Employnet

Staff Benefits Management & Administrators

2018 HEALTH INSURANCE ENROLLMENT & ACKNOWLEDGEMENT GUIDE

2018 OFFER OF MEDICAL BENEFITS

This notification is to inform you that you are eligible for medical benefits under your employer's open enrollment effective the 1st of the month following 60 days from the date of hire.

The application enrollment deadline is 30 days from the date of receipt of this notice. If you wish to decline coverage, no formal declination of coverage is necessary; you may disregard all contents of this enrollment guide following the acknowledgment. Applications not received by the 30th day following receipt of this notice will result in a lost opportunity to enroll in benefits until September 1, 2018.

Types of Medical Coverage:

1. **Minimum Essential Coverage (MEC):** This coverage **ONLY** covers 63 preventative services. Please note MEC does NOT cover any additional services. This plan meets the minimum requirement to eliminate the Individual Mandate Penalty.
2. **MEC Plus:** Covers all preventative services outlined in MEC and provides additional medical services offered at a copay. MEC Plus also includes HealthiestYou telehealth program. **Note: MEC Plus does not cover emergency or out-of-network services.**
3. **Anthem Elements Choice MVP PPO 6350 (CA Only):** This coverage is a minimum value plan. This program features a $6,350.00 deductible in which all services, except preventative, are subject to the deductible. **Please note you must pay the first $6,350.00 of all medial costs before the policy benefits take effect.**
4. **Anthem Elements Choice MVP PPO 6350 (Out-of-State):** This coverage is a minimum value plan. This program features a $6,350.00 deductible in which all services, except preventative, are subject to the deductible. **Please note you must pay the first $6,350.00 of all medial costs before the policy benefits take effect.**

*Costs of plans are based on affordability as mandated under the Affordable Care Act (ACA). Employees will not pay greater than 9.69% of their salary on medical benefits. Rates will be calculated upon interest.

ACKNOWLEDGEMENT OF RECEIPT

I, _____, hereby acknowledge receipt of the of 2018 offer of health benefits.

I have been provided with the Enrollment Guideline packet and with the information pertaining to the application and open enrollment deadlines. I have been offered a plan for myself and my dependents that provides both minimum essential coverage (MEC) and minimum value plans. I understand the cost to me is not higher than 9.69% of my wages.

I understand that if I do not enroll by the indicated dates, it will be understood that I have declined coverage for the entire year of 2018, and will not be able to enroll into benefits until September 1, 2018.

✎Signature _____ Date __ __ / __ __ / __ __ __ __

Name _____ Social Security Number __ __ __ - __ __ - __ __ __ __

ENROLLMENT FORM

EMPLOYEE INFORMATION

Name _____

Employer Name _____

Date of Birth __ __ / __ __ / __ __ __ __ Sex ☐ M ☐ F

Address _____

City _____ State __ __ Zip __ __ __ __ __

Social Security Number __ __ __ - __ __ - __ __ __ __

Hire Date __ __ / __ __ / __ __ __ __

Phone Number __ __ __ - __ __ __ - __ __ __ __

Email _____

DEPENDENT INFORMATION

Name _____

Social Security Number __ __ __ - __ __ - __ __ __ __

Date of Birth __ __ / __ __ / __ __ __ __ Sex ☐ M ☐ F

Relationship ☐ Spouse ☐ Child

Name _____

Social Security Number __ __ __ - __ __ - __ __ __ __

Date of Birth __ __ / __ __ / __ __ __ __ Sex ☐ M ☐ F

Relationship ☐ Spouse ☐ Child

Name_____

Social Security Number __ __ __ - __ __ - __ __ __ __

Date of Birth __ __ / __ __ / __ __ __ __ Sex ☐ M ☐ F

Relationship ☐ Spouse ☐ Child

Name_____

Social Security Number __ __ __ - __ __ - __ __ __ __

Date of Birth __ __ / __ __ / __ __ __ __ Sex ☐ M ☐ F

Relationship ☐ Spouse ☐ Child

MEDICAL

Minimum Essential Coverage – **MEC** – (Eliminates $695 Penalty)

- ☐ **$5.77/week** **Employee Only**
- ☐ **$11.54/week** **Employee + Spouse**
- ☐ **$11.54/week** **Employee + Children**
- ☐ **$23.08/week** **Employee + Family**

MEC Plus

- ☐ **$20.00/week** **Employee Only**
- ☐ **$55.08/week** **Employee + Spouse**
- ☐ **$39.07/week** **Employee + Children**
- ☐ **$78.74/week** **Employee + Family**

Anthem Elements Choice MVP PPO (CA Only)

- ☐ **$102.98/week** **Employee Only**
- ☐ **$226.56/week** **Employee + Spouse**
- ☐ **$185.37/week** **Employee + Children**
- ☐ **$319.12/week** **Employee + Family**

Anthem Elements Choice MVP PPO

- ☐ **$90.87/week** **Employee Only**
- ☐ **$204.52/week** **Employee + Spouse**
- ☐ **$163.56/week** **Employee + Children**
- ☐ **$281.80/week** **Employee + Family**

☐ **DECLINE all Medical options**

Name _____ Social Security Number __ __ __ - __ __ - __ __ __ __

ENROLLMENT FORM

DENTAL

HMO Dental

☐	$2.86/week	Employee Only
☐	$5.73/week	Employee + Spouse
☐	$5.16/week	Employee + Children
☐	$8.61/week	Employee + Family

PPO Dental

☐	$11.42/week	Employee Only
☐	$22.84/week	Employee + Spouse
☐	$27.26/week	Employee + Children
☐	$42.42/week	Employee + Family

☐ **DECLINE all Dental plan options**

*Dental plans are administered through Premier Access

VISION

☐	$2.28/week	Employee Only
☐	$3.91/week	Employee + Children
☐	$3.97/week	Employee + Spouse
☐	$5.64/week	Employee + Family

☐ **DECLINE all Vision options**

*Vision plan is administered through Premier Access

I declare the information provided above is complete and accurate. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from SBMA. ***Please review pricing and benefit summaries prior to finalizing your selections.***

Signature _____ **Date** __ __ / __ __ / __ __ __ __

Medical Benefit Summary

MEDICAL BENEFITS SUMMARY/COMPARISON	MEC		MEC Plus	
No Out of Network Benefits are covered and are subject to full out-of-pocket expense	In Network	Out of Network	In Network	Out of Network
Annual Maximum/Lifetime Maximum Benefit	Unlimited	Not Covered	Unlimited	Not Covered
Deductible (per covered person)	$0	Not Covered	$0	Not Covered
Out-of-Pocket Maximum (per covered person)	N/A	Not Covered	$1,850	Not Covered

Medical Benefits	MEC		MEC Plus	
Preventative Care/Screenings/Immunizations (see MEC benefits)	Covered 100%	Not Covered	Covered 100%	Not Covered
Urgent Care Visits	Not Covered	Not Covered	$50 copay	Not Covered
Primary Care Visits (Excluding Well Baby/Preventative/X-Rays)	Not Covered	Not Covered	$15 copay	Not Covered
Specialists Visits	Not Covered	Not Covered	$25 copay	Not Covered
Non-Preventative Well Baby Visits and Care	Not Covered	Not Covered	$20 copay	Not Covered
Laboratory Outpatient and Professional Services	Not Covered	Not Covered	$50 copay	Not Covered
X-Rays	Not Covered	Not Covered	$50 copay	Not Covered

***Note only services listed above are covered at covered under their respective plans.**
Services not covered under either plan include: Emergency Room Services, Inpatient Hospital Visits (Including MHSA), Outpatient Mental/Behavioral Health and Substance Abuse Services, Diagnostic Imaging, Rehabilitative Speech Therapy, Rehabilitative and Rehabilitative Physical Therapy, Skilled Nursing Facility, Durable Medical Equipment, and Outpatient Facility (e.g. Ambulatory Surgery Center.

Prescription Drug Benefits	MEC		MEC Plus	
	In Network	Out of Network	In Network	Out of Network
Generic Drugs	Not Covered	Not Covered	$5 copay	Not Covered

***Note only Generic Drugs are covered under MEC Plus**
Prescription Drugs not covered under either plan include: Preferred Brand Drugs, Non-Preferred Brand Drugs and Specialty High-Cost Drugs.

MultiPlan.
Imagine more…

Find a Provider in Four Easy Steps

To locate providers participating in the PHCS and/or Multiplan networks call (800) 922-4362 or visit www.multiplan.com and click "Search for a Doctor of Facility." Then follow the steps below to identify your providers of choice.

Step 1: Identify Your Network Logo – Choose "Other network logos" and select "PHCS Specific Services Call to Confirm" which is the matching logo on the front of your medical ID card (see below). Then select "continue."

Step 2: Provider Type – Choose between Doctor of Facility and select "continue."
Step 3: Refine Provider Criteria – Choose your location by using one of the following combinations: zip code plus distance, city plus state or county plus state. Then choose the Type of Doctor or Type of Facility depending on the provider type you chose in step 2. Then select "continue."
Step 4: Results – Providers matching your search criteria will be displayed on the page(s) to follow.

Anthem Elements Choice EQ HSA 6350 - At A Glance

California & Out of State

Covered Medical Benefits	In-Network	Non-Network
Overall Deductible	$6,350 single $12,700 family	$19,050 single $38,100 family
Out-of-Pocket Limit	$6,550 single $13,100 family	$19,650 single $39,300 family
Preventative Care/Screenings/Immunizations	No Charge	50% coinsurance
Primary Care Visits, Specialist Care Visits, Prenatal and Post-natal care	0% coinsurance	50% coinsurance
Retail health clinic, On-Line Visit, Chiropractor Services, Acupuncture	0% coinsurance	50% coinsurance
Allergy testing, Chemo/radiation therapy, Hemodialysis	0% coinsurance	50% coinsurance
Prescription drugs (drugs dispensed in office thru infusion/injection)	0% coinsurance	50% coinsurance
Lab: Office, Freestanding Lab, Outpatient Hospital	0% coinsurance	50% coinsurance
X-ray: Office, Freestanding Radiology Center, Outpatient Hospital	0% coinsurance	50% coinsurance
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans): Office, Freestanding Radiology Center, Outpatient Hospital (costs may vary by site of service)	0% coinsurance	50% coinsurance
Emergency Services	**In-Network**	**Non-Network**
Emergency room facility services	0% coinsurance	Covered as In-Network
Emergency room doctor and other services	0% coinsurance	Covered as In-Network
Ambulance (air and ground)	0% coinsurance	Covered as In-Network
Urgent Care (office setting)	0% coinsurance	50% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse	**In-Network**	**Non-Network**
Doctor office visit	0% coinsurance; after deductible is met	50% after deductible is met
Facility visit	0% coinsurance; after deductible is met	50% after deductible is met
Outpatient Surgery/Hospitalization	**In-Network**	**Non-Network**
Hospital/Freestanding Surgical Center	0% coinsurance	50% coinsurance
Hospital Stay facility fees	0% coinsurance	50% coinsurance
Doctors and other services	0% coinsurance	50% coinsurance
Recovery & Rehabilitation/Cardiac Rehabilitation	**In-Network**	**Non-Network**
Home health care/Office visit	0% coinsurance	50% coinsurance
Outpatient hospital/habilitation services	0% coinsurance	50% coinsurance
Skilled nursing care (in a facility)	0% coinsurance	50% coinsurance
Hospice	0% coinsurance	50% coinsurance
Durable Medical equipment	0% coinsurance	50% coinsurance
Prosthetic devices	0% coinsurance	50% coinsurance
Covered Prescription Drug Benefits	**In-Network**	**Non-Network**
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Preventative Pharmacy	No charge (retail only)	50% coinsurance up to $250 per prespcrition (retail only)
Prescription Drug Coverage	**In-Network**	**Non-Network**
Tier1a - Typically Lower Cost Generic (per prescription) covers up to 30 day supply (retail) and up 90 day supply (home delivery)	$5 copay (retail only) / $12.50 copay (home delivery only)	50% coinsurance up to $250 (retail only)
Tier1b - Typically Generic (per prescription) covers up to 30 day supply (retail) and up 90 day supply (home delivery)	$15 copay (retail only) / $37.50 copay (home delivery only)	50% coinsurance up to $250 (retail only)
Tier2 - Typically Preferred/Brand (per prescription) covers up to 30 day supply (retail) and up 90 day supply (home delivery)	$50 copay (retail only) / $150 copay (home delivery only)	50% coinsurance up to $250 (retail only)
Tier3 - Typically Non-Preferred/Specialty Drugs (per prescription) covers up to 30 day supply (retail) and up 90 day supply (home delivery) *certain drugs require preauthorization approval	$65 copay (retail only) / $195 copay (home delivery only)	50% coinsurance up to $250 (retail only)
Tier4 - Specialty Drugs (per prescription) covers up to 30 day supply (retail and home delivery) *classified specialty drugs must be obtained through Specialty Pharmacy Program	30% coinsurance up to $250 (retail and home delivery)	50% coinsurance up to $250 (retail only)

PREMIER ACCESS
Dental and Vision

DHMO400 BENEFITS

DESCRIPTION	ADA code	DHMO 400 COPAY
Preventive Services		
Periodic Oral Exam	D0120	$0
Comprehensive Exam	D0150	$0
Full Mouth Series (FMX)	D0210	$0
Panoramic	D0330	$0
Periapical X-rays	D0220	$0
Bitewings- four films	D0274	$0
Adult Cleanings	D1110	$0
Child Cleanings	D1120	$0
Adult/Child Fluoride Treatment	D1203/1204	$0
Sealants 1st and 2nd Molars	D1351	$15.00
Space Maintainers	D1525	$80.00
Basic Services		
Restorations - Amalgam Fillings	D2161	$22.00
Extractions - Erupted tooth	D7140	$14.00
Surgical Removal - Erupted tooth	D7210	$55.00
Root Canal Therapy - Anterior	D3310	$125.00
Root Canal Therapy - Bi-cuspid	D3320	$215.00
Root Canal Therapy - Molar	D3330	$365.00
Scaling & Root Planing, per quadrant	D4341	$55.00
Major Services		
Crowns	D2750	$200.00
Bridges - per unit	D6210	$200.00
Complete Denture - per arch	D5110	$360.00
Partial Denture - per arch	D5211	$325.00
Orthodontia (Child)	D8080	$1975.00 †
(Adult)	D8090	$2175.00 †

† *based on 24 month treatment plan: additional ortho co-pays may apply, see Certificate of Insurance for full break down*

Premier Access Dental and Vision provides you and your family with quality dental benefits at an affordable cost. The program is designed to encourage regular dentist visits to maintain oral health. When enrolling, you select a contracted dentist to provide services for you and your family. The size of a provider network is meaningless without the assurance of quality care. Our dental providers consist of dental facilities that have been carefully screened for quality.

Plan Benefit Highlights

- Posterior Composites
- Oral Cancer Screening
- Additional Cleanings
- Cosmetic Procedures such as Labial Veneers & External Bleaching
- Defined Fees for Metal Upgrades
- Unlimited Benefits*
- General Anesthesia and IV Sedation Covered

Why Choose Premier Access?

- ☑ A-Rated by AM Best
- ☑ Over 4000 Provider Access Points
- ☑ Over 20 years in the Managed Care Business

The Patient Charge Schedule is a summary of the covered services. Please check the Evidence of Coverage for full details. These services are covered only when covered dental services are performed by your Network Dentist, unless otherwise authorized by Premier Access Dental and Vision as described in your plan documents. The benefits shown are performed as deemed appropriate by the attending Primary Care Dentist (PCD) subject to the limitations and exclusions of the program. Enrollees should discuss all treatment options with their PCD prior to services being rendered.

Our Member Services Department is available Monday thru Friday 8 a.m. to 6 p.m. to answer questions and provide any help you may need at 866.650.3660

* refer to your Evidence of Coverage for details

PREMIER ACCESS

Your Dental Plan

Employnet, Inc – PPO Plan 1-123

Available to All Employees

	PCN**	PPO**	Non Network
Class I/Preventive- Cleanings, Exams, Fluoride, Radiographs - Periapical, Radiographs - Bitewings, Radiographs - FMX	100%	100%	100%*
Class II/Basic- Sealants, Space Maintainers, Emergency Pain, Restorations (Amalgams & Anterior Resin), Simple Extractions, Surgical Extractions, Oral Surgery, Endodontics, Periodontal Maintenance, Non- Surgical Periodontics, Surgical Periodontics, Stainless Steel Crowns_(<19), Anesthesia, Specialist Consultations	90%	80%	80%*
Class III/ Major- Inlays, Onlays, Crowns, Crown Repairs, Bridges, Dentures, Bridge and Denture Repairs	60%	50%	50%*
Calendar Year Deductible (3 per family) Waived for Preventive	$25 Yes	$50 Yes	$50 Yes
Calendar Year Maximum	$1,000	$1,000	$1,000
Class IV/ Orthodontia	N/A		
Ortho Lifetime Maximum	N/A		
Waiting Period	There are no waiting periods for Major Services for Timely Applicants.		

* Covered charges are based on the lower of : 1) the dentist's actual charge for the service, 2) the dentist's usual charge for the service, 3) or the UCR amount for the service based on the 90th percentile of dentists in the same geographic area.
**Premier Access does not guarantee all services can be rendered by a contracted PCN or PPO provider. You may be subject to a deductible and co insurance for an out of network Specialist.

Information

How It Works

The Dental Program offered is administered by Premier Access Insurance Company, a national carrier and widely accepted dental plan.

What is important to know about your dental plan is that you may see any dentist. Although, there are PCN (Premier Choice Network) and PPO provider lists available, and the benefits are enhanced if you elect to use either network, you may elect to see the dentist of your choice without penalty. Using the PCN or PPO providers, you maximize your benefits and reduce your out-of-pocket costs.

The PPO dentists offer discounted care (about 30%) and the plan normally pays a higher level of benefit when using an in-network provider. Additionally, the PCN/PPO dentist cannot "balance bill" you for amounts greater than the contracted rate.

Out-of-State Network and Claims

The Premier Access Dental network is available to eligible members outside the State of California, with over 110,000 dentists to choose from. A complete provider listing is available on the internet at: www.premierlife.com. It is important that you confirm with your dentist at the time of treatment that they are participating in the Premier Access network. For a dentist near you call 888.715.0760.

Please check your Certificate of Insurance for a description of coverage, limitations and exclusions under the plan. Some services require prior authorization.

How to Reach Us

Premier Access Claim Dept. P.O. Box 659010 Sacramento, Ca. 95865-9010	Member Services Line **888.715.0760**	On the Web www.premierlife.com

PREMIER ACCESS
Dental and Vision

Administered by MESVision®
Brilliant Vision Care
Since 1976

Premier Access Vision Plan $125/$125 12|12|24

VOLUNTARY

SUMMARY OF VISION BENEFITS

Co-pay: $10/$25
Comprehensive Vision Exam: One every 12 months
Lenses:* One pair every 12 months
Frame: One frame every 24 months
Contact Lenses:* One pair every 12 months

This is a brief outline of the plan and is not to be accepted or construed as a substitute for the provisions of the contract.

The Policy provides full coverage for Covered Services when you go to a Participating Provider of the MESVision network. If Covered Services are provided by a Non-Participating Provider, charges will be paid, but not to exceed the following Schedule of Allowances.

	Participating Provider	Non-Participating Provider
Comprehensive Examination	Covered	Up to $40.00
Single Vision Lenses	Covered	Up to $30.00
Bifocal Lenses	Covered	Up to $50.00
Trifocal Lenses	Covered	Up to $65.00
Polycarbonate Lenses***	Up to $85.00	Up to $55.00
Progressive Lenses	Up to $89.50	Up to $65.00
Aphakic Monofocal	Covered	Up to $125.00
Aphakic Multifocal	Covered	Up to $125.00
Frame Retail Allowance*	Up to $125.00	Up to $40.00
Frame Wholesale Equivalent*	Up to $56.60	
Contact Lenses **		
Medically Necessary	Covered	Up to $250.00
Cosmetic or Convenience	Up to $125.00	Up to $125.00

* Participating Providers allow a selection of frames that retail up to $125.00 with lenses that fit an eyesize less than 61 millimeters. If a more expensive frame is selected, you are responsible for the additional cost above $125.00. If the lenses received are 61 millimeters or above, the charge for the oversize lenses is your responsibility. Retail frame benefits will be converted to wholesale equivalent prices at certain provider locations, see our website or provider directory for further information.

** This benefit is in addition to the comprehensive vision examination, but in lieu of lenses and frame. If contact lenses are for cosmetic or convenience purposes, the Policy will pay up to $125.00 toward the contact lens evaluation, fitting costs and materials. Any balance is your responsibility. If contact lenses are medically necessary, they are a fully covered benefit. Approval from MESVision is required. Please refer to your Policy if you require additional information.

***For Dependent Children through age 18

DISCOUNTS:

A 20% discount is available for cosmetic extras, such as tints, coatings and other add-on charges to standard lenses, after Covered Services are rendered. The discount may be applied to charges for the frame or contact lenses (except disposable or replacement contact lenses) over the stated allowances. The 20% discount also applies to additional pairs of glasses and/or pairs of standard contact lenses. To determine whether a provider offers the 20% discount, an insured individual can review their Participating Provider Directory, call MESVision or visit www.MESVision.com. Discounts are available through TLCVision for conventional and custom LASIK procedures with the TLCVision Advantage Program.

Preventative Services

ADULTS

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use to prevent cardiovascular disease for men and women of certain ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults over 50
7. Depression screening for adults
8. Diabetes (Type 2) screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for everyone ages 15 to 65, and other ages at increased risk
11. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
a. Hepatitis A
b. Hepatitis B
c. Herpes Zoster
d. Human Papillomavirus
e. Influenza (Flu Shot)
f. Measles, Mumps, Rubella
g. Meningococcal
h. Pneumococcal
i. Tetanus, Diphtheria, Pertussis
j. Varicella
12. Obesity screening and counseling for all adults
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
14. Syphilis screening for all adults at higher risk
15. Tobacco Use screening for all adults and cessation interventions for tobacco users

For more information on these services visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

WOMEN

1. Anemia screening on a routine basis for pregnant women
2. Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer
3. Breast Cancer Mammography screenings every 1 to 2 years for women over 40
4. Breast Cancer Chemoprevention counseling for women at higher risk
5. Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
6. Cervical Cancer screening for sexually active women
7. Chlamydia Infection screening for younger women and other women at higher risk
8. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). (May not apply if Company is exempt)
9. Domestic and interpersonal violence screening and counseling for all women
10. Folic Acid supplements for women who may become pregnant
11. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
12. Gonorrhea screening for all women at higher risk
13. Hepatitis B screening for pregnant women at their first prenatal visit
14. HIV screening and counseling for sexually active women
15. Human Papillomavirus (HPV) DNA Test every 3 years for women with normal cytology results who are 30 or older
16. Osteoporosis screening for women over age 60 depending on risk factors
17. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
18. Sexually Transmitted Infections counseling for sexually active women
19. Syphilis screening for all pregnant women or other women at increased risk
20. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
21. Urinary tract or other infection screening for pregnant women
22. Well-woman visits to get recommended services for women *under 65*

CHILDREN

1. Autism screening for children at 18 and 24 weeks
2. Behavioral assessments for children at the following ages: 0 to 11 weeks, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
3. Blood Pressure screening for children at the following ages: 0 to 11 weeks, 1 to 4 years , 5 to 10 years, 11 to 14 years, 15 to 17 years.
4. Cervical Dysplasia screening for sexually active females
5. Depression screening for adolescents
6. Developmental screening for children under age 3
7. Dyslipidemia screening for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
8. Fluoride Chemoprevention supplements for children without fluoride in their water source
9. Gonorrhea preventive medication for the eyes of all newborns
10. Hearing screening for all newborns
11. Height, Weight and Body Mass Index measurements for children at the following ages: 0 to 11 weeks, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
12. Hematocrit or Hemoglobin screening for children
13. Hemoglobinopathies or sickle cell screening for newborns
14. HIV screening for adolescents at higher risk
15. Hypothyroidism screening for newborns
16. Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
a. Diphtheria, Tetanus, Pertussis
b. Haemophilus influenzae type b
c. Hepatitis A
d. Hepatitis B
e. Human Papillomavirus
f. Inactivated Poliovirus
g. Influenza (Flu Shot)
h. Measles, Mumps, Rubella
i. Meningococcal
j. Pneumococcal
k. Rotavirus
l. Varicella
17. Iron supplements for children ages 6 to 12 weeks at risk for anemia
18. Lead screening for children at risk of exposure
19. Medical History for all children throughout development at the following ages: 0 to 11 weeks, 1 to 4 years , 5 to 10 years , 11 to 14 years , 15 to 17 years.
20.Obesity screening and counseling