covered. In all cases, if your child receives services that we say are not Covered, or if your child receives services in excess of what has been approved, you will be responsible for the payment for those services. If you disagree with our decision and would like it to be reviewed, you can appeal by following the Inquiry and Review procedures from Section 12.

H. Additional information

We will provide you with the following additional information when you request it by calling or writing our Customer Service department:

1. Our current Provider Directory. This lists our current provider network, including names and locations of Participating Providers by specialty and names of providers who are not accepting new Members. You may also find our Provider Directory on our website at priorityhealth.com.
2. The professional credentials of our Participating Providers, including, but not limited to, Participating Providers who are board certified in the specialty of pain medicine and the evaluation and treatment of intractable pain and have reported that certification to us, and the Participating Hospitals where they have privileges.
3. The telephone number of the Michigan Department of Community Health where you can call to find out information regarding disciplinary actions or formal complaints filed against a provider.
4. Any prior approval requirements and any limitations, restrictions or exclusions on services, benefits or providers.

5. The type of financial relationships between us and our provider network.
6. How we evaluate new technology for inclusion as a Covered Service.
7. How we evaluate new drugs for inclusion in our formulary.

You may request this information by calling or writing our Customer Service department at the address and phone numbers below.

Priority Health Government Programs, Inc.
Customer Service Department, MS 1105
PO Box 269
Grand Rapids, MI 49501- 0269
616 464-8102 or 888 975-8102
email: customer.service@priorityhealth.com
or visit our website at priorityhealth.com, search keyword "MICChild"

Section 3 Eligibility

Eligibility is determined by Michigan Enrolls or another Administrative Contractor as named by the state of Michigan. Michigan Enrolls can be reached by calling 888 367-6557.

Section 4 Enrollment

The State's Administrative Contractor will be responsible for enrolling your child in the health and dental plan chosen by you.

Section 5 Premiums

Contact Michigan Enrolls or the state Administrative Contractor for Premium information. Michigan Enrolls can be reached by calling 888 367-6557.

Section 6 Schedule of Covered Services

Your child is entitled to the Covered Services described in this Section 6 when those services are:

1. Medically/Clinically Necessary as defined in this Certificate; and
2. Provided by your child's PCP, or Provided by a Participating Provider and approved in advance by us when we consider approval necessary, or Provided by a Non-Participating Provider upon referral from your PCP and approved in advance by us unless we tell you otherwise in this Certificate; and
3. Not excluded elsewhere in this Certificate or in an amendment attached to this Certificate.

You should carefully review the rest of this Certificate and any amendments for more information about the extent of your child's Coverage. Whether or not a service is Medically/Clinically Necessary may be determined according to medical policies established by us with the input of Physicians we do not employ.

The Covered Services are:

A. Primary Care - Primary care is the care provided by your PCP.

1. Health Maintenance and Preventive Care
The following services are Covered Services for your child even though they are not provided in connection with the diagnosis and treatment of an Illness or Injury:
 - a. Well baby care, including routine physical examinations and clinical screenings given at two weeks, one month, two months, four months and six months from the date of birth plus two visits between one year and

two years from the date of birth or as directed by your child's PCP or other Participating Provider.

- b. Routine pediatric services from a Participating pediatrician without referral from your child's PCP.
- c. Routine pediatric and adult immunizations for infectious disease, as recommended by our Preventive Health Committee. One vision screening and one hearing screening during each Contract Year to determine vision and hearing losses. If further vision or hearing services are necessary, the child's PCP will refer to the applicable specialist. Vision care and hearing care are covered as described later in Section 6.B(37) and 6.B(18). See Section 7(45) for vision services that are not Covered.
- d. One routine "well woman" examination, including a gynecological examination and breast examination, during each Contract Year. Your daughter may visit a Participating obstetrician/gynecologist or nurse midwife acting within the scope of his or her license or specialty certification for her annual well woman examination and routine pregnancy services without a referral.
- e. Breast cancer screening mammography as directed by your PCP or as required by law.
- f. Maternity care as described in Section 6.C.
- g. Diagnostic and therapeutic radiology services and laboratory tests not excluded under Sections 7 and 8 in this Certificate.
- h. Smoking cessation counseling.

- 2. Provider Care
All services listed in this Section 6 provided by your child's PCP during an office visit, Hospital visit, or house call, for the diagnosis and treatment of a Covered Illness or Injury.

B. Referral Care

Referral care is care provided by a Specialist Provider, including Participating Providers and Non-Participating Providers. Referral care must be approved in advance by us when we consider approval necessary, including all non-emergency referral care provided by Non-Participating Providers.

- 1. Acupuncture therapy
Treatments are Covered up to a maximum of 20 treatments in a Calendar Year when performed by (not just under the direction of) a Physician (MD or DO) and approved in advance by us.
- 2. Allergy testing
Allergy testing, evaluations and injections including serum costs. See Section 7(4) for allergy tests that are not Covered.
- 3. Ambulance Services
Covered as described in Section 2.F(3).
- 4. Ambulatory Surgical Services and Supplies
Outpatient services and supplies furnished by a surgery center along with a Covered surgical procedure on the day of the procedure.
- 5. Cataract surgery
Facility and professional costs for surgery for the treatment of cataracts. The first lens implant is also Covered.
- 6. Chiropractic Care
Manual manipulations of the spine, initial office evaluation, x-rays related to back and spine if not previously performed by another provider and first-aid treatment of musculoskeletal Injury. Your child's PCP

must approve all chiropractic services in advance. Chiropractic care is limited to 24 visits per Calendar Year.

- 7. Contraceptive Devices
Contraceptive devices that require a prescription or Physician insertion or removal are Covered up to one per Calendar Year.
- 8. Dental Hospitalization
Hospital, ancillary and anesthesia charges may be Covered for your child as follows:
 - a. The excision of teeth partly or completely impacted in the bone of the jaw,
 - b. The excision of teeth that will not erupt through the gum,
 - c. The excision of other teeth that cannot be removed without cutting into bone,
 - d. The excision of a tooth root without extracting the entire tooth, but not including root canal therapy,
 - e. Apicoectomy, and
 - f. Charges for dental services, office consultations and appliance therapy related to the above procedures.

General anesthesia for adults requires our prior approval.
- 9. Diabetic Services and Supplies
Services and Supplies for Members with diabetes, as follows:
 - a. Blood glucose monitors and blood glucose monitors for the legally blind,
 - b. Test strips for glucose monitors, visual readings and urine test strips, lancets and spring-powered lancet devices,
 - c. Syringes, and
 - d. Diabetes self management training to ensure that parents of children with diabetes are trained to do the proper self-management and treatment of their child's diabetic condition.

10. Domestic Violence

Medically/Clinically Necessary treatment, services and supplies for Injuries resulting from domestic violence.

11. Drugs for Cancer Therapy and Cancer Clinical Trials

Drugs for cancer therapy and clinical trials, and the reasonable cost of administering them, are Covered regardless of whether the federal Food and Drug Administration (FDA) has approved the drugs to be used for the type of tumor for which the drugs are being used, as required by State law. Certain drugs may not be Covered if a majority of experts believe that further studies or clinical trials are needed to determine the toxicity, safety or efficacy of the drugs.

Routine patient costs in connection with certain Phase II and Phase III cancer clinical trials may be Covered if approved in advance by our Medical Director.

12. Durable Medical Equipment

Durable Medical Equipment (DME) is equipment intended for repeated use to meet a medical need and is:

- a. Prescribed by your child's PCP or by a Participating Provider upon referral from your child's PCP;
- b. Approved in advance by us, when required; and
- c. Obtained from a Participating Provider.

The following items are also Covered:

- a. Training or education on the use of DME; and
- b. Disposable supplies necessary for the proper functioning or application of the DME.

Coverage is for standard DME. Equipment that is not conventional or not Medically/Clinically Necessary as determined by us,

or for the convenience of the Member or caregivers will not be Covered. We may substitute one type or brand of DME for another when the items are comparable in meeting your child's medical needs.

All maintenance and repairs that result from misuse or abuse are your responsibility. The decision to rent, purchase, repair or replace DME is up to us at our discretion.

Coverage for DME is limited to one piece of same use equipment. We will Cover the repair or replacement, fitting and adjustment of Covered DME that is the result of normal use, body growth or body change. Equipment must be appropriate for home use.

See Section 7(11) for DME that is not Covered.

13. Education

Education to manage chronic disease states such as diabetes or asthma.

Education programs must be conducted by Participating Providers and approved in advance by us.

14. Emergency treatment

Covered without prior authorization if Medically/Clinically Necessary as defined in state law (read more about emergency treatment in Section 2.F).

15. End Stage Renal Disease

Services and supplies, including hemodialysis and peritoneal dialysis, necessary to diagnose and treat end stage renal disease.

16. Eye Care

Coverage is limited to the treatment of medical conditions and diseases of the eye. See Section 7(45) for vision services that are not Covered, MICHild Certificate of Coverage 19 and "Vision Care" under Section 6.B(37) for services that are Covered.

17. Family Planning

The following are Covered Services for your child even if they are not provided in connection with the diagnosis and treatment of an Illness or Injury. No referral is necessary if you receive these services at an approved family planning center:

- a. Diagnostic, counseling, and planning services for treatment of the underlying cause of infertility.
- b. Diaphragms, including measurement and fitting, and IUDs, including insertion and removal.
- c. Advice on contraception and family planning, including childbirth education.

Procedures to assist your child in having children are excluded as described in Section 7(20) under "Infertility."

18. Hearing Care

Covered for the following services and supplies payable once in every 36 consecutive months:

- a. Audiometric examination to measure hearing ability, including tests for air conduction, bone conduction, speech reception and speech discrimination,
- b. Hearing aid evaluation tests to determine what type of hearing aid(s) should be prescribed to compensate for loss of hearing,
- c. One hearing aid or binaural aids including in-the-ear, behind-the-ear, and on-the-body designs, with ear molds, if necessary,
- d. Dispensing fees for the normal services required in the fitting of a hearing aid, and
- e. Hearing aid conformity tests to evaluate the performance of a hearing aid and its conformity to the original prescription after the aid has been fitted.

Hearing aid repairs or replacement parts (including batteries and ear molds) are not Covered. Benefits are also not payable for the replacement of lost or broken hearing aids unless the 36 month Coverage limitation does not apply.

19. Home Health Care

When your child is confined to the home. Intermittent skilled services, when approved in advance by us and furnished in the home by a Home Health Care Agency or by a registered nurse, licensed practical nurse, physical therapist, occupational therapist, respiratory therapist or speech therapist. Custodial care is not Covered, even if your child receives home health care services along with custodial care. Home Health Care is covered for 120 days per calendar year when provided through a Medicare certified home health care agency, your child's Physician recommends home care and the Physician prepares a treatment plan. All home care must be approved in advance by us.

20. Hospice Care

Inpatient and outpatient Hospice Care is Covered when your Physician informs us that your child's condition is terminal and your child could benefit from Hospice services, you choose to have hospice services for your child, and the care is provided by a Medicare certified hospice program. We will cover up to 210 days of Hospice Care in a child's lifetime -- two periods of 90 days each and one period of 30 days. Covered hospice services may include:

- a. Nursing care
- b. Home health aide and homemakers services
- c. Short-term inpatient care
- d. Medical supplies and drugs
- e. Physical, speech and occupational therapy

- f. Medical social work services
- g. Bereavement counseling

21. Hospital Care

- a. Inpatient Care
Hospital inpatient services and supplies including services performed by Health Professionals, semi-private room and board, general nursing care, observation care and related services and supplies. Non-emergency Hospital stays, other than Hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section, must be approved in advance by us.

- b. Outpatient Care
Hospital services and supplies listed in subsection (21)(a) that your child receives on an outpatient basis.

22. Intractable Pain Evaluation

Evaluation and treatment of intractable pain.

23. Medical Supplies

- a. Medical supplies received while your child is an inpatient or in connection with a home health visit are Covered at your child's Hospital benefit level as set forth in this Certificate.
- b. Some medical supplies are Covered under your child's Durable Medical Equipment Coverage including such supplies as catheters, syringes, ostomy supplies, feeding tubes, including enteral and TPN feedings, lancets, sterile gauze and tape.

See Section 7(30) for outpatient medical supplies that are not Covered.

24. Obesity

Weight loss counseling is Covered for morbid obesity when prescribed by a Physician.

25. Oral Surgery

Coverage for oral surgery is limited to the following:

- a. The treatment of a jaw fracture, dislocation, or wound;
- b. The treatment of cysts, tumors, or other diseased tissues of the jaw, other facial bones, mouth, lip, tongue, accessory sinuses, salivary glands, or the ducts;
- c. Rebuilding or repair of soft tissues of the mouth or lip needed to correct anatomical functional impairment caused by congenital birth defect or accidental Injury within 48 hours of Injury;
- d. Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with tooth repair or extraction;
- e. The alteration of the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement; and
- f. Charges for dental services, office consultations and appliance therapy related to the above procedures.

Coverage for oral surgery must be approved in advance by us in consultation with your child's PCP or another Participating Provider (and if necessary a dental consultant) as Medically/Clinically Necessary.

Orthodontic treatment is not a Covered Service, even when provided along with oral surgery.

Dental surgery in preparation for implants or dentures, including preparation of the bone, or dental surgery done in connection with any of the Covered Services listed above is not Covered. Read Sections 7 and 8 to learn more about Coverage limitations and exclusions.

26. Orthognathic Surgery

“Orthognathic surgery” is defined as oral surgical therapy involving the repositioning (but not removal) of an individual tooth, arch segment, or entire arch, if the surgery is provided along with a course of orthodontic treatment to correct bodily dysfunction. We will only Cover the following orthognathic surgery services, and only when the services are approved in advance by our Medical Director in consultation with your child’s PCP or another Participating Provider (and if necessary a dental consultant) as Medically/Clinically Necessary:

- a. Referral care for evaluation and orthognathic treatment.
- b. Cephalometric study and x-rays.
- c. Orthognathic surgery and post-operative care.
- d. Hospitalization

Orthodontic treatment is not a Covered Service, even when provided along with orthognathic surgery.

27. Outpatient Prescription Drugs

These drugs are Covered in full with a Generic substitution process. Prescriptions will be dispensed in quantities prescribed by Providers up to a 30-day supply. Prescriptions will be covered if included on the Priority Health Government Program’s formulary. Coverage for some drugs requires prior approval from us, including non-formulary medications and off-label use of Food and Drug Administration approved drugs.

Outpatient prescription drugs include the following for the treatment of diabetes:

- a. Insulin, as prescribed by a Physician;
- b. Non-experimental medication for controlling blood sugar, if prescribed by a Physician; and

- c. Medications used in the treatment of foot ailments, infections and other medical conditions of the foot ankle, or nails associated with diabetes, if prescribed by a Physician, including a podiatrist.

28. Port Wine Stains

We will Cover laser therapy for removal of port wine stains only when approved in advance by us in consultation with your child’s PCP as Medically/Clinically Necessary. In general, Coverage is only provided for removal of port wine stains on the face and neck without other complicating medical conditions.

29. Prosthetic and Orthotic/Support Devices

- Surgically implanted internal prosthetic devices and special appliances/devices that are worn externally, when the appliances or devices:
- a. Temporarily or permanently replace all or part of the functions of an inoperative or malfunctioning internal body organ, or an external body part lost, weakened or deformed as a result of Injury or Illness.
 - b. Prescribed by your child’s PCP or another Participating Provider and approved in advance by us.
 - c. Orthopedic shoe inserts are Covered when prescribed by your child’s PCP, or another Participating Provider.

When an appliance or device is Covered, we will repair or replace it if necessary because of normal growth or normal wear and tear. We will not replace appliances that are lost or stolen. You have Coverage for standard prosthetics and orthotic/support devices only. Prosthetic or orthotic devices that are not conventional, not Medically/Clinically Necessary as determined by us, or for the convenience of the Member or caregivers are not Covered.

See Section 7(34) for additional exclusions.

30. Provider Care

All services listed in this Section 6 provided by a Participating Provider or Non-Participating Provider during an office visit, Hospital visit or house call for the diagnosis and treatment of an Illness or Injury provided by or upon referral by your PCP and approved in advance by us if necessary.

Referral by your PCP and approval by us is required if the referral Provider is a Non-Participating Provider.

31. Radiology Examination and Laboratory Procedures

Diagnostic and therapeutic radiology services and laboratory tests not excluded under Sections 7 and 8 in this Certificate.

32. Reconstructive Surgery

Reconstructive surgery to correct congenital birth defects and/or effects of Illness or Injury, if:

- a. The defects and/or effects of Illness or Injury cause clinical functional impairment. Clinical functional impairment exists when the defects and/or effects of Illness or Injury:
 - i. Cause significant disability or major psychological trauma,
 - ii. Interfere with employment or regular attendance at school,
 - iii. Require surgery that is a component of a program of reconstructive surgery for congenital deformity or trauma, or
 - iv. Contribute to major health problems, and
- b. We reasonably expect the surgery to correct the condition; and
- c. The services are approved in advance by us in consultation with your child’s

PCP or another Participating Provider and your child receives them within two years of the event that caused the impairment, unless either of the following applies:

- i. The impairment was not recognized at the time of the event. In that case, treatment must begin within two years of the time that the problem is identified;
- ii. Your child's treatment needs to be delayed because of developmental reasons.

We will Cover treatment to completion that needs to be performed in stages if that treatment begins within two years of the event causing the impairment so long as your child remains a Member. We will do that even if the treatment takes longer than two years. We will make the final decision about Coverage in consultation with your child's PCP.

Necessary surgery following cancer surgery (such as following a mastectomy) and major trauma (severe lacerations and burns) is a Covered Service as required by law.

In compliance with the Women's Health and Cancer Rights Act of 1998, we will consult with your child's PCP to determine Coverage for these services:

- a. Reconstruction of the breast on which a mastectomy was performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphademas.

Orthodontic treatment is not a Covered Service, even when provided along with reconstructive surgery.

Psychological reasons do not represent a

medical or surgical necessity unless your child is undergoing psychotherapy for issues solely related to the Illness or Injury for which the reconstructive surgery is requested. See Section 7(7) for Cosmetic and Reconstructive Surgery that is not Covered.

33. Short-term Rehabilitative Therapy

Physical therapy, cardiac rehabilitation, pulmonary therapy, occupational therapy, biofeedback and speech therapy for treatment of medical diagnoses if due to:

- a. An Injury;
- b. An Illness; or
- c. A congenital defect for which your child has received corrective surgery.

Short-term rehabilitative therapy services are Covered if:

- a. Your child receives them as an outpatient or in the home, and
- b. The therapy is restorative in nature and there is progressive meaningful improvement in your child's ability to perform functional day-to-day activities that are significant in the Member's life roles within 90 days, and
- c. A Participating Physician refers, directs and monitors the services.

Short-term rehabilitative therapy is limited by the following:

- a. We will only Cover a combined maximum of sixty (60) visits per calendar year for physical therapy, occupational therapy and speech therapy.
- b. Therapy for any individual condition must occur within 90 days of the initiation of outpatient therapy. Long-term therapy, including that beyond the initial 90 days following the initiation of outpatient therapy, must be prior approved.

See Section 7 (35) for rehabilitation and therapy services that are not Covered.

34. Skilled Nursing, Subacute, Long-term Acute, and Rehabilitation Facility Care Care and treatment, including therapy, and room and board in semi-private accommodations, at a Skilled Nursing, Subacute, or Rehabilitation Facility for a maximum of 120 days per admission when we have approved a treatment plan in advance. The treatment plan will be approved based on our determination of Medical/Clinical Necessity and appropriateness. Once benefits have been exhausted, they are renewable once there has been a lapse of at least 90 days from discharge date to the next admission date.

Custodial care is not Covered, even if your child receives skilled nursing services or therapies along with custodial care. Admission to a Skilled Nursing, Subacute, Long-term Acute or Rehabilitation Facility is not Covered if the necessary care or therapies can be provided safely in the home. Custodial care and services are excluded as described in Section 7(9) under "Custodial Care."

35. Temporomandibular Joint Syndrome (TMJS)

"Temporomandibular Joint Syndrome" or "TMJS" means muscle tension and spasms related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction. Your child has Coverage for the following services if they are approved in advance by us:

- a. Office visits for medical evaluation and treatment of TMJS
- b. Medical evaluation and treatment of TMJS
- c. X-rays of the temporomandibular joint including contrast studies, but not dental x-rays

- d. Myofunctional therapy
- e. Surgery to the temporomandibular joint, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis

36. Transplants

Work-ups for transplants and transplants of the following organs at a facility approved by us, but only when we have pre-approved the transplant as appropriate, Medically/Clinically Necessary and non-experimental:

- a. Cornea
- b. Heart
- c. Lung
- d. Kidney
- e. Bone marrow
- f. Liver
- g. Pancreas
- h. Small bowel

Extrarenal organ transplants (skin, bone, heart, lung, heart-lung, liver, pancreas, bone marrow including allogenic, autologous, and peripheral stem cell harvesting, and small bowel) are Covered on a patient specific basis when determined Medically Necessary according to currently accepted standards of care. All costs associated with transplant surgery and care are Covered. Covered related care may include but is not limited to organ procurement, donor searching and typing, harvesting of organs, and related donor medical costs. Related travel, lodging, and meals are not Covered.

Coverage includes Hospital, surgical and laboratory and x-ray expenses incurred by the person donating an organ or tissue to your child if the donor does not have transplant coverage under any other health care plan.

We will Cover expenses related to the typing or screening of a potential donor only if the person proposed to receive the transplant is a Member. We will Cover computer organ bank searches and any subsequent testing necessary after a potential donor is identified, unless covered by another health plan. See Section 7(29) under “Organ, Tissue and Blood Cell Donors” for expenses that are not Covered. Your benefits under this section are limited to one work-up per transplant.

This provision is not intended to conflict with the Coverage for drugs for cancer therapy which is Covered as described above in Section 6.B(11).

Transplants of artificial organs are not Covered.

37. Vision Care

Services and supplies relating to vision care, including: one eye exam every 12 months to determine the need and proper prescription for corrective lenses, one pair of single vision, multi-focal or cataract lenses, ophthalmic frames every 24 months, or every 12 months with a prescription change, or contact lenses when medically necessary or therapeutic to correct visual impairment when glasses are insufficient to correct the visual impairment.

Repair of frames/lenses are not Covered. Replacement of frames/lenses due to loss or breakage (if they cannot be repaired) are not Covered.

C. Maternity Care

1. Hospital and Provider Care

Services and supplies furnished by a Hospital or Provider for prenatal care, postnatal care, Hospital delivery, and care for the complications of pregnancy. Your daughter may visit a participating obstetrician/gynecologist or nurse midwife

acting within the scope of his or her license or specialty certification without referral. Your daughter may seek obstetrician/gynecologist and Hospital services out of network if she is pregnant at the time of enrollment. An inpatient stay for a mother and her baby for 48 hours following a vaginal delivery and 96 hours following a cesarean section do not require our prior approval.

The mother and newborn have the right to stay no less than 48 hours following a normal vaginal delivery or no less than 96 hours following a cesarean section. If the mother and her attending Physician agree, the mother and the Newborn may be discharged from the Hospital sooner and these restrictions would not apply.

Coverage does not include routine maternity care provided while your child is outside of the Service Area unless prior approved by us.

D. Medical Emergency and Urgent Care

See Section 2.F for information about your child's Coverage for a Medical Emergency and Urgent Care.

E. MICHild Covered Services NOT Provided By PHGP

Your Child may be eligible for certain services that are not Covered by this certificate including:

1. Dental services, except those described in Section 6.B;
2. Services provided by a school district and billed through the Intermediate School District;
3. Mental health services, including prescriptions written by Community Mental Health Services Programs; and
4. Substance abuse services and medication prescribed specifically for the purpose of substance abuse treatment.

Section 7 Exclusions From Coverage

We will not Cover any service, treatment or supply listed in this Section 7, unless:

- We provide Coverage for the service, treatment or supply in any amendment attached to the Certificate; or
- Coverage is required under applicable state or federal law.

The following is a list of exclusions from your child's Coverage:

1. Abortions

All services and supplies relating to elective abortions to terminate pregnancy are not Covered unless a Physician certifies that the abortion is medically necessary to save the life of the mother or if for a pregnancy that is the result of rape or incest. Treatment for medical complications occurring as a result of an elective abortion and for spontaneous, incomplete or threatened abortions and for ectopic pregnancies is Covered.

2. Adaptive Aids/Self-Help Items

Services and supplies designed for self-assistance. Examples include, among other things, reachers, feeding, dressing and bathroom aids, and augmentive communication devices.

3. Against Medical Advice

There is no Coverage for any service or treatment plan if you voluntarily refuse that service or treatment plan for your child, or any related service or treatment plan, against the advice of a Participating Provider. Also, there is no Coverage for any service or treatment plan if you voluntarily discharge your child, or your child is otherwise discharged, against the advice of a provider.

Noncompliance with treatment plans includes, but is not limited to:

- a. Failure to take prescribed medication.
 - b. Failure to follow through with outpatient treatment after inpatient or other intensive level of care.
 - c. Failure to comply with treatment plans or care contracts between you and a Provider or you and us.
4. Allergy Testing
Skin titration (Rinkle Method), cytotoxicity testing (Bryan's Test), MAST testing, urine autoinjections, and provocative and neutralization testing for allergies. See Section 6.B(2) for allergy tests that are Covered.
5. Biofeedback
Biofeedback for Mental Health Diagnoses.
6. Clinical Ecology and Environmental Medicine
Services and supplies provided to effect changes in or treatment to your child and/or your child's physical environment. "Clinical ecology" and "environmental medicine" means medical practice that is based on the belief that exposure to low levels of numerous common substances in the environment can be responsible for a variety of symptoms affecting numerous body systems.
7. Cosmetic or Reconstructive Services
Services that are NOT specifically Covered under Section 6.B(32). Cosmetic or reconstructive services, prescription drugs, treatment, therapies, or procedures done primarily to improve the way any part of the body looks. Coverage is excluded for, among other things:
- a. Abdominoplasty (to remove excess fat),
 - b. Blepharoplasty of lower lids,
 - c. Breast augmentation except when provided as part of post-mastectomy reconstructive services (see Section 6.B(32) for a fuller description of Covered Services),
 - d. Chemical peel for acne,
 - e. Collagen implants,
 - f. Diastasis recti repair,
 - g. Electrolysis for excessive hair growth, even if caused by an underlying medical condition,
 - h. Excision of excess skin and keloids, including treatment of keloids by laser or injections.
 - i. Fat grafts,
 - j. Hair transplants or repair of any congenital or acquired hair defect,
 - k. Liposuction, unless an integral part of another Covered procedure,
 - l. Procedures performed for excessive sweating,
 - m. Removal of spider veins,
 - n. Rhytidectomy,
 - o. Rhinophyma treatment,
 - p. Salabrasion,
 - q. Scar revision except for facial scars,
 - r. Surgery to repair extra or sagging skin, and
 - s. Tattoo removal.
- Psychological reasons do not represent a medical or surgical necessity unless your child is undergoing psychotherapy for issues solely related to the Illness or Injury for which cosmetic surgery is requested.
8. Court Ordered Services
Services required by court order and services required to file an action with a court, including evaluations and testing, or services required as a condition of parole or probation. We will Cover services

according to the terms of this Certificate if they are Medically/Clinically Necessary and you have not exhausted your benefits for the Contract Year.

9. Custodial and Maintenance Care

Any care your child receives if, in our opinion, your child has reached the maximum level of mental and/or physical function and your child will not continue to improve significantly. Custodial and maintenance care includes room and board, therapies, nursing care, home health aides and personal care designed to help your child in the activities of daily living and home care that your child receives, or could receive, from members of your family.

10. Dental Services and Dental Surgery

All dental services unless we tell you otherwise in this Certificate, including, among other things:

- a. Routine dental services,
- b. Dental x-rays,
- c. Dental surgery such as root canals and tooth extractions,
- d. Orthodontia and orthodontic x-rays, even when provided in conjunction with other treatment or surgery,
- e. Orthognathic surgery except as specifically Covered under Section 6.B(27),
- f. Dental prostheses, including implants and dentures and preparation of the bone to receive implants and dentures,
- g. Rebuilding or repair of soft tissues of the mouth or lip except as specifically Covered in Section 6.B(25),
- h. Bite splints used for dental purposes or for TMJS,
- i. Treatment of congenital dental defects, such as missing or abnormally developed teeth, and,

- j. Treatment, services and supplies related to periodontal/inflammatory gum disease.

Dental services required due to accidents are not Covered. This exclusion does not apply to medical services that are Medically/Clinically Necessary such as suturing of lacerations required in connection with an accident.

Inpatient or outpatient hospital services, such as anesthesia and facility charges, received in connection with Non-Covered dental services are not Covered unless prior approved by us. Hospital, ancillary and anesthesia services are covered for pediatric Members as described in Section 6.B(8).

11. Durable Medical Equipment

Equipment and devices solely for the convenience of you or your caregiver, home fixtures, modifications, and equipment installation, and self-help, communication or adaptive aids. Wheelchair Coverage is generally limited to a manually operated wheelchair unless prior approved by us. We reserve the right to limit replacement of Durable Medical Equipment to the expected life of the equipment. See Section 6.B(12) for Durable Medical Equipment that is Covered.

12. Ear Plugs

13. Educational Services

School based services are excluded. These services can be obtained through your local school system and include:

- a. Services for remedial education, including evaluation or treatment of learning disabilities, developmental and learning disorders, and behavioral training,
- b. Services, treatment or diagnostic

testing related to learning disabilities or developmental delays,

- c. Education testing or training,
- d. Services and supplies for mental retardation,
- e. Physical, occupational, speech, cognitive and sensory integration therapy for developmental delay and cognitive disorders,
- f. Cognitive rehabilitation,
- g. School-based services,
- h. Scholastic/Educational Testing is not Covered. Intelligence, developmental delays and learning disability testing and evaluations should be requested and conducted by the child's school district.

14. Experimental, Investigational or Unproven Services

Any drug, device, treatment or procedure that is experimental, investigational or unproven. A drug, device, treatment or procedure is experimental, investigational or unproven if one or more of the following applies:

- a. The drug or device cannot be lawfully marketed in the United States without the approval of the Food and Drug Administration (FDA) and that approval has not been granted;
- b. An institutional review board or other body oversees the administration of the drug, device, treatment or procedure or approves or reviews research concerning safety, toxicity or efficacy;
- c. The patient informed consent documents describe the drug, device, treatment or procedure as experimental or investigational or in other terms that indicate the service is being evaluated for its safety, toxicity or efficacy;

- d. Reliable evidence shows that the drug, device, treatment or procedure is:
- i. The subject of on-going phase I or Phase II clinical trials;
 - ii. The research, experimental study, or investigational arm of on-going Phase III clinical trials; or
 - iii. Otherwise under study to determine its toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis.
- e. Reliable Evidence shows that a majority of experts believe that further studies or clinical trials are needed to determine the toxicity, safety, or efficacy of the drug, device, treatment or procedure as compared with a standard means of treatment or diagnosis. "Reliable Evidence" includes any of the following:
- i. Published reports and articles in authoritative medical and scientific literature;
 - ii. A written protocol or protocols used by the treating facility or the protocol(s) of another facility studying the same or a similar drug, device, treatment or procedure; or
 - iii. Patient informed consent documents used by the treating facility or by another facility studying the same or a similar drug, device, treatment or procedure.

This exclusion does not apply to drugs for cancer therapy described in Section 6.B(11).

Coverage is available for routine patient costs in connection with certain Phase II and Phase III cancer clinical trials.

For information about which trials are Covered, your child's PCP should contact our medical director.

15. Food, Supplements and Formula
All food, formula and nutritional supplements including, but not limited to, infant formula, protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements are not Covered. Enteral feedings may be covered if criteria under the applicable medical policy are met.
16. Foot Care
- a. Routine foot care, including corn and callous removal, nail trimming, and other hygienic or maintenance care.
 - b. Cleaning, soaking, and skin cream application for the feet.
17. Hair Analysis and Treatment for Hair Loss
18. Health Promotion Classes
Classes covering such subjects as stress management, parenting and lifestyle changes, except for approved maternity education programs or when a part of our chronic disease management programs.
19. Illegal Acts
Treatment, services and supplies in connection with any Injury or Illness caused by your child's:
- a. Commission of, or attempt to commit, a felony; or
 - b. Engagement in an illegal occupation;
- We reserve the right to recover the cost of services and supplies that were initially Covered by us and later determined to be excluded as described in this Illegal Acts section.
20. Infertility
All services and supplies relating to treatments for infertility including, among other things, artificial insemination,

in-vitro fertilization, embryo or ovum transfer procedures, any other assisted reproduction procedure, fees to a surrogate parent, prescription drugs designed to achieve pregnancy, and services to reverse voluntary sterilizations. Diagnostic services are Covered as described in Section 6.B(17) Family Planning.

21. Leave of Absence
Charges incurred when your child is on an overnight or weekend pass during an inpatient stay.
22. Marital and Relationship Enhancement Counseling
23. Mental Health/Substance Abuse
These services are excluded under this Plan but are provided or arranged through the local Community Mental Health Boards. You may contact your local Community Mental Health Board, substance abuse coordinating agency or us for assistance in finding a provider.
24. No Legal Obligation to Pay
Any service or supply that you would not have a legal obligation to pay for on behalf of your child without this Coverage, including, among other things, any service performed or item supplied by a relative of your child if, in the absence of this Coverage, you would not be charged for the service or item.
25. No-Show Charges
Any missed appointment fee charged by a Participating Provider because you failed to bring your child to an appointment, except in the case of a Medical Emergency.
26. Non-Participating Providers
Non-participating Providers are those not listed in our provider directory. For the most complete directory call our Customer Service department or visit our website at priorityhealth.com. Services and supplies from Providers who have not contracted with us to provide services and supplies

under this Certificate except in the case of Medical Emergency, those obtained from Tribal Health Centers, child and adolescent health centers, FQHCs or if approved by us in writing prior to obtaining the services and supplies are not Covered.

27. Not Medically/Clinically Necessary

Service or supplies that we determine are not Medically/Clinically Necessary. If you disagree with us about Medical/Clinical Necessity, you (or your child's Participating Provider, if you wish) may request a review of our determination as described in Section 12. But unless and until we agree with you that the services and supplies will be Covered Services, they will be excluded from Coverage.

If we exclude Coverage because a service or supply is not Medically/Clinically necessary, that decision is a determination about benefits and not a medical treatment determination or recommendation. You, with your child's Participating Provider, may choose to go ahead with the planned treatment at your own expense, and request a review of our denial of your claim for Coverage under our inquiry and review procedure as set forth in Section 12.

28. Obstetrical Delivery in the Home

Services and supplies received in connection with an obstetrical delivery in the home.

29. Organ, Tissue and Blood Cell Donors

Community wide searches for a donor. All donor expenses, even those of a child enrolled in PHGP for transplant recipients who are not enrolled in PHGP. See Section 6.B(36) under "Transplants" for information about what transplant expenses are Covered.

30. Outpatient Supplies

Certain outpatient medical supplies that are consumable or disposable supplies, including, among other things, gloves,

bandages, diapers, adhesive tape, alcohol wipes, and elastic bandages. See Section 6.B(23) for medical supplies that are Covered.

31. Over-the-Counter (Non-Prescription) Drugs

32. Personal Comfort or Convenience Items, Household Fixtures and Equipment

- a. Services and supplies not directly related to your child's care, such as, among other things: guest meals and accommodations; telephone charges; travel expenses; take home supplies; and similar costs,
- b. The purchase or rental of household fixtures, such as, among other things: escalators, elevators, swimming pools and similar fixtures,
- c. The purchase or rental of household equipment that have customary non-medical purposes, such as, among other things: exercise cycles; air purifiers; central or unit air conditioners; water purifiers; non-allergenic pillows; mattresses or waterbeds; spas, tanning equipment and other similar equipment,
- d. Car seats and modifications to motorized vehicles.

33. Private Duty Nursing

34. Prosthetic and Orthotic/Support Devices
Orthopedic shoes and other supportive devices of the feet. See Section 6.B(29) for prosthetic and orthotic/support devices that are Covered.

35. Rehabilitation and Therapy Services

- a. Long-term rehabilitation services that are not restorative in nature. Long-term therapy, specifically therapy beyond 90 days following the initiation of therapy, is not Covered if, in the opinion of our Medical Director, there is not

meaningful improvement in your child's ability to perform functional day-to-day activities that are significant in the child's life roles. Therapy for the purpose of maintaining physical condition or maintenance therapy for a chronic condition including, but not limited to, cerebral palsy and developmental delays, is not Covered.

- b. Physical, speech or occupational therapy to correct an impairment, when the impairment is not due to Illness, Injury or a congenital defect for which your child has received corrective surgery.
- c. Long-term cognitive rehabilitative therapy. Cognitive rehabilitative therapy is defined as neurological training or retraining. Short-term rehabilitative therapy is Covered as described in Section 6.B(33).
- d. Strength training and exercise programs.
- e. Rehabilitation services obtained from non-Health Professionals, including massage therapists.
- f. Summer programs meant to maintain physical condition or developmental status during periods when school programs are unavailable.
- g. All therapies for developmental delays, apraxias and cognitive disorders, including physical, occupational, speech, cognitive and sensory integration therapy.
- h. Vocational rehabilitation, including work training, work related therapy, work hardening, work site evaluation and all return to work programs. Short term rehabilitative therapy is Covered as described in Section 6.B (33).

36. **Relational, Educational, and Sleep Therapy**
 Relational, educational and sleep therapy and any related diagnostic testing. This exclusion does not apply to therapy or testing provided as part of a Covered inpatient Hospital service.
37. **Religious Counseling**
 Services and treatment related to religious counseling, including counseling provided by a religious counselor who is not a Participating Provider.
38. **Residential or Assisted Living**
 Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, health care aides, and personal care designed to help your child in activities of daily living or to keep your child from continuing unhealthy activities.
39. **Sex Change or Transformation**
 Any procedure or treatment designed to change your child's physical characteristics from your child's biologically determined sex to those of the opposite sex. This exclusion applies despite any diagnosis of gender role or psychosexual orientation problems.
40. **Sex Therapy**
 Services and treatment related to sex therapy.
41. **Third Party Requirements**
 Services required or recommended by third parties, including, but are not limited to:
- Physical examinations in excess of those required by federal guidelines performed by your child's PCP or another Participating Provider,
 - Physical examinations performed by a Physician other than your child's PCP, and
 - Diagnostic services and immunizations related to getting or keeping a job,
- getting or keeping any license issued by a governmental body, getting insurance coverage, foreign travel, adopting children, school admission or attendance and participation in athletics.
42. **Tobacco Cessation Treatment**
 All related services and supplies for the treatment of tobacco abuse, except for smoking cessation counseling provided by your child's PCP or another Participating Provider.
43. **Treatment in a Federal, State, or Governmental Facility**
 Services and supplies provided while in detention or incarcerated in a facility such as a youth home, jail or prison, when in the custody of law enforcement officers or on release for the sole purpose of receiving medical treatment are excluded to the extent permitted by law.
44. **Unauthorized Services and Supplies**
- Services and supplies that your child's PCP or another Participating Provider did not perform, prescribe, or arrange according to the guidelines of this Certificate.
 - Services and supplies that were provided without any required advance approval by us.
 - Services and supplies from any Nonparticipating Provider upon self-referral by you.
 - Services and supplies sought only for the purpose of obtaining benefits under this Certificate and for which there is no evidence that such services or supplies are Medically/Clinically Necessary.
- This exclusion does not apply to services necessary to treat a Medical Emergency or Urgent Care situation. See Section 2.C for a list of services that must be prior approved by us.
45. **Vision Care**
- Non-prescription ophthalmic lenses and frames.
 - Special independent diagnostic tests or treatment procedures.
 - Any other eye or vision service not specifically listed in Section 6.B(37) of this Certificate.
 - Services and supplies relating to eye exercises, visual training, orthoptics, sensory integration therapy, radial keratotomy, laser surgeries and other refractive keratoplasties.
46. **Vocational Rehabilitation**
 Evaluations of the worksite, work-hardening and work-related therapy.
47. **Weight Control**
 All services and supplies related to weight control treatment See Section 6.B(24) for Covered Services for extreme obesity.

Section 8 Limitations

Your child may only receive services from his or her PCP or another Participating Provider. Your child may receive an annual well-woman examination or routine obstetrical services provided by a participating obstetrician/gynecologist or routine pediatric services provided by a participating pediatrician as described in Section 2.C without referral. Certain services require approval by us in advance. Do not go to a Non-Participating provider unless your child's PCP or another Participating Provider has referred your child and we have approved the referral first. Otherwise, you must pay for the services. Your child may visit FQHCs, child and adolescent health centers or Tribal Health Centers without referral. You also must pay for services your child receives in excess of approved services. You may call our Customer

Service department to find out if we have approved the services.

NOTE: *Sometimes your child's PCP may refer your child for or suggest a service that we do not Cover. Just because your child's PCP or another Participating Provider refers your child or suggests the service does not mean your child will have Coverage for that service. Remember – if your child receives services that we do not Cover, you may have to pay for the services.*

A. Benefit Maximums

Some of the Covered Services described in this Certificate are subject to maximum limitations. Once your child has reached a maximum for a Covered Service, you will be responsible for the cost of additional services.

B. Work-Related Illness or Injury

If your child is eligible for Worker's Compensation Coverage due to a work related Illness or Injury, this Certificate will not Cover any services related to that work related Illness or Injury.

C. Services While in Detention or Incarcerated

We will not pay for services and supplies provided while in detention or incarcerated in a facility such as a youth home, jail or prison.

D. Services Received While Enrolled in MICHild

We will only pay for Covered Services your child receives while your child is enrolled with PHGP. A service is considered to be received on the date on which services or supplies are provided to your child. We will only Cover services and supplies for the

diagnosis or treatment of Illness or Injury, except as specifically provided elsewhere in this Certificate.

E. Uncontrollable Events

A national disaster, war, riot, civil insurrection, epidemic, or other event we cannot control may make our offices, personnel, or financial resources unable to provide or arrange for the provision of Covered Services. To the extent that happens, we will not be liable if your child does not receive those services or if they are delayed. But we will make a good faith effort to see that they are provided, considering the impact of the event.

Section 9 Member Rights and Responsibilities

As a Member of PHGP your child has the following rights:

- Your child may receive prompt medical care appropriate for medical conditions, including emergency care if necessary.
- You may receive information regarding appropriate or medically necessary treatment options which will enable you to make an informed decision about the treatment your child receives, regardless of cost or benefit Coverage.
- You may receive information about us, our services, our providers and Member rights and responsibilities.
- You may participate in decisions regarding your child's health care.
- We will treat you and your child with respect.
- We will protect your child's privacy.
- We will keep your child's medical and financial records maintained by us confidential, whether in electronic or written form. We will not disclose

information from your child's medical records without your consent, except when required by law, in connection with the administration of this plan, or for anonymous use in statistical studies and medical research. We will notify you in a timely manner if we release personal information about you in response to a court order unless we tell you otherwise in this Certificate.

- You may inspect your child's medical records at the office of the proper PCP or other Participating Provider during normal business hours. The provider may limit a parent's or legal guardian's access to a minor's medical records without the minor's consent, as provided by law.
- You may contact us to discuss concerns about the quality of care your child has received from a Participating Provider.
- You may register a complaint or file a formal review with us or the State of Michigan, if you experience a problem with us or a provider.
- You and your child may expect our staff and our Participating Providers to meet all requirements concerning Member rights.
- You may initiate a legal proceeding if you experience a problem with us or a provider.
- You may review a summary of PHGP's annual report, and inspect the full report on file with the Michigan Department of Community Health or the Office of Financial and Insurance Regulation.

On behalf of your child you have the responsibility to:

- You must read the Certificate of Coverage and Member materials, and comply with the requirements.
- We recommend that you coordinate all medical services through your child's

Primary Care Provider, except in the case of a Medical Emergency.

- Your child must receive a well-child physical examination from your child's PCP within one year of joining this plan.
- You must contact Participating Providers to arrange for medical appointments, and notify providers in a timely manner if your child's appointment must be canceled.
- You must obtain prior approval from your child's PCP and us for services as noted in this Certificate, including all services from providers who are not listed in the Priority Health Government Programs, Inc. Provider Directory, and comply with the limits of any approval of services.
- You must present your child's ID Card to the provider before he or she receives a service.
- You must use Participating Providers for all services and equipment not requiring prior approval unless we tell you otherwise in this Certificate.
- You must follow our instructions and the instructions given to you by your child's provider that you have agreed to follow. We or your child's providers may ask you to enter into an explicit written agreement to ensure you understand the instructions.
- You must supply, to the extent possible, information needed by us and health care professionals to provide proper care to your child.
- You must notify providers and us if your child has other health insurance coverage.
- You must provide truthful information in any information provided to us.
- You must promptly notify us of any change in address for your child.
- You must promptly notify us if your child's ID card is lost or stolen.

Section 10 Claims Provisions

You are responsible for the cost of any services your child receives from Non-Participating Providers unless those services were arranged by your child's PCP and approved in advance by us, unless your child needs them to treat a Medical Emergency or Urgent Care situation, or unless we tell you otherwise in this Certificate. When your child needs Urgent Care services, you must try to contact your child's PCP before your child obtains those services. Otherwise, you will be responsible for any of the services your child receives. Your child's PCP will tell you either to go to his or her office or to another Participating Provider's office. If after several attempts you cannot reach your child's PCP and your child's problem requires Urgent Care, go to a participating Urgent Care Center or Participating Hospital emergency room.

If you must pay a health care provider for Covered Services, ask us in writing to be reimbursed for those services. With your request, you must give us proof of payment that is acceptable to us. You must make your request within 60 days of the date your child obtained the services. If you do not ask for reimbursement within 60 days, we can limit or refuse reimbursement. But we will not limit or refuse reimbursement if it is not reasonably possible for you to give us proof of payment in the required time, as long as you give us the required information as soon as reasonably possible. We will never be liable for a claim or reimbursement request if we obtain proof of payment for it more than 180 days after the date your child received the services, unless you are legally incapacitated. We will only reimburse you for Covered Services.

Send your itemized medical bills promptly to us at:

Priority Health Government Programs, Inc.
 Claims Department, MS 2205
 PO Box 298
 Grand Rapids, MI 49501-0298

Before we pay health care providers or reimburse you for services your child receives, we may require you to give us more information or documentation to prove they are Covered Services. We will not be liable for a claim or reimbursement request if we ask for additional information from you and you do not respond within 60 days after we request the additional information, unless you are legally incapacitated. Our right to that information or documentation may be limited by state or federal law.

If you are not satisfied with any benefit determination we have made, you can dispute it under the inquiry and review procedure. Read Section 12 to find out more about that procedure.

Section 11 Termination of Coverage

A. Disenrollment from MIChild

Your child may be disenrolled from MIChild according to state or federal regulations.

B. Disenrollment from the Health Plan

Your child may be disenrolled from PHGP for the following reasons (among others):

1. Your child moves from our Service Area.
2. Termination for cause as outlined in Section 11.C.
3. Our contract with DCH is terminated for any reason.

NOTE: *If your child is still eligible for Coverage under Section 3 of this*

Certificate, we will not terminate your child's Coverage based on your child's health or health care needs. Also, we will not terminate your child's Coverage just because you used the inquiry and review procedure to file a complaint against us.

C. Termination For Cause

We can ask the State to disenroll your child from this plan for any of the following reasons:

1. Improper actions by you or your child that are inconsistent with membership in PHGP, including:
 - a. Fraud, abuse of the Plan, or
 - b. Intentional misconduct; or
 - c. If, in our opinion, your or your child's behavior makes it medically infeasible for us to safely or prudently render Covered Services to your child.

We can ask the State to disenroll your child from this plan for cause immediately if any of the following happens:

1. We find out you or your child have committed or attempted to commit fraud against us; or
2. You or your child have been dishonest with us about some important or material matter; or
3. You or your child let someone else use your child's ID Card, or receive benefits in your child's place; or
4. You or your child act so disruptively that you upset our ordinary operations or those of a Participating Provider, including but not limited to, verbally or physically threatening us or a Participating Provider.

Such termination is subject to the written review procedures described in Section 12 below, except that we must immediately provide you or your child with a notice of termination, along with the procedures for

expeditious review. We must contact the DCH and supply supporting documentation for the possible disenrollment. The effective date of your child's disenrollment will be the last day of the month in which DCH approves the disenrollment.

NOTE: *If you are still eligible for Coverage under Section 3 of this Certificate, we will not request disenrollment based on your health or your health care needs. Also, we will not request disenrollment just because you used the review procedure to file a complaint against us. The State must provide you with a Certificate of Creditable Coverage upon your disenrollment from MICHild.*

Section 12 Inquiry and Review Procedures

We hope that you are always happy with the service your child receives from us. We know, however, that from time to time you may have a problem or concern that you want us to address. If you have a question, concern or complaint about us, please call our Customer Service department at 888 975-8102 or 616 464-8102. Our Customer Service representatives will help you with your problem as quickly as possible.

If you are not happy with the answers that our representative has provided, you or someone acting on your behalf can send us a formal complaint. This formal complaint is handled through our review process. You have 90 days from the date you learn of a problem to file a complaint with us. You can file a complaint to ask us to change a decision about any of the following:

- Benefits (may include experimental or investigational or not Medically/Clinically Necessary or appropriate services)
- Eligibility

- Payment of claims (in whole or in part)
- How we've handled payment or coordination of health care services
- Contracts with our providers
- Availability of care or providers
- Delivery or quality of health care services or
- A decision not in your favor. This may include services that have been reviewed by PHGP and denied, reduced or terminated. It also may include a slow response to a request for a decision from us.

Here is a summary of the steps you can take:

A. Review Procedure

Step 1: Contact our Customer Service department to file a Level 1 Review with us. You or your child's authorized representative must file a Level 1 Review within 90 days of an adverse determination or learning of an adverse determination, whichever is later. Our Level 1 Internal Review Committee will meet to discuss your review and we will mail you a written response. Our Level 1 Internal Review Committee is comprised of PHGP employees, including senior managers and a Physician from our network, none of whom were involved in the initial determination or who are subordinates of someone who made the initial decision.

Step 2: If your Level 1 Review has not been resolved to your satisfaction, you or your child's authorized representative may request a hearing before our Level 2 Internal Review Committee. You must file this request within 3 days after receiving your Level 1 Review decision. The Level 2 Review Committee is comprised of community Physicians from our network, our Members, employers who offer Priority Health to their employees and our employees, none of whom were involved in the initial determination or the decision of the Level 1 Review Committee or who are

subordinates of someone who served on the Level 1 Review Committee.

We will let you know the date and time for the hearing. You or your child's authorized representative may attend the portion of the Level 2 Review Committee hearing that applies to your review. Immediately after the hearing, we will send you a written decision.

If you have not yet received the services: Steps 1 and 2 combined must be completed with a final decision made within a total of 30 calendar days after we receive your request for review. Up to 10 business days can be added to receive information from Health Professionals or others with information necessary to resolve your concern. Neither Step 1 nor Step 2 may take more than 15 days, respectively.

If you have already received the services: Steps 1 and 2 combined must be completed with a final determination made within a total of 35 calendar days after we receive your Level 1 and Level 2 review. We may also add up to 10 business days to receive information from Health Professionals or others with information necessary to resolve your case if it is helpful to your concern. Neither Step 1 nor Step 2 may take more than 30 days, respectively.

Step 3: If you are not satisfied with the resolution of your problem or complaint after completing all the steps of our inquiry and Review Procedure, you or your child's authorized representative may request a review by the Office of Financial and Insurance Regulation within 60 days of our final decision. Direct reviews to the Commissioner at the following address and telephone number:

Office of Financial and Insurance Regulation
 Health Plans Division
 611 West Ottawa, Third Floor
 P. O. Box 30220
 Lansing, Michigan 48909-7720
 877 999-6442
michigan.gov/ofir

B. Expedited Review Procedure

If your child's Physician tells us (either in writing or by telephone) that the time it takes for us to review your concern under the normal Level 1 Review Procedure would put your child's life in serious danger, interfere with your child's full recovery or delay treatment for severe pain, we will follow an "expedited review" procedure. Steps 1 and 2 in an "expedited review" procedure must be completed within 72-hours of receipt of your request. If you, your child or your child's Physician request an extension of the 72-hour "expedited review" timeframe, the Level 1 and Level 2 reviews will revert to the standard 35 calendar day timeframe. You may file a request for an "expedited review" with the Office of Financial and Insurance Regulation immediately after you have filed a request for an "expedited review" with us. If you are not satisfied with the resolution of your problem or complaint after completing PHGP's "expedited review" procedure, you may appeal within 10 days of our final decision to the Office of Financial and Insurance Regulation.

C. Obtaining Information About the Inquiry and Review Procedure

To obtain a complete copy of our Level 1 Review or "expedited review" Procedures and Level 1 Review Form, or to find out more about your Level 2 review rights, please contact our Customer Service department.

D. Filing a Lawsuit Against Priority Health Government Programs, Inc.

You have the right to bring an action for benefits under Section 500.3422 of the Michigan Insurance Code. However, before filing a lawsuit against us, you or your child's authorized representative must complete our Inquiry and Review Procedure as described in this Section 12. In addition, no action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days

after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of (3) three years after the time written proof of loss is required to be furnished.

Section 13 Continuation, Conversion or Extension of Benefits

There are no continuation or conversion rights or extension of benefits provisions associated with the MiChild program.

Section 14 Third Party Payments and Subrogation/Reimbursement

A. Coordination of Benefits with MiChild

In most cases, your child is not eligible for MiChild benefits if your child has other comprehensive insurance coverage. If your child is Injured in an automobile accident and the accident is covered by automobile insurance, we will be the Secondary Payer with respect to the automobile or other insurance.

If your child has insurance in addition to MiChild, call the Customer Service department at 888 975-8102 to tell us what it is. The other insurance must always be billed before us. We will not pay any expenses that are covered by the other insurance.

B. Subrogation and Reimbursement

Your child may experience an Illness or Injury for which a third party is currently responsible or was responsible for in the past. When we pay for Covered Services that relate to that

Illness or Injury for which you or your child have or had a legal or equitable cause of action against a third party, you assign (or transfer) to us, on your own and your child's behalf, rights of recovery with regard to that cause of action. These rights of recovery include a right to subrogation (which means that we can stand in you or your child's shoes and sue a third party directly for your child's Illness or Injury) and a right of reimbursement (which means that we have a right to be reimbursed out of any recoveries you or your child receive or have received from third parties relating to your child's Illness or Injury). These rights of recovery extend to any recoveries from third-parties, including but not limited to tort-feasors, underinsured/uninsured motorist coverage, other substitute coverage, any other group or non-group policy of insurance providing health and/or accident coverage (including, but not limited to, any insurance policy having to do with payment of medical benefits that result from an automobile accident, and any riders or attachments to that policy). These rights of recovery also extend to all forms of recovery whether legal or equitable, in the form of policy proceeds, settlement or judgment, or based in tort, contract, or in any other body of law. Our rights of recovery will be to the fullest extent permitted by law, and shall equal, as a dollar amount, the total amount paid by us, or the cost of services provided by us, plus reasonable collection costs, relating to the Illness or Injury at issue.

You must tell us immediately, in writing, about any situation that might allow us to invoke our rights of recovery under this section. (This would include informing us about any past recoveries you or your child received that relate to an Illness or Injury for which we are paying Covered Services.) You must also cooperate with us to help protect our rights of recovery under this section. Neither you, nor anyone acting for you, including legal counsel, may do anything to harm our rights under

this section. If you or your child receives any proceeds of a policy, settlement or judgment, and if we have a right of reimbursement with regard to those proceeds, you must hold those proceeds in trust for us. (We can recover from you any expenses we incur because you failed to cooperate in enforcing our rights under this section.) You agree that our rights of recovery precede any other party's rights of recovery. Specifically with regard to our right of reimbursement, we will have first priority claim against any monies you or your child recovers. Our reimbursement claim will be paid before any other claims are paid, whether or not you or your child has recovered the total amount of your child's damages. If you or your child receive policy proceeds, settle a claim or action against a third party or receive a judgment, you or your child will be considered to have been "made whole" by the proceeds, settlement or judgment, and the federal law "make whole" concept will not apply. We have the right to be reimbursed in full before any amounts (including attorney's fees incurred by you or your child) are deducted from the policy proceeds, judgment or settlement. Our rights of recovery are not limited by designation of certain funds as being or not being intended for payment of medical services.

For purposes of this subsection 14.B, the terms "you" or "your child" includes you, your child, and/or any other person(s) claiming through or on behalf of you or your child, including but not limited to relatives, guardians, heirs, assigns and successors.

Section 15 Non-Duplication of Benefits

The benefits under this Certificate are not intended to duplicate any benefits to which your child is, or would be, entitled under any other federal or state government program, nor are they intended to duplicate any "no

fault" benefits. All sums payable under such programs or policies for services provided pursuant to this Certificate shall be payable and retained by us. On behalf of each of your children, you shall complete and submit to us such consents, releases, assignments and other documents as may be requested by us in order to obtain or assure reimbursement in connection with any governmental program or "no fault" benefits for which Members are eligible.

Your child's benefits under this Certificate cannot be doubled up with any benefits your child is, or could be, eligible for under Medicare or any other federal or state government program. If we Cover a service that is also covered by one of those programs, any sums payable under that program for that service must be paid to us. We will apply the rules for Coordination of Benefits described in Section 14 after your benefits from us have been calculated under the rules in this section. We will reduce Allowable Expenses by any benefits available for those expenses under Medicare or any other federal or state governmental program. You must fill out and return to us any documents we ask for to make sure we receive reimbursement by those programs.

Section 16 Definitions

Administrative Contractor. The entity that contracts with DCH to provide administrative support for the MICHild program.

Agreement. The Agreement between the State of Michigan and us. The Agreement is a contract for health benefits. The Agreement includes this Certificate, any amendments and any attachments. A copy of the Agreement is available on request from us and may also be available from the State of Michigan.

Certificate of Coverage. The document that you receive from us that describes your and your child's and our rights and duties. It includes the enrollment form and any amendments and attachments to the document. The Certificate is your agreement with us for the care of your child.

Certificate of Creditable Coverage. A certificate issued to you on behalf of your child upon termination of Coverage under this Certificate by the Enrollment Contractor.

CMH. A community mental health agency.

Contract Year. The period of time that starts on the day your child's Coverage is effective and ends 365 days later (unless the Certificate, the Administrative Contractor, or the state say otherwise).

Covered Services, Coverage, Cover or Covered. Those services and supplies that your child is entitled to under this Certificate, if they are Medically/Clinically Necessary and your child has met all other requirements of this Certificate. This Certificate limits what we will pay for some services and supplies. When we say we will "Cover" a service or supply, that means we will treat the service or supply as a Covered Service.

DCH. The Michigan Department of Community Health, the agency of the State of Michigan that operates the MIChild program.

DHS. The Department of Human Services, the agency of the State of Michigan that operates the eligibility portion of the State's Medicaid program.

Disabled or Disability. Under the Social Security Act, you are Disabled or have a Disability if, taking into account your age, education and past work experience, you are unable to perform any substantial gainful activity by reason of a medically determinable physical or mental impairment, or a combination of impairments, which can

be expected to result in death or which has lasted or can be expected to last at least 12 consecutive months.

Durable Medical Equipment. Equipment which is: (a) made for repeated use; (b) mainly used for a medical purpose; (c) appropriate to use at home; and (d) generally not useful unless a person has an Illness or Injury.

FQHC. Federally Qualified Health Centers are public and private non-profit healthcare organizations that meet certain criteria under the Medicare and Medicaid programs of the Social Security Act and receive funds under the Health Center Program.

Health Professional. An individual licensed, certified or authorized under state law to practice a health profession.

Home Health Care Agency. An agency or organization that is licensed to provide skilled nursing services and other therapeutic services in an outpatient setting.

Hospice Care. Services for the terminally ill and their families including pain management and other supportive services.

Hospital. An appropriately licensed acute care institution that provides inpatient medical care and treatment for ill and injured persons through medical, diagnostic, and major surgical facilities. All services must be provided on its premises under the supervision of a staff of Physicians and with 24 hour-a-day nursing and Physician service.

ID Card. The Member Identification Card you receive from us as evidence of your child's enrollment with us.

Ill or Illness. A sickness or a disease, including congenital defects or birth abnormalities.

Injury or Injured. Accidental bodily Injury.

Medicaid/Medical Assistance Program. A federal/state program authorized under Title XIX of the Social Security Act, as amended, 42 U.S.C. 1396 et seq.; and Section 105 of

Act No. 280 of the Public Acts of 1939, as amended, being 400.105 of the Michigan Compiled Laws; which provides federal matching funds for a medical assistance program. Specified medical and financial eligibility requirements must be met to be covered under Medicaid.

Medical Director. A Michigan-licensed Physician we have designated to supervise and manage the medical aspects of our health care delivery system.

Medical Emergency. The sudden onset of a medical condition with signs and symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to your child's health, or serious dysfunction of any bodily organ or part.

Medically/Clinically Necessary. The services or supplies needed to diagnose, care for or treat your child's physical condition. The Medical Director, or anyone acting at the Medical Director's request, in consultation with your child's PCP or another Participating Provider, determines whether services or supplies are Medically/Clinically Necessary according to our medical and behavioral health policies that have been approved by community physicians and other providers.

Medically/Clinically Necessary services and supplies must be widely accepted professionally in the medical community as effective, appropriate, and essential, based upon nationally accepted standards of the health care specialty involved.

All of the following are considered not to be Medically/Clinically Necessary:

- Those services rendered by a Health Professional that do not require the technical skills of such a provider;
- Those services and supplies furnished mainly for the personal comfort or convenience of your child, anyone who

cares for your child, or anyone who is part of your family;

- Those services and supplies furnished to your child only because your child is an inpatient on any day on which your child's physical or mental condition could safely and adequately be diagnosed or treated as an outpatient; and
- Any service or supply beyond those services sufficient to safely and adequately diagnose or treat your physical or mental condition.

Medicare. Title XVIII of the Social Security Act, as amended.

Member. A child enrolled with us under this plan.

Motorized Vehicle. Any self-propelled vehicle, designed for use on or off public roads, waterways or in the air. Including, but not limited to, automobiles, motorcycles, snowmobiles and personal watercraft.

Newborn. A Newborn child is defined as a child 30 days old or younger.

Non-Occupational Illness and Non-Occupational Injury. An Illness or Injury that does not arise out of (or in the course of) any work for pay or profit, and does not in any way result from an Illness or Injury that arose from work for pay or profit. But, if we obtain proof that your child is covered under a Worker's Compensation law or similar law, but that your child is not covered for a particular Illness or Injury under that law, that Illness or Injury will be considered "non-occupational" regardless of cause.

Non-Participating Provider. A Health Professional or other entity, including a hospital or outpatient facility that has not contracted with us to provide Covered Services to Members. Health Professionals who practice outside of our Service Area are Non-Participating Providers. Non-Participating

Providers are not listed in the Priority Health Government Programs, Inc. Provider Directory.

Open Enrollment Period. A period of time established by the State during which eligible children may be enrolled in the MICHild program.

Out-of-Area Services. Those services and supplies provided outside our Service Area by Non-Participating Providers.

Participating Hospital. A Hospital that contracts with us to provide Covered Services to Members. Participating Hospitals are located within our Service Area and are listed in our Provider Directory.

Participating Physician. A Physician who contracts with us to provide Covered Services to Members. Participating Physicians are listed in our Provider Directory.

Participating Provider. A Health Professional or other entity that contracts with us to provide Covered Services to Members. Most Participating Providers practice within our Service Area and are listed in our Provider Directory.

Physician. An appropriately licensed Physician or surgeon.

Premium. The amount you pay to the Administrative Contractor for Coverage under the MICHild program.

Primary Care Provider ("PCP"). The Participating Provider, as chosen under Section 2.A, who is responsible to provide, arrange, and coordinate all aspects of your child's health care.

Priority Health Government Programs, Inc. (PHGP). The Michigan nonprofit corporation and licensed health maintenance organization providing benefits under this Certificate of Coverage.

Reasonable and Customary Charges. The charge for a Covered Service that is the

lower of: (a) the provider's usual charge for furnishing the service; and (b) the charge we determine to be the prevailing charge level made for the service or supply in the geographical area where it is furnished. In determining the reasonable charge for a service or supply that is unusual, or not often provided in the area, or provided by only a small number of providers in the area, we may consider things like the complexity of the service, the degree of skill needed, the type or specialty of the provider, the range of services provided by a facility, and the prevailing charge in other areas.

Residential Treatment. 24-hour services provided in a facility where the focus of care is custodial, and inpatient Medical/Clinical Necessary criteria are not met.

Service Area. A geographical area, designated by us and approved by the State of Michigan, in which we are authorized to offer Covered Services. In general, the Service Area for this plan is located in West Michigan. We publish precise Service Area boundaries and you may obtain information about our Service Area from our Customer Service department.

Skilled Nursing, Subacute, Long-term Acute or Inpatient Rehabilitation or Facility. A facility that is appropriately licensed to provide services in lieu of hospitalization including skilled nursing care and related services, subacute and long-term acute services and short-term rehabilitative therapy care on an inpatient basis.

Specialist Provider. A Participating Provider, other than a PCP, under contract with us to provide Covered Services upon referral by your child's PCP and approval in advance by us. Your child may seek an annual well-woman examination or routine obstetrical services from a participating obstetrician/gynecologist or routine pediatric services from a participating pediatrician without referral from his or her PCP or us.

Urgent Care. Services provided at a licensed facility other than a Hospital to treat non-life threatening conditions that require immediate medical attention to limit severity and prevent complications.

Urgent Care Center. A licensed facility, not including a Hospital, that provides Urgent Care for the immediate treatment only of an Injury or Illness.

We, us, our, Priority Health or PHGP. Priority Health Government Programs, Inc.

You, your or yourself. The parent or guardian of a Member.

Section 17 General Provisions

A. Independent Contractors

We do not directly provide any health care services under this Certificate, and we have no right or responsibility to make medical treatment decisions. Medical treatment decisions may only be made by Health Professionals in consultation with you and your child. We are only obligated under this Certificate to provide Members a network of health care services.

We are responsible for making benefit determinations under this Certificate and our contracts with Participating Providers. Health Professionals are responsible for making independent medical judgments. Health Professionals and you may choose to continue medical treatment for your child even if we deny Coverage for those treatments. In such event, you will be responsible for the cost of those treatments.

Health Professionals, on your child's behalf, and you may ask for a review of any of our benefit decisions. Any review must follow the Inquiry and Review procedure explained in Section 12.

B. Authorization to Release Medical Information

By enrolling with us, you authorize any person or entity having information about your child's medical care including all personal health information to release any and all such information to us. You, and your child to the extent permitted by law, consent to our release, to the extent permitted by law, of any and all personal medical information to third parties: (i) to allow us to administer directly or through such third parties, our health plans; (ii) to assist in providing your child with medical benefits or education information; (iii) for anonymous use in bona fide statistical studies and medical research; (iv) to determine the quality of health care services provided; or (v) as required by law. If not previously revoked in writing, your consent will expire only upon termination of your child's membership with us. If you revoke your consent for us to release information to third parties or to receive information regarding your child's medical care, we may terminate your child's Coverage if your revocation makes it impossible for us to fulfill our responsibilities under this Certificate.

The information to which this authorization relates includes, but is not limited to, medical records, reports, data, and claims information relating to diagnosis, prognosis and treatment for physical and mental illness, mental health, communicable diseases, serious communicable diseases and infections, and other conditions, ailments, sicknesses and diseases, including human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS).

You agree to cooperate with us, and our Participating Providers, by providing your child's health history information and by helping us to obtain your child's medical records if we ask. If we ask you for a signed authorization for release of medical records, you agree to provide us with one. Except

for the reasons described above, we will keep medical information about your child confidential.

NOTE: *This Section 17.B will be superseded by Section 18, in accordance with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as of April 14, 2003.*

C. Entire Agreement

This Certificate of Coverage, the enrollment form, and any amendments or attachments, is the entire Agreement between you and us. Beginning on the effective date of Coverage, this Certificate supersedes all other agreements for health care services and benefits between you and us.

D. Non-assignment

You may not assign or transfer any of your child's rights to benefits or services under this Certificate.

E. Conformity with State and Federal Law

We will apply this Certificate in agreement with state and federal laws and regulations. If any part of this Certificate does not agree with state or federal laws or regulations, we will change our procedures to agree with the laws and regulations.

Section 18 Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to You

Priority Health Government Programs, Inc. (“PHGP”) understands the importance of handling protected health information with care. We are committed to protecting the privacy of our members’ health information in every setting. State and federal laws require us to make sure that your health information is kept private.

When you enroll with PHGP or use services provided by one of our plans, your protected health information may be released to us and by us. This information is used and disclosed to coordinate and oversee your medical treatment, pay your medical claims and assist in health care operations. The use and disclosure of your health information ends when your coverage ends, except to pay for services received relating to the time that you were covered or for certain health care operations of PHGP or our providers.

Federal law requires that we provide you with this Notice of Privacy Practices. This Notice states our legal duties and privacy practices regarding your protected health information. It also states your rights under these laws with respect to the use and disclosure of your health information. We are required by law to follow the terms of the Notice currently in effect.

Use and Release of Your Health Information

The sections below describe the ways PHGP uses and releases your health information. Your health information is not shared with anyone who does not have a “need to know” to perform one of the tasks below.

Treatment. We may use your health information or disclose it to third parties to coordinate and oversee your medical care. For example, we may use your health information to help you find a doctor or a hospital that can treat your specific health needs.

Payment. We may use your health information or disclose it to third parties to pay for your medical care. For example, we may use your health information when we receive a claim for payment. Your claim tells us what services you received and may include a diagnosis. We may also disclose this information to another insurer if you are covered under more than one health plan.

Health Care Operations. We may use your health information and disclose it to third parties in order to assist in our everyday work activities such as looking at the quality of your care, carrying out utilization review, confirming benefit eligibility, employee training and review processes, monitoring and auditing activities, and our business management and general administrative duties. For example, your health information may be released to members of our staff to review the quality of care and outcomes. Your health information may also be released to doctors or doctor groups involved in your care to improve patient care.

Other Permitted or Required Uses and Disclosures

PHGP may also use or release your health information:

- When required by state or federal law and the use or disclosure complies with and is limited to the requirements of such law
- When permitted for law enforcement purposes
- When permitted to be released to government authorities in cases of abuse, neglect or domestic violence (in which case, you will be notified unless the notification would place you at risk of serious harm)
- When permitted for certain public health activities, such as disease control or public health investigations
- When permitted to be released to public health authorities in child abuse and neglect investigations
- When permitted to be released for certain FDA investigations and activities, such as investigations of product defects or to permit product recalls, repairs or replacements
- When permitted to prevent a serious threat to an individual or a community’s health and safety
- When permitted by certain court proceedings (either judicial or administrative)
- When permitted for health oversight activities led by governmental agencies and authorized by law
- When permitted to be released about an inmate to a correctional facility, or otherwise permitted for release in law enforcement custodial situations
- When information about a deceased individual is required by a coroner, medical examiner, law enforcement official or funeral director to carry out their legal duties
- When permitted to be released to cadaveric organ, eye or tissue donation and transplant organizations
- For research purposes when the research has been approved by an institutional review board that has reviewed proposals and established protocols to ensure the privacy of your health information
- When authorized by and to the extent necessary to comply with workers’ compensation laws

- When permitted for purposes of providing you with treatment alternatives or other health-related benefits and services
- When permitted to be released to the Armed Forces for active personnel
- When permitted to be released to the Veterans Administration for determining if you are eligible for benefits
- When permitted to be released to Intelligence Agencies for national security
- When permitted to be released to the Department of State for foreign services reasons (e.g. security clearance)
- When permitted to be released to Government Agencies for protection of the President

In order to use or disclose your health information in the above ways, we may have to follow additional state and federal requirements. Also, in some cases, we may share your information with one of our “business associates,” a person or company that provides certain services to PHGP. In those cases, we will have a contract with the business associate, as needed. This contract will require the business associate to confirm they will keep your health information private.

Disclosures to Health Plan Sponsors

PHGP may share health information with the Michigan Department of Community Health (DCH). The DCH may use this information to develop premium information for health insurance coverage or to decide whether to modify, amend or terminate the plan. We may also share your protected health information to help DCH seek available subsidies.

Other Uses of Health Information – By Authorization Only

Other uses and disclosures of health information not covered by this Notice or the

laws that apply to us will be made only with your written authorization. Some common examples of when Authorization is typically needed for certain releases of information concern mental health issues, substance abuse issues, prenatal and pregnancy related issues, venereal disease or HIV/AIDS and grievance/appeals. We can provide you with a Sample Authorization Form.

If you provide us with an authorization to use or release health information about you, you may end that authorization at any time by writing to PHGP’s Compliance Department. (See Contact Information section) If you end your authorization, we will no longer use or release health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization.

A parent, legal guardian, or properly named patient advocate may represent you and provide us with an authorization (or may end an authorization) to use or release health information about you if you cannot provide an authorization. Court documents may be required to verify this authority.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. Therefore, if any state or federal privacy law requires us to provide you with more privacy protections, we are obligated to comply with that law in addition to HIPAA.

Confidentiality in all Settings

We have policies and procedures in place that protect the privacy of your information.

- Every employee signs a statement when they are hired that they understand they are required to keep member information

private. They also learn about the actions the company will take if the privacy policies are not followed.

- PHGP has strict control of access to electronic and paper information specific to members. Only those users authorized with a password have access to electronic information. Paper information is stored in secure locations. Access is only given to those who need it to manage care for members or for administrative purposes.

We tell all third parties with whom we share information about our privacy policies. These third parties must follow our privacy policies unless they have policies of their own equal to ours.

We review our confidentiality policies and procedures every year. We also review how we collect, use, dispose of and disclose your information. Members (or prospective members) and providers have the right to review PHGP’s confidentiality policies and procedures. You may get copies by contacting our Compliance Department. (See Contact Information section)

Your Rights Regarding Your Health Information

You have the following rights:

Right to Inspect and Copy

You have a right to look at and get a copy of health information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes. There are other limited circumstances in which we may deny your request to inspect and copy under federal and state law. If you are denied access to health information, you may request that the denial be reviewed.

To inspect and copy health information, contact PHGP’s Compliance Department in writing. (See Contact Information section)

If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request.

Right to Amend

You have the right to request that we amend any health information (medical or billing) we have about you.

However, we will not amend any record that:

- We did not create (unless there is a reasonable basis to believe that the creator of the information is no longer available to act on the requested amendment)
- Is not part of the medical or billing information we have about you
- Is not part of information which you would be permitted to inspect and copy
- Is determined by us to be accurate and complete

To request that we amend your health information, you must write to our Compliance Department (See Contact Information section) and include a reason to support the change.

Right to Know About Disclosures

You have the right to know when your health information is disclosed to third parties. You can request a list of disclosures going back six years from the date of your request. This list will not include disclosures:

- To carry out treatment, payment or health care operations
- That were made to you
- For national security or intelligence purposes
- To correctional institutions or law enforcement officials
- That were incidental to a use or disclosure that was permitted or required
- That were made with an authorization by the individual

- Of a subset of information called a “limited data set”
- That were prior to April 14, 2003

To request a list of disclosures, you must send your request in writing to our Compliance Department. (See Contact Information section) Your request must specify the time period desired. There will be no charge for the first list you request within a 12-month period. There may be a small charge for any further requests. We will let you know of the cost involved and you may choose to stop or change your request at that time before any costs occur.

Right to Request Restrictions

You have the right to request a limit on the health information that we use or disclose about you. We are not required by law to agree to your request. If we do agree to your request for restriction, we will comply with it unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to our Compliance Department. (See Contact Information section) In your request, you must tell us:

- What information you want to limit
- Whether you want to limit our use, disclosure or both
- To whom you want the limits to apply

We will notify you of receiving your request, either in writing or by telephone, of the restrictions we have put in place.

Right to Request Confidential Communications

PHGP will agree to any reasonable request asking that you receive information from the health plan by different means or at a different location. For us to honor this request, you must clearly state that the disclosure of all or part of that information without the change could be a risk to you.

To request confidential communications, you must make your request in writing to our Compliance Department. (See Contact Information section)

Right to a Paper Copy of This Notice

You have the right to a paper copy of PHGP's current Notice upon request. To obtain a paper copy of this Notice, please call our Customer Service Department. (See Contact Information section) Otherwise, you may also print a copy of this Notice from our website at priorityhealth.com.

Changes to this Notice

PHGP has the right to change the terms of this Notice. We have the right to make these changes apply to health information we already have about you as well as any we receive in the future. We will always post a copy of the current Notice on our website. You will also receive materially revised Notices within 60 days of their effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with PHGP and/or the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS). To file a complaint with us, please call or send a written explanation of the issue to our Compliance Department. (See Contact Information section) You will not be penalized for filing a complaint.

Contact Information

If you have any questions or complaints, please contact Priority Health Government Programs' Compliance Department or Customer Service Department as noted above at:

Priority Health Government Programs, Inc.
Compliance Department, MS 3230
PO Box 269
Grand Rapids MI 49501-0269
616 942-0954 or 800 942-0954

If this information is unclear or if you do not understand it, please call us for assistance at 888 975-8102 (for TDD service, please call 616 464-8485).

This Notice is effective: April 14, 2003.

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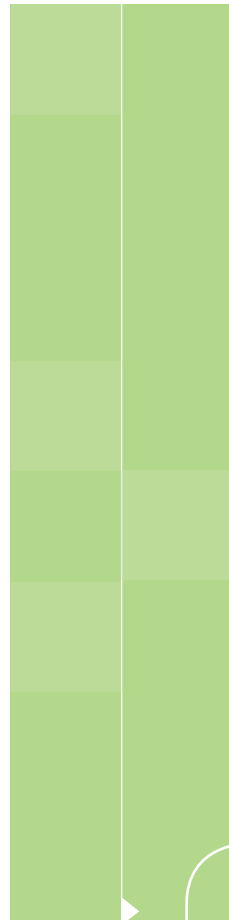
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Understanding your coverage

Preventive health
care guidelines



Preventive services are immunizations, screenings, lab tests and other services that either help prevent illness or help find diseases or medical problems before you experience symptoms.

These guidelines list preventive services covered by your Priority Health plan. For more detailed information, see your plan documents or our website at priorityhealth.com or the federal government list of preventive services at healthcare.gov.



How Priority Health covers preventive services

When services listed are performed for preventive purposes, Priority Health will pay for them as follows:

- If your plan is not grandfathered*, these services will be covered at 100%. You will not need to pay anything.
- If your plan is grandfathered*, these services will be covered at your preventive health care services benefit level. If your plan covers prescription drugs, the drugs listed here will be covered according to your prescription drug rider. If your plan doesn't cover prescription drugs, the drugs listed here aren't covered by Priority Health.

Sometimes a doctor may provide or order these approved preventive services more frequently than suggested in these guidelines. When this happens, these approved preventive services are still considered preventive and your plan's deductible will not apply.

*A plan's grandfathered status under the Affordable Care Act is determined at the first renewal after March 23, 2010, and each renewal after that date. Please ask your employer if your plan is a grandfathered plan. Or you may call our Customer Service department using the phone number on the back of your member ID card.

When are services *preventive*?

Not all tests and screenings that your doctor may recommend for you are preventive services. Tests and services to monitor, diagnose or treat diseases, even if listed here, may not be covered as preventive services in some situations.

If the services you receive are not preventive services, your deductible will apply, along with applicable office visit copays and coinsurance for tests and screening.

Here are some examples:

- If you have a chronic disease, your doctor may run certain tests on a regular basis to monitor your condition. Because these tests are part of managing your illness, they are not considered preventive services.
- If you have a preventive screening and the results indicate a health problem, your doctor may run additional tests to help diagnose the condition or confirm a diagnosis. Such follow-up tests are not considered preventive services.
- If your doctor orders tests based on existing symptoms, these tests would not be considered preventive services.
- If your doctor recommends a screening or test that is not on this list, your deductible and applicable copayments and coinsurance will apply. Sometimes a doctor may recommend a test that is not on this list. In some cases, there is not enough medical evidence to suggest that it has an overall benefit. It's important to talk to your doctor and understand why your doctor thinks a service is right for you.






 = Preventive service

 = Not preventive service

Examples of preventive and non-preventive services

Before you have a test or screening, it's good to understand if it will be covered as a preventive service in your plan. Remember – if the service is not preventive, your deductible and applicable copayments and coinsurance will apply. The following examples may help.

Colorectal cancer screening

-  If your doctor recommends a routine colonoscopy or sigmoidoscopy to screen for early signs of colorectal cancer based on your age or family history, the procedure is considered a preventive service and is covered under the preventive benefit.
-  If you are having a colonoscopy or sigmoidoscopy for another reason – for example, to diagnose problems with bleeding or irregularity – the service is not considered preventive.
-  If a polyp (an abnormal growth that can sometimes be precancerous) is discovered and removed during your preventive colonoscopy, your doctor will often send the sample to a lab to be tested for cancer. While the screening colonoscopy and removal of the polyp is considered preventive, the pathology testing (if needed) is diagnostic.

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Diabetes screening



A blood glucose test is used to detect whether you have a problem with your blood sugar control, even though you may not have any symptoms. This is a preventive service when screening for diabetes.



If it is confirmed that you have diabetes, your doctor will want to check your glucose control regularly over time using a different test called an “A1c.” This becomes part of monitoring your condition and making sure that your diabetes is under control, and is not considered preventive.

Cervical cancer screening



The pap test is the standard screening procedure for determining if a woman has early signs of cervical cancer. Screening for cervical cancer using the pap test is covered as a preventive service.



Under some conditions, your doctor might recommend that you also get a human papillomavirus (HPV) test, either to diagnose whether an HPV infection may be causing abnormal cells in your cervix or to provide an additional level of screening for cervical cancer. The HPV test is considered diagnostic.

Metabolic panels



Your doctor may recommend that you have a metabolic panel to check certain aspects of your blood chemistry. This test is not considered a preventive service, because there is not enough medical evidence to show that it helps to detect or prevent treatable diseases before symptoms occur. Sometimes this test is done to monitor the effects of a health condition or treatment on different functions in your body. In either case, the test is considered diagnostic.

Get Answers

If you have questions about preventive services, please call the Customer Service number on the back of your Priority Health ID card.

Physical exam frequency

Age	Recommendation
Newborns	Three to five days after discharge
0 to 2 years	Well child visits at 1, 2, 4, 6, 9, 12, 15, 18 and 24 months
3 to 6 years	Routine visit at 30 months. One visit every 12 months for ages 3 to 6 years
7 to 10 years	One visit every 12 to 24 months
11 to 18 years	One visit annually
19 to 21 years	One visit every 2 to 3 years, annually if desired
22 years and older	One visit every 24 months, annually if desired

Immunization vaccines for children from birth to age 18



Immunizations	
Diphtheria, tetanus, pertussis	At ages 2, 4, 6 and 18 months, once between 4 and 6 years, a single dose of Tdap for booster between ages 11 and 12 and subsequently every 10 years
Haemophilus influenzae type B	At ages 2, 4, 6 and 15 to 18 months
Hepatitis A	Two doses at least six months apart at ages 12 to 23 months. From age 2 to 18 years, at physician's discretion: two doses at least six months apart if not vaccinated previously and at high risk
Hepatitis B	Three doses in the first 18 months. (First dose of Hep B to be administered to all newborns before leaving the hospital.) May begin three-dose series age 2 to 18 years if not vaccinated in infancy
Human papillomavirus (HPV)	Three dose series at age 11 to 12 years on a zero, two and six-month schedule for females. Minimum spacing: four weeks between #1 and #2; 12 weeks between #2 and #3; must be 24 weeks between doses #1 and #3
Inactivated poliovirus	At ages 2, 4 and 6 to 18 months, once between ages 4 and 6 years
Influenza	For healthy children receiving the immunization for the first time, ages 6 months to 9 years, two doses separated by four weeks. Annually for children 2 years and older after first immunization
Measles, mumps, rubella (MMR)	Two vaccinations, the first at ages 12 to 15 months. MMR vaccinations should never be given less than one month apart. Second vaccination given between ages 4 and 6 years. After age 7, two doses if not previously vaccinated or no history of disease
Meningococcal	One dose for ages 2 to 10 years if high risk. One dose between 11 to 12 years. One dose 13 to 18 years if not previously vaccinated
Pneumococcal	For all children ages 23 months and younger, four doses at 2, 4, 6, and 12 to 15 months. For ages 2 to 6 years, a single dose, if not immunized previously for healthy children. One additional dose for children with underlying medical conditions who have already received three doses. Vaccinate high risk groups after age 7
Rotavirus	At 2, 4 and 6 months
Varicella	One vaccination between ages 12 and 18 months. Second dose to be given at 4 to 6 years. Two-dose series for children 7 years to adult if no history of varicella and no previous vaccination



Assessments and screenings for children from birth to age 18

Assessments, screenings and counseling	
Alcohol and drug use assessments	All adolescents, during each visit for age 11 to 18 years
Anticipatory guidelines as defined by Bright Futures	For all children at physician discretion
Autism screening	Children at 18 and 24 months
Blood pressure	Beginning at 3 years
Cervical dysplasia/cancer screening	At start of sexual activity for females
Chlamydia infection, gonorrhea and syphilis screenings	All sexually active adolescents to be screened for sexually transmitted infections (STIs)
Congenital hypothyroidism screening	Newborns
Depression screening and behavioral assessments	Children of all ages
Developmental screening	Children under the age of 3 to be checked at 9, 18 and 30 months
Dyslipidemia screening	Risk assessment at 2, 4, 6, 8 and 10 years old, then annually through age 21. (Routine lab testing not recommended, but may be done for children identified as high risk)
Gonorrhea preventive medication	For the eyes of all newborns
Hearing screening	All newborns, 4, 5, 6, 8 and 10 years. After 11 years if at high risk
Height, weight and body mass percentile measurements	Height and weight at each visit up to 2 years. Starting at 2 years body mass percentile at each visit
Hematocrit or hemoglobin screening	Once at 12 months, once between ages 11 and 21, once annually for menstruating adolescents
HIV screening	Annually for adolescents at high risk
Lead screening	Children at risk of exposure. Risk assessment for lead exposure between ages 6 and 12 months and again at 24 months and assess for risk between ages 2 to 6. Blood tests for those identified as high risk
Medical history	All children throughout development
Newborn screenings as identified by the federal Health Resources and Services Administration	Once at birth, screenings include but are not limited to PKU and sickle cell screenings
Obesity screening and physical activity and nutrition counseling	6 years and older
Oral health risk assessment	12, 18, 24 and 30 months. 3 and 6 years
Sexually transmitted infection (STI) prevention counseling	Adolescents at higher risk, anticipatory guidance at physician discretion for ages 11 to 18 years
Tuberculin testing	Children at high risk of tuberculosis
Urinalysis	Once between ages 11 and 21
Vision screening	3, 4, 5, 6, 8, 10, 12, 15 and 18 years

Immunization vaccines for adults



Immunizations	
Hepatitis A	For high risk groups
Hepatitis B	For high risk groups
Herpes zoster	One dose at age 60 and older
Human papillomovirus	Three dose series at age 19 to 26 years on a zero, two and six-month schedule for females. Minimum spacing: four weeks between #1 and #2; 12 weeks between #2 and #3; must be 24 weeks between doses #1 and #3
Influenza	Annually
Measles, mumps, rubella (MMR)	One to two doses if not vaccinated previously or no history of disease. For high risk groups age 40 years and older
Meningococcal	For ages 19 to 24, one dose if not vaccinated previously. For high risk groups 24 years and older
Pneumococcal	For high risk groups under age 65. One after age 65
Tetanus, diphtheria and pertussis (Td/Tdap)	Every 10 years (One dose of Tdap if pertussis booster was not received previously) After 65 Td alone
Varicella	Two-dose series for adults if no history of varicella and no previous vaccination





Assessments and screenings for adults

Assessments, screenings and counseling	
Abdominal aortic aneurysm screening	Men between ages 65 and 75 who have ever smoked, a one-time screening for abdominal aortic aneurysm
Alcohol misuse screening	All adults at physical exam
Anticipatory guidance for family and intimate partner violence, breast self-exam, menopause counseling, safety, injury prevention	At physician discretion for all adults
Bacteriuria (urinary tract or other infection screening)	Pregnant women
Blood pressure screening	All adults at physical exam
Breast feeding counseling	Interventions to support and promote breast feeding for new mothers
Cervical dysplasia/cancer screening	Start screening at beginning of sexual activity or at 21, whichever is first. Annual screening up to age 30. For ages 30 and older, screening every two to three years. Suggest stopping at 70 if three or more normal Pap tests in a row, no abnormal Pap test in previous 10 years and not at high risk
Chlamydia infection, gonorrhea and syphilis screenings	All sexually active adults to be screened for sexually transmitted infections (STIs)
Colorectal cancer screening	Adults over 50. Beginning at age 50, one of the following screening options: <ul style="list-style-type: none"> • Fecal occult blood test annually • Flexible sigmoidoscopy every five years • Colonoscopy every 10 years. Those with a family history (first degree relative) of colorectal cancer or adenomatous polyps: begin screening at age 40 or 10 years before the youngest case in the immediate family. Colonoscopy every five years. Consider stopping screening at age 75. Use individual consideration between ages 75 and 85. Screening is not recommended for individuals older than 85
Counseling for breast cancer chemoprevention	Women at high risk
Counseling related to BRCA screening	Women at high risk
Depression screening	All adults, during each physical exam
Diabetes screening	Fasting plasma glucose test every three years in adults with hypertension or hyperlipidemia
Diet counseling	Adults at higher risk for chronic disease
Height, weight and body mass percentile measurements	All adults during physical exam
Hematocrit or hemoglobin screening	Once every two years for adults
Hepatitis B screening	Pregnant women at their first prenatal visit
HIV screening	Annually for adults at high risk
Iron deficient anemia screening	On a routine basis for pregnant women

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Lipoprotein profile	For all adults age 20 and older, a fasting lipoprotein profile (total cholesterol, LDL, HDL and triglyceride) once every five years
Mammography	Women ages 40 to 49, every one to two years. Annually for ages 50 and older
Obesity screening and counseling	All adults
Osteoporosis screening	Once every two years as a part of physical exam (does not include bone density test) for women 40 to 64 years old. Bone density test beginning at 65, or at 60 for women at risk
Rh incompatibility screening	All pregnant women on first visit and follow-up testing for women at higher risk
Sexually transmitted infection (STI) prevention counseling	Adults at higher risk
Tobacco use screening	All adults during each visit (includes cessation interventions for tobacco users) expanded counseling for pregnant tobacco users
Tuberculin testing	Adults at higher risk of tuberculosis
Urinalysis	Once between ages 11 and 21

Drugs (prescription required)

Prescription	Recommendation
Fluoride supplements	Children without fluoride in their water source
Folic acid supplements	Women who may become pregnant
Iron supplements	Children ages 6 to 12 months at risk for iron deficiency anemia
Low-dose aspirin therapy for the prevention of cardiovascular disease	Men ages 45 to 79 years, women age 55 to 79 years and others with risk factors. Consult your doctor before beginning aspirin therapy

Note: *The drugs listed above are provided at no charge for non-grandfathered plans. If your plan is grandfathered, the drugs listed here will be covered according to your prescription drug rider. If your grandfathered plan doesn't cover prescription drugs, the drugs listed here aren't covered.*

The Preventive Health Care Guidelines were approved by Priority Health network physicians.

***For physician use only:** Specific EPSDT requirements may vary from the guidelines.*

Please refer to the online Provider Manual to review the EPSDT periodicity chart for the mandated health screening program for Medicaid recipients younger than age 21.

References:

American Academy of Family Physicians

American Academy of Pediatrics

American Cancer Society

American College of Obstetricians and Gynecologists

American College of Physicians

American Medical Association

Centers for Disease Control

National Cancer Institute

U.S. Preventive Services Task Force, U.S. Public Health Service

Healthcare.gov

Go to ahrq.gov/clinic/prevenix.htm for a complete list of evidence-based preventive services and risk factors from USPSTF.

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