Board of County Commissioners

Eva J. Henry - District #1
Charles "Chaz" Tedesco - District #2
Emma Pinter - District #3
Steve O'Dorisio - District #4
Mary Hodge - District #5

PUBLIC HEARING AGENDA

NOTICE TO READERS: The Board of County Commissioners' meeting packets are prepared several days prior to the meeting. This information is reviewed and studied by the Board members to gain a basic understanding, thus eliminating lengthy discussions. Timely action and short discussion on agenda items does not reflect a lack of thought or analysis on the Board's part. An informational packet is available for public inspection in the Board's Office one day prior to the meeting.

THIS AGENDA IS SUBJECT TO CHANGE

Tuesday
August 6, 2019
9:30 AM

1. **ROLL CALL**

2. **PLEDGE OF ALLEGIANCE**

3. **MOTION TO APPROVE AGENDA**

4. **AWARDS AND PRESENTATIONS**

   A. Proclamation of August 2019 as Child Support Awareness Month

5. **PUBLIC COMMENT**

   A. Citizen Communication

   A total of 30 minutes is allocated at this time for public comment and each speaker will be limited to 3 minutes. If there are additional requests from the public to address the Board, time will be allocated at the end of the meeting to complete public comment. The chair requests that there be no public comment on issues for which a prior public hearing has been held before this Board.

   B. Elected Officials' Communication

6. **CONSENT CALENDAR**

   A. List of Expenditures Under the Dates of July 15-19, 2019

   B. List of Expenditures Under the Dates of July 22-23, 2019

   C. Minutes of the Commissioners' Proceedings from July 23, 2019

   D. Adams County Public Trustee Operational Expense for the Quarter Ending June 2019

E. Resolution Setting the Service Plan Hearing Date for Pecos Logistics Park Metropolitan District (PLN2019-00005)
(File approved by ELT)

F. Resolution Approving the Agreement between the County of Adams, Colorado and Adams 12 Five Star Schools to Provide Medicaid Application Processing at Adams 12 Five Star Schools Facility
(File approved by ELT)

G. Resolution Regarding the Defense and Indemnification of Andrew Titus, Max Hefner, Adam Mohr, and Ross Yniguez as Defendants in a Civil Lawsuit Pursuant to C.R.S. § 24-10-101, Et Seq.
(File approved by ELT)

H. Resolution Approving a Perpetual Access Easement from Adams County to the City of Thornton for Sewer Line Access Purposes
(File approved by ELT)

I. Resolution Approving Adams County's Scientific and Cultural Facilities District Funding Distribution Plan for 2019/2020
(File approved by ELT)

J. Resolution Approving a Letter of Support for the Conservation Fund's Grant Application to Great Outdoors Colorado for a Conservation Easement in Historic Splendid Valley
(File approved by ELT)

K. Resolution Appointing the Board of County Commissioners to Act as the Local Weed Advisory Board for Adams County, Colorado
(File approved by ELT)

L. Resolution Appointing Mary Doran to the Family Preservation Commission as a Tri-County Health Department Representative
(File approved by ELT)

M. Resolution Appointing Deborah Hunt to the Family Preservation Commission as a Community Member Representative
(File approved by ELT)

N. Resolution Appointing Brian Kenna to the Family Preservation Commission as an Adams County Human Services Representative
(File approved by ELT)

O. Resolution Appointing Gretchen Lapham to the Library District Board of Trustees
(File approved by ELT)

P. Resolution Appointing Candice Leimkuhler to the Family Preservation Commission as a Community Reach Center Representative
(File approved by ELT)

Q. Resolution Appointing Lindsay Lierman to the Family Preservation Commission as a Court Appointed Special Advocate Representative
(File approved by ELT)

R. Resolution Appointing Ellen Sandoval to the Family Preservation Commission as an Adams County Human Services Representative
(File approved by ELT)

S. Resolution Approving Amendment One between Adams County and North Metro Community Services Inc., for Services for Persons with Developmental Disabilities
(File approved by ELT)

T. Resolution Approving the Contract to Buy and Sell Real Estate between Adams County and the Adams County Communications Center Authority Regarding 7373 Birch Street
(File approved by ELT)

7. NEW BUSINESS

A. COUNTY MANAGER

1. Resolution Approving a Cooperative Agreement between Adams County and Toshiba America Business Solutions, Inc., for County Wide Managed Print Services
(File approved by ELT)

2. Resolution Approving an Agreement between Adams County and Colorado Carpet Center, Inc., for Carpet Replacement at the Government Center and Justice Center Buildings
(File approved by ELT)

3. Resolution Adopting Amendments to Adams County's Group Agreements with Kaiser Permanente
(File approved by ELT)

4. Resolution Adopting Amendments to Adams County's Contracts with United Healthcare Services
(File approved by ELT)

5. Resolution Approving Delta Dental Benefits Contracts
(File approved by ELT)

6. Resolution Approving the 2019 Amendment No. 2 to the Unum Group Disability Insurance Policy
(File approved by ELT)

B. COUNTY ATTORNEY

8. LAND USE HEARINGS

A. Cases to be Heard

1. RCU2018-00032 Jamaso Pipeline
(File approved by ELT)

9. ADJOURNMENT

AND SUCH OTHER MATTERS OF PUBLIC BUSINESS WHICH MAY ARISE

Proclamation

"Child Support Awareness Month"

August 2019

Whereas, Adams County recognizes that every child matters and joins the nation in recognizing August as Child Support Awareness Month; and,

Whereas, child support is a vital source of income for households in Adams County, many of them low-income families; and,

Whereas, strengthening families improves the lives of children by promoting their safety and well-being and provides economic security; and

Whereas, Adams County applauds the parents who support their children and make child support payments consistently to care for them; and,

Whereas, child support professionals are important assets to the county, working in collaboration with parents and other community partners to ensure that children and families receive quality services; and,

Whereas, it is important to increase public awareness of the child support program through outreach and education to reinforce the position that all parents must take responsibility for the financial, emotional, and physical support of their children.

Now, Therefore, Be It Resolved That, the Board of Commissioners of the County of Adams, State of Colorado, proclaims the month of August 2019 as

"Child Support Awareness Month"

and encourages all citizens of Adams County to work together to make our children's future stable and bright.

In witness whereof, we have set our hands and caused the seal of the county to be affixed August 6, 2019.

County of Adams

Net Warrant by Fund Summary

Fund Number	Fund Description	Amount
1	General Fund	1,105,064.26
4	Capital Facilities Fund	124,348.48
5	Golf Course Enterprise Fund	101,072.03
6	Equipment Service Fund	215,590.96
7	Stormwater Utility Fund	51.21
13	Road & Bridge Fund	1,113,960.19
19	Insurance Fund	371,392.08
24	Conservation Trust Fund	2,266.25
27	Open Space Projects Fund	3,263.49
28	Open Space Sales Tax Fund	250,804.00
30	Community Dev Block Grant Fund	26,409.82
31	Head Start Fund	1,102.82
34	Comm Services Blk Grant Fund	15,015.92
35	Workforce & Business Center	210.00
43	Colorado Air & Space Port	24,594.76
50	FLATROCK Facility Fund	340.00
		3,355,486.27

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00005390	320719	DLR GROUP	07/15/19	2,685.00
00005391	884035	SEKI SHINSUKE	07/15/19	4,000.00
00005400	628019	BIG PAULIE PRODUCTIONS LLC	07/17/19	7,000.00
00005401	628019	BIG PAULIE PRODUCTIONS LLC	07/17/19	500.00
00005402	628019	BIG PAULIE PRODUCTIONS LLC	07/17/19	10,000.00
00005403	628019	BIG PAULIE PRODUCTIONS LLC	07/17/19	20,000.00
00005404	628019	BIG PAULIE PRODUCTIONS LLC	07/17/19	15,000.00
00005411	37193	CINA & CINA FORENSIC CONSULTIN	07/18/19	20,000.00
00005413	628019	BIG PAULIE PRODUCTIONS LLC	07/19/19	16,750.00
00005414	536294	G SQUARED DESIGN LLC	07/19/19	24,315.78
00739292	255194	CHAMBERS HOLDINGS LLC	07/15/19	15,986.70
00739295	871361	EVANS CONSULTING	07/15/19	1,820.00
00739296	173928	GUIDANCE CORPORATE REALTY ADVI	07/15/19	7,602.37
00739323	410759	ABC LEGAL SERVICES	07/16/19	19.00
00739325	42779	ADAMS COUNTY COMMUNICATION CEN	07/16/19	393,066.10
00739326	4936	ADAMS COUNTY ECONOMIC DEVELOP	07/16/19	131,516.00
00739327	91631	ADAMSON POLICE PRODUCTS	07/16/19	635.00
00739328	884800	ADKINS SANDRA J	07/16/19	139.00
00739330	383698	ALLIED UNIVERSAL SECURITY SERV	07/16/19	21,120.40
00739333	322973	ARMORED KNIGHTS INC	07/16/19	2,036.52
00739334	219183	BALL FRANK J	07/16/19	19.00
00739335	661015	CHP METRO NORTH LLC	07/16/19	1,050.00
00739336	248364	CITY OF BRIGHTON	07/16/19	8,333.99
00739337	625677	CODE 4 SECURITY SERVICES LLC	07/16/19	2,832.00
00739338	884815	COLORADO LEGAL SERVICES	07/16/19	19.00
00739339	274030	COMMUNICATION CONSTRUCTION & E	07/16/19	4,794.50
00739340	13049	COMMUNITY REACH CENTER	07/16/19	31,428.26
00739341	884808	DAWSON ROBERT	07/16/19	19.00
00739342	519505	DENOVO VENTURES LLC	07/16/19	2,940.00
00739343	884813	DIVINE HOMES DENVER LLC	07/16/19	66.00
00739344	689893	EARLY CHILDHOOD PARTNERSHIP OF	07/16/19	1,000.00
00739345	851814	EL RODEO NIGHT CLUB LLC	07/16/19	17,500.00
00739348	374467	EZ MESSENGER	07/16/19	19.00
00739349	773412	FEDERAL RESOURCES SUPPLY COMPA	07/16/19	35,158.32
00739351	57888	FRANCY LAW FIRM, PLLC	07/16/19	19.00
00739352	57888	FRANCY LAW FIRM, PLLC	07/16/19	19.00

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739353	57888	FRANCY LAW FIRM, PLLC	07/16/19	19.00
00739354	12689	GALLS LLC	07/16/19	3,744.26
00739357	358482	HOLST AND BOETTCHER	07/16/19	19.00
00739359	26418	JOHN DEERE COMPANY	07/16/19	25,955.14
00739361	485045	KORBY LANDSCAPE LLC	07/16/19	8,030.80
00739362	884796	MCKEE DORA ANN	07/16/19	19.00
00739364	247198	MGT OF AMERICA INC	07/16/19	8,025.00
00739365	305419	MIDLAND FUNDING LLC	07/16/19	19.00
00739366	884795	MONCADA LAURA	07/16/19	66.00
00739367	374475	MOORE LAW GROUP APC	07/16/19	19.00
00739368	32509	NCS PEARSON INC	07/16/19	642.00
00739369	570347	NELSON AND KENNARD	07/16/19	19.00
00739370	33716	OLD VINE PINNACLE ASSOCIATES	07/16/19	800.00
00739371	470643	ONENECK IT SOLUTIONS LLC	07/16/19	6,609.92
00739372	496938	OUTDOOR PROMOTIONS OF COLORADO	07/16/19	3,815.00
00739374	669054	PROVEST LITIGATION SERVICES	07/16/19	19.00
00739375	884809	QUINTERO-RUIZ MARTIN ALEJANDRO	07/16/19	19.00
00739376	431519	REGROUP	07/16/19	6,427.00
00739377	643019	REPUBLIC NATIONAL DISTRIBUTING	07/16/19	182.69
00739378	884804	SALAPICH NELSON PAMELA	07/16/19	19.00
00739379	255505	SHERMAN & HOWARD LLC	07/16/19	3,931.25
00739380	227044	SOUTHWESTERN PAINTING	07/16/19	32,452.00
00739381	884788	SPECIALIZED ATTORNEY SERVICES	07/16/19	19.00
00739382	42818	STATE OF COLORADO	07/16/19	8,359.16
00739383	243343	STENGER AND STENGER	07/16/19	38.00
00739384	414653	STOKES AND WOLF	07/16/19	19.00
00739387	599714	SUMMIT FOOD SERVICE LLC	07/16/19	64,873.99
00739388	66264	SYSTEMS GROUP	07/16/19	200.00
00739390	13951	TDS TELECOM	07/16/19	893.49
00739392	884784	THE JOHNSON LAW OFFICE	07/16/19	19.00
00739393	509155	TOWERS PAINTING	07/16/19	725.00
00739394	666214	TYGRETT DEBRA R	07/16/19	272.00
00739395	13262	TYLER TECHNOLOGIES INC	07/16/19	760.27
00739396	13262	TYLER TECHNOLOGIES INC	07/16/19	4,093.88
00739397	884783	URIBE LESLIE	07/16/19	19.00
00739398	158184	UTILITY NOTIFICATION CENTER OF	07/16/19	441.62

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739399	94433	VARGO MYERS JANSON PC	07/16/19	19.00
00739400	805847	WADSWORTH WARNER CONRARDY	07/16/19	19.00
00739401	51910	WAGNER RENTS	07/16/19	1,413.56
00739402	884790	WENZEL DANIELLA NICHOLE	07/16/19	19.00
00739403	40340	WINDSTREAM COMMUNICATIONS	07/16/19	1,882.65
00739406	433987	ADCO DISTRICT ATTORNEY'S OFFIC	07/18/19	920.68
00739407	348770	ADMIT ONE PRODUCTS	07/18/19	1,271.24
00739408	327129	AIRGAS USA LLC	07/18/19	164.42
00739409	383698	ALLIED UNIVERSAL SECURITY SERV	07/18/19	12,076.62
00739410	12012	ALSCO AMERICAN INDUSTRIAL	07/18/19	176.33
00739411	884603	ARMENDIAZ AVITA	07/18/19	10.00
00739412	105179	BALDWIN MARY	07/18/19	150.00
00739413	744825	BALLMAN DEB	07/18/19	100.00
00739414	885535	BUNN BILL	07/18/19	75.00
00739415	884593	CARPENTER MATTHEW MICHAEL	07/18/19	123.00
00739416	28303	CENTURA HEALTH	07/18/19	600.00
00739417	37266	CENTURY LINK	07/18/19	88.99
00739420	885551	CERVANTES LIZETH	07/18/19	75.00
00739421	885536	CHATMAN THERESA	07/18/19	75.00
00739423	112904	CHRISTIAN VICKI	07/18/19	150.00
00739424	2381	COLO ANALYTICAL LABORATORY	07/18/19	72.00
00739426	33480	COLO BUREAU OF INVESTIGATION	07/18/19	330.00
00739428	636100	COLOR CORRAL	07/18/19	3,811.96
00739429	612089	COMMERCIAL CLEANING SYSTEMS	07/18/19	500.00
00739430	218467	CRAMER STEPHEN S	07/18/19	150.00
00739431	885561	CYR RENEE MICHELE	07/18/19	770.00
00739432	624283	ELLIOTT MARIA ANGELICA	07/18/19	150.00
00739433	2963	FEY TOM E	07/18/19	150.00
00739434	541231	FINELINE GRAPHICS	07/18/19	269.04
00739435	885562	FINNING DENISE M	07/18/19	770.00
00739436	463649	GABLEHOUSE GRANBERG LLC	07/18/19	1,904.00
00739437	105186	GARNETT BARARA	07/18/19	150.00
00739438	294059	GROUNDS SERVICE COMPANY	07/18/19	519.00
00739439	885546	GUERRERO CHARRITO	07/18/19	75.00
00739440	89290	HARROLD PAMELA	07/18/19	150.00
00739441	4387	HETTINGER KATHLEEN S	07/18/19	150.00

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739442	24624	HICO	07/18/19	11.50
00739443	79260	IDEXX DISTRIBUTION INC	07/18/19	535.60
00739444	885509	JOHNSON KAREN	07/18/19	150.00
00739445	885507	JONES TYLER JANE	07/18/19	150.00
00739446	884604	KRUS DANIEL HARRISON	07/18/19	100.00
00739448	262991	MACKEY BRIANNA L	07/18/19	150.00
00739449	729564	METRO TRANSPORTATION PLANNING	07/18/19	2,283.35
00739450	247198	MGT OF AMERICA INC	07/18/19	2,675.00
00739451	597186	MICHELSON FOUND ANIMALS FOUNDA	07/18/19	1,787.00
00739452	13591	MWI VETERINARY SUPPLY CO	07/18/19	2,117.49
00739453	13422	NORTHGLENN AMBULANCE	07/18/19	1,062.60
00739455	45515	OFFICE SCAPES	07/18/19	5,112.21
00739456	885544	PADILLA ELIDIA	07/18/19	75.00
00739457	669732	PATTERSON VETERINARY SUPPLY IN	07/18/19	18.73
00739458	45133	PPS INTERIORS	07/18/19	710.00
00739459	837076	PSYCHOLOGICAL DIMENSIONS	07/18/19	450.00
00739460	885552	QUIROZ CINDY	07/18/19	500.00
00739461	430098	REPUBLIC SERVICES #535	07/18/19	7,515.21
00739464	599714	SUMMIT FOOD SERVICE LLC	07/18/19	282.37
00739465	37005	TOSHIBA BUSINESS SOLUTIONS	07/18/19	86.10
00739466	885740	TRUMBLE COLE	07/18/19	100.00
00739467	338508	WRIGHTWAY INDUSTRIES INC	07/18/19	769.77
00739468	885537	YSLAS CHERYL	07/18/19	75.00
00739469	16236	ADAMS 12 FIVE STAR SCHOOLS	07/19/19	400.00
00739472	100611	ATCO INTERNATIONAL	07/19/19	230.00
00739473	45084	BASELINE ASSOCIATES INC	07/19/19	420.00
00739475	886837	CAAP	07/19/19	400.00
00739477	250958	COHEN MILSTEIN SELLERS & TOLL	07/19/19	708.75
00739479	99357	COLO MEDICAL WASTE INC	07/19/19	988.00
00739480	2157	COLO OCCUPATIONAL MEDICINE PHY	07/19/19	480.00
00739482	810159	CORHIO	07/19/19	300.00
00739483	40658	CROWN EQUIPMENT CORP	07/19/19	83.00
00739484	105110	CULLIGAN	07/19/19	217.00
00739485	678436	DOMENICO JOSEPH	07/19/19	65.00
00739486	808844	DUPRIEST JOHN FIELDEN	07/19/19	65.00
00739487	35867	ELDORADO ARTESIAN SPRINGS INC	07/19/19	109.87

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739488	47723	FEDEX	07/19/19	315.82
00739489	698569	FOREST SEAN	07/19/19	65.00
00739490	293118	GARNER, ROSIE	07/19/19	65.00
00739491	689772	GENEDX INC	07/19/19	4,500.00
00739493	293122	HERRERA, AARON	07/19/19	65.00
00739495	40843	LANGUAGE LINE SERVICES	07/19/19	44.28
00739496	8801432	MESA COUNTY	07/19/19	600.00
00739497	16428	NICOLETTI-FLATER ASSOCIATES	07/19/19	2,700.00
00739498	124449	NMS LABS	07/19/19	13,924.00
00739500	13778	NORTH WASHINGTON ST WATER & SA	07/19/19	19,801.32
00739501	885741	OCHSNER CAITLYN	07/19/19	2,000.00
00739503	473343	PALEO DNA	07/19/19	350.00
00739504	100332	PERKINELMER GENETICS	07/19/19	50.00
00739505	637390	PLAKORUS DAVID	07/19/19	65.00
00739506	53054	RICHARDSON SHARON	07/19/19	65.00
00739507	153452	RMFMA	07/19/19	500.00
00739509	669061	SCL HEALTH	07/19/19	181.00
00739512	51001	SOUTHLAND MEDICAL LLC	07/19/19	1,294.08
00739513	42818	STATE OF COLORADO	07/19/19	5,856.96
00739517	385142	THOMPSON GREGORY PAUL	07/19/19	65.00
00739518	22538	THOMSON REUTERS - WEST	07/19/19	372.00
00739519	117701	UNIPATH	07/19/19	3,960.00
00739520	300982	UNITED SITE SERVICES	07/19/19	6,716.35
			Fund Total	**1,105,064.26**

4 Capital Facilities Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00005415	536294	G SQUARED DESIGN LLC	07/19/19	97,263.11
00739346	650729	ELEMENTS	07/16/19	27,085.37
			Fund Total	**124,348.48**

5 Golf Course Enterprise Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00005393	6177	PROFESSIONAL RECREATION MGMT I	07/16/19	21,253.08
00005395	6177	PROFESSIONAL RECREATION MGMT I	07/17/19	65,283.48
00739324	1087	ACUITY SPECIALTY PRODUCTS INC	07/16/19	138.11
00739331	544497	ALPINE ARBORISTS PRO TREE CARE	07/16/19	8,830.00
00739332	12012	ALSCO AMERICAN INDUSTRIAL	07/16/19	97.43
00739355	160270	GOLF & SPORT SOLUTIONS	07/16/19	1,949.50
00739356	804964	GRAINGER	07/16/19	76.08
00739358	2202	INTERSTATE BATTERY OF ROCKIES	07/16/19	258.75
00739373	884504	PRO LIFT DOORS OF BRIGHTON	07/16/19	2,700.00
00739404	13822	XCEL ENERGY	07/16/19	485.60
			Fund Total	**101,072.03**

6 Equipment Service Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739347	374964	ELWAY DEALERS	07/16/19	22,136.00
00739360	824075	JOHN ELWAY CHRYSLER JEEP DODGE	07/16/19	26,697.00
00739391	790907	THE GOODYEAR TIRE AND RUBBER C	07/16/19	1,629.60
00739405	23962	ACS MANAGEMENT LLC	07/18/19	3,900.00
00739447	788559	LOYAS AUTO DETAILING	07/18/19	100.00
00739462	16237	SAM HILL OIL INC	07/18/19	17,918.36
00739474	356584	BRUCKNER TRUCK SALES INC	07/19/19	143,210.00
			Fund Total	**215,590.96**

7 Stormwater Utility Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739422	406522	CHESTELSON JULIAN B AND	07/18/19	51.21
			Fund Total	**51.21**

13 Road & Bridge Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00005397	89295	ARVADA CITY OF	07/17/19	11,486.85
00005398	89296	AURORA CITY OF	07/17/19	249,456.37
00005399	89297	BENNETT TOWN OF	07/17/19	8,791.69
00005405	89298	BRIGHTON CITY OF	07/17/19	136,122.92
00005406	89299	COMMERCE CITY CITY OF	07/17/19	141,152.07
00005407	89300	FEDERAL HEIGHTS CITY OF	07/17/19	29,689.81
00005408	89301	NORTHGLENN CITY OF	07/17/19	82,734.81
00005409	89302	THORNTON CITY OF	07/17/19	288,419.94
00005410	89304	WESTMINSTER CITY OF	07/17/19	166,105.73
			Fund Total	**1,113,960.19**

19 Insurance Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00005389	423439	DELTA DENTAL OF COLO	07/15/19	14,091.88
00005396	773185	THRIVE AT HOME NUTRITION LLC	07/17/19	363.84
00005416	37223	UNITED HEALTH CARE INSURANCE C	07/19/19	91,000.82
00739297	342013	KILLMER LANE & NEWMAN LLP COLT	07/15/19	250,000.00
00739300	52339	UNITED STATES TREASURY	07/15/19	3,322.76
00739350	182042	FIT SOLDIERS FITNESS BOOT CAMP	07/16/19	3,090.00
00739427	17565	COLO FRAME & SUSPENSION	07/18/19	9,522.78
			Fund Total	**371,392.08**

24 Conservation Trust Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739385	266133	STREAM DESIGN LLC	07/16/19	1,966.25
00739494	13771	JOE'S TOWING & RECOVERY	07/19/19	300.00
			Fund Total	**2,266.25**

27 Open Space Projects Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739386	266133	STREAM DESIGN LLC	07/16/19	3,263.49
			Fund Total	**3,263.49**

28 Open Space Sales Tax Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739481	16566	COMMERCE CITY CITY OF	07/19/19	250,804.00
			Fund Total	**250,804.00**

30 Community Dev Block Grant Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00005392	866134	PG CONSTRUCTION SERVICES INC	07/16/19	7,849.82
00005394	29064	TIERRA ROJO CONSTRUCTION	07/16/19	3,660.00
00739329	497263	AFFORDABLE REMODELING SOLUTION	07/16/19	14,900.00
			Fund Total	**26,409.82**

31 Head Start Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739418	37266	CENTURY LINK	07/18/19	178.69
00739419	37266	CENTURY LINK	07/18/19	129.13
00739454	55021	NULINX INTERNATIONAL	07/18/19	795.00
			Fund Total	**1,102.82**

34 Comm Services Blk Grant Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739291	5991	ALMOST HOME INC	07/15/19	3,595.92
00739293	190240	ECPAC	07/15/19	2,967.05
00739294	689894	ETHIOPIAN COMMUNITY DEVELOPMEN	07/15/19	1,000.01
00739298	689895	NEW LEGACY CHARTER SCHOOL	07/15/19	5,772.94
00739299	58925	SERVICIOS DE LA RAZA INC	07/15/19	1,680.00
			Fund Total	**15,015.92**

35 Workforce & Business Center

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739476	885499	CERCEDA CARINA	07/19/19	60.00
00739492	885498	HERNANDEZ BADENA EVANGELINA	07/19/19	50.00
00739502	871150	ORTIZ ROJAS EMILY S	07/19/19	40.00
00739508	885495	SANCHEZ KIMBERLY	07/19/19	20.00
00739510	885506	SMITH KAIYA	07/19/19	40.00
			Fund Total	**210.00**

43 Colorado Air & Space Port

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00005412	80249	OFFEN PETROLEUM INC	07/18/19	1,501.79
00739363	871154	MEI TOTAL ELEVATOR SOLUTIONS	07/16/19	463.51
00739463	33604	STATE OF COLORADO	07/18/19	39.04
00739470	346886	AERIAL SURVEYS INTERNATIONAL L	07/19/19	796.50
00739471	80118	AT&T CORP	07/19/19	105.75
00739478	2381	COLO ANALYTICAL LABORATORY	07/19/19	52.00
00739499	582469	NORLOFF RICHARD W	07/19/19	17,695.15
00739511	49310	SOUTH PARK EMBROIDERY	07/19/19	854.15
00739514	33604	STATE OF COLORADO	07/19/19	1,208.00
00739515	33604	STATE OF COLORADO	07/19/19	536.36
00739516	93074	SYSCO DENVER	07/19/19	1,342.51
			Fund Total	**24,594.76**

50 FLATROCK Facility Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739389	66264	SYSTEMS GROUP	07/16/19	300.00
00739425	2381	COLO ANALYTICAL LABORATORY	07/18/19	40.00
			Fund Total	**340.00**

Grand Total	**3,355,486.27**

1011	Board of County Commissioners	Fund	Voucher	Batch No	GL Date	Amount
	Special Events					
	EARLY CHILDHOOD PARTNERSHIP OF	00001	956112	341851	07/10/19	1,000.00
					Account Total	1,000.00
	Travel & Transportation					
	MESA COUNTY	00001	956566	342422	07/17/19	600.00
					Account Total	600.00
					Department Total	1,600.00

1024	Budget Office	Fund	Voucher	Batch No	GL Date	Amount
	Office Furniture					
	OFFICE SCAPES	00001	956283	342202	07/15/19	5,112.21
					Account Total	5,112.21
					Department Total	5,112.21

4306	Cafe	Fund	Voucher	Batch No	GL Date	Amount
	Snack Bar Supplies					
	SYSCO DENVER	00043	956632	342465	07/17/19	1,342.51
					Account Total	1,342.51
					Department Total	1,342.51

4	Capital Facilities Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	ELEMENTS	00004	956343	342246	07/15/19	27,085.37
	G SQUARED DESIGN LLC	00004	956718	342676	07/19/19	97,263.11
					Account Total	124,348.48
					Department Total	124,348.48

43	Colorado Air & Space Port	Fund	Voucher	Batch No	GL Date	Amount
	Colorado Sales Tax Payable					
	STATE OF COLORADO	00043	956646	342541	07/18/19	1,208.16
	STATE OF COLORADO	00043	956647	342541	07/18/19	15.60
	STATE OF COLORADO	00043	956647	342541	07/18/19	520.77
					Account Total	1,744.53
	Received not Vouchered Clrg					
	MEI TOTAL ELEVATOR SOLUTIONS	00043	956387	342246	07/15/19	463.51
					Account Total	463.51
					Department Total	2,208.04

24	Conservation Trust Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	STREAM DESIGN LLC	00024	956406	342246	07/15/19	1,966.25
					Account Total	1,966.25
					Department Total	1,966.25

2031	County Coroner	Fund	Voucher	Batch No	GL Date	Amount
	Maintenance Contracts					
	CROWN LIFT TRUCKS	00001	956694	342589	07/18/19	83.00
					Account Total	83.00
	Medical Services					
	CINA & CINA FORENSIC CONSULTIN	00001	956599	342457	07/17/19	20,000.00
					Account Total	20,000.00
	Operating Supplies					
	ELDORADO ARTESIAN SPRINGS INC	00001	956670	342589	07/18/19	38.95
	ELDORADO ARTESIAN SPRINGS INC	00001	956671	342589	07/18/19	11.00
	ELDORADO ARTESIAN SPRINGS INC	00001	956672	342589	07/18/19	38.95
	ELDORADO ARTESIAN SPRINGS INC	00001	956673	342589	07/18/19	20.97
	SOUTHLAND MEDICAL LLC	00001	956680	342589	07/18/19	1,076.12
	SOUTHLAND MEDICAL LLC	00001	956681	342589	07/18/19	217.96
					Account Total	1,403.95
	Other Professional Serv					
	BASELINE ASSOCIATES INC	00001	956696	342589	07/18/19	420.00
	COLO MEDICAL WASTE INC	00001	956677	342589	07/18/19	988.00
	COLO OCCUPATIONAL MEDICINE PHY	00001	956693	342589	07/18/19	480.00
	FEDEX	00001	956685	342589	07/18/19	24.44
	FEDEX	00001	956686	342589	07/18/19	64.56
	FEDEX	00001	956687	342589	07/18/19	18.18
	FEDEX	00001	956688	342589	07/18/19	32.30
	FEDEX	00001	956689	342589	07/18/19	34.44
	FEDEX	00001	956690	342589	07/18/19	16.02
	FEDEX	00001	956691	342589	07/18/19	87.77
	FEDEX	00001	956692	342589	07/18/19	38.11
	GENEDX INC	00001	956682	342589	07/18/19	3,000.00
	GENEDX INC	00001	956683	342589	07/18/19	1,500.00
	LANGUAGE LINE SERVICES	00001	956678	342589	07/18/19	44.28
	NICOLETTI-FLATER ASSOCIATES	00001	956698	342589	07/18/19	2,700.00
	NMS LABS	00001	956679	342589	07/18/19	13,924.00
	PALEO DNA	00001	956684	342589	07/18/19	350.00
	PERKINELMER GENETICS	00001	956695	342589	07/18/19	50.00
	SCL HEALTH	00001	956669	342589	07/18/19	181.00
	THOMSON REUTERS - WEST	00001	956674	342589	07/18/19	372.00

2031	County Coroner	Fund	Voucher	Batch No	GL Date	Amount
	UNIPATH	00001	956675	342589	07/18/19	2,442.00
	UNIPATH	00001	956676	342589	07/18/19	1,518.00
					Account Total	28,285.10
	Subscrip/Publications					
	CORHIO	00001	956697	342589	07/18/19	300.00
					Account Total	300.00
					Department Total	50,072.05

1031	County Treasurer	Fund	Voucher	Batch No	GL Date	Amount
	Operating Supplies					
	PPS INTERIORS	00001	956285	342202	07/15/19	710.00
					Account Total	710.00
	Other Professional Serv					
	EVANS CONSULTING	00001	956280	342131	07/12/19	682.50
	EVANS CONSULTING	00001	956281	342131	07/12/19	1,137.50
					Account Total	1,820.00
					Department Total	2,530.00

4302	CASP Administration	Fund	Voucher	Batch No	GL Date	Amount
	Telephone					
	AT&T CORP	00043	956226	342102	07/12/19	91.79
					Account Total	91.79
					Department Total	91.79

4308	CASP ATCT	Fund	Voucher	Batch No	GL Date	Amount
	Telephone					
	AT&T CORP	00043	956226	342102	07/12/19	6.98
					Account Total	6.98
					Department Total	6.98

4303	CASP FBO	Fund	Voucher	Batch No	GL Date	Amount
	Licenses and Fees					
	STATE OF COLORADO	00043	956646	342541	07/18/19	.16-
	STATE OF COLORADO	00043	956647	342541	07/18/19	.01-
					Account Total	.17-
	Transient Hanger Expense					
	AERIAL SURVEYS INTERNATIONAL L	00043	956628	342465	07/17/19	796.50
	NORLOFF RICHARD W	00043	956630	342465	07/17/19	17,695.15
					Account Total	18,491.65
	Uniforms & Cleaning					
	SOUTH PARK EMBROIDERY	00043	956631	342465	07/17/19	261.72
	SOUTH PARK EMBROIDERY	00043	956668	342577	07/18/19	222.50
					Account Total	484.22
					Department Total	18,975.70

4304	CASP Operations/Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Gasoline					
	OFFEN PETROLEUM INC	00043	956633	342535	07/18/19	1,501.79
					Account Total	1,501.79
	Licenses and Fees					
	STATE OF COLORADO	00043	956600	342459	07/17/19	39.04
					Account Total	39.04
	Telephone					
	AT&T CORP	00043	956226	342102	07/12/19	6.98
					Account Total	6.98
	Uniforms & Cleaning					
	SOUTH PARK EMBROIDERY	00043	956631	342465	07/17/19	369.93
					Account Total	369.93
					Department Total	1,917.74

941017	CDBG 2017/2018	Fund	Voucher	Batch No	GL Date	Amount
	Grants to Other Institutions					
	AFFORDABLE REMODELING SOLUTION	00030	955653	341158	07/01/19	14,900.00
	PG CONSTRUCTION SERVICES INC	00030	955654	341159	07/01/19	7,849.82
					Account Total	22,749.82
					Department Total	22,749.82

941018	CDBG 2018/2019	Fund	Voucher	Batch No	GL Date	Amount
	Grants to Other Institutions					
	TIERRA ROJO CONSTRUCTION	00030	956339	342247	07/15/19	3,660.00
					Account Total	3,660.00
					Department Total	3,660.00

1023	CLK Motor Vehicle	Fund	Voucher	Batch No	GL Date	Amount
	Operating Supplies					
	ALSCO AMERICAN INDUSTRIAL	00001	956189	342086	07/12/19	26.89
	ALSCO AMERICAN INDUSTRIAL	00001	956190	342086	07/12/19	17.19
	ALSCO AMERICAN INDUSTRIAL	00001	956191	342086	07/12/19	27.29
	ALSCO AMERICAN INDUSTRIAL	00001	956476	342341	07/16/19	19.53
	ALSCO AMERICAN INDUSTRIAL	00001	956477	342341	07/16/19	19.82
	ALSCO AMERICAN INDUSTRIAL	00001	956478	342341	07/16/19	17.19
	ALSCO AMERICAN INDUSTRIAL	00001	956479	342341	07/16/19	28.89
	ALSCO AMERICAN INDUSTRIAL	00001	956480	342341	07/16/19	19.53
	HICO	00001	956192	342086	07/12/19	11.50
					Account Total	187.83
	Security Service					
	ALLIED UNIVERSAL SECURITY SERV	00001	956186	342086	07/12/19	1,724.85
	ALLIED UNIVERSAL SECURITY SERV	00001	956187	342086	07/12/19	1,684.61
	ALLIED UNIVERSAL SECURITY SERV	00001	956188	342086	07/12/19	1,724.85
	ALLIED UNIVERSAL SECURITY SERV	00001	956474	342341	07/16/19	1,534.39
	ALLIED UNIVERSAL SECURITY SERV	00001	956475	342341	07/16/19	1,545.12
					Account Total	8,213.82
					Department Total	8,401.65

951016	CSBG	Fund	Voucher	Batch No	GL Date	Amount
	Grants to Other Instit					
	ALMOST HOME INC	00034	956277	342125	07/12/19	3,595.92
	ECPAC	00034	956275	342125	07/12/19	2,967.05
	ETHIOPIAN COMMUNITY DEVELOPMEN	00034	956279	342125	07/12/19	1,000.01
	NEW LEGACY CHARTER SCHOOL	00034	956278	342125	07/12/19	5,772.94
	SERVICIOS DE LA RAZA INC	00034	956276	342125	07/12/19	1,680.00
					Account Total	15,015.92
					Department Total	15,015.92

6021	CT- Trails- Plan/Design Const	Fund	Voucher	Batch No	GL Date	Amount
	Operating Supplies					
	JOE'S TOWING & RECOVERY	00024	956532	342417	07/17/19	300.00
					Account Total	300.00
					Department Total	300.00

1051	District Attorney	Fund	Voucher	Batch No	GL Date	Amount
	Operating Supplies					
	TOSHIBA BUSINESS SOLUTIONS	00001	956486	342344	07/16/19	86.10
					Account Total	86.10
	Witness Fees					
	ADCO DISTRICT ATTORNEY'S OFFIC	00001	956483	342344	07/16/19	43.47
	ADCO DISTRICT ATTORNEY'S OFFIC	00001	956483	342344	07/16/19	241.89
	ADCO DISTRICT ATTORNEY'S OFFIC	00001	956483	342344	07/16/19	358.87
	ADCO DISTRICT ATTORNEY'S OFFIC	00001	956483	342344	07/16/19	83.84
	ADCO DISTRICT ATTORNEY'S OFFIC	00001	956483	342344	07/16/19	54.25
	ADCO DISTRICT ATTORNEY'S OFFIC	00001	956483	342344	07/16/19	138.36
					Account Total	920.68
					Department Total	1,006.78

7041	Economic Development Center	Fund	Voucher	Batch No	GL Date	Amount
	Grants to Other Instit					
	ADAMS COUNTY ECONOMIC DEVELOP	00001	956175	341954	07/11/19	131,516.00
					Account Total	131,516.00
					Department Total	131,516.00

6	Equipment Service Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	ACS MANAGEMENT LLC	00006	956616	342462	07/17/19	3,900.00
	BRUCKNER TRUCK SALES INC	00006	956712	342669	07/19/19	143,210.00
	ELWAY DEALERS	00006	956381	342246	07/15/19	22,136.00
	JOHN ELWAY CHRYSLER JEEP DODGE	00006	956382	342246	07/15/19	26,697.00
	SAM HILL OIL INC	00006	956615	342462	07/17/19	16,316.00
	SAM HILL OIL INC	00006	956617	342462	07/17/19	1,602.36
	THE GOODYEAR TIRE AND RUBBER C	00006	956348	342246	07/15/19	1,629.60
					Account Total	215,490.96
					Department Total	215,490.96

9114	Fleet- Commerce	Fund	Voucher	Batch No	GL Date	Amount
	Vehicle Repair & Maint					
	LOYAS AUTO DETAILING	00006	956481	342345	07/16/19	100.00
					Account Total	100.00
					Department Total	100.00

50	FLATROCK Facility Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	SYSTEMS GROUP	00050	956404	342246	07/15/19	300.00
					Account Total	300.00
					Department Total	300.00

1091	FO - Administration	Fund	Voucher	Batch No	GL Date	Amount
	Building Rental					
	CHAMBERS HOLDINGS LLC	00001	956246	342121	07/12/19	15,986.70
					Account Total	15,986.70
	Consultant Services					
	GUIDANCE CORPORATE REALTY ADVI	00001	956242	342119	07/12/19	1,995.00
	GUIDANCE CORPORATE REALTY ADVI	00001	956243	342119	07/12/19	1,838.25
	GUIDANCE CORPORATE REALTY ADVI	00001	956244	342119	07/12/19	3,063.75
	GUIDANCE CORPORATE REALTY ADVI	00001	956245	342119	07/12/19	705.37
					Account Total	7,602.37
					Department Total	23,589.07

1075	FO - Administration Bldg	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	REPUBLIC SERVICES #535	00001	956290	342202	07/15/19	16.69
					Account Total	16.69
					Department Total	16.69

1114	FO - District Attorney Bldg.	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	REPUBLIC SERVICES #535	00001	956297	342202	07/15/19	133.53
					Account Total	133.53
					Department Total	133.53

2090	FO - Flatrock Facility	Fund	Voucher	Batch No	GL Date	Amount
	Building Repair & Maint					
	COLO ANALYTICAL LABORATORY	00050	956302	342202	07/15/19	40.00
					Account Total	40.00
					Department Total	40.00

1077	FO - Government Center	Fund	Voucher	Batch No	GL Date	Amount
	Building Repair & Maint					
	FINELINE GRAPHICS	00001	956284	342202	07/15/19	269.04
					Account Total	269.04
	Water/Sewer/Sanitation					
	REPUBLIC SERVICES #535	00001	956296	342202	07/15/19	300.46
					Account Total	300.46
					Department Total	569.50

1070	FO - Honnen/Plan&Devel/MV Ware	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	REPUBLIC SERVICES #535	00001	956295	342202	07/15/19	166.92
	REPUBLIC SERVICES #535	00001	956298	342202	07/15/19	467.39
					Account Total	634.31
					Department Total	634.31

1071	FO - Justice Center	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	REPUBLIC SERVICES #535	00001	956293	342202	07/15/19	712.20
					Account Total	712.20
					Department Total	712.20

2009	FO - Sheriff Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Building Repair & Maint					
	COMMERCIAL CLEANING SYSTEMS	00001	956287	342202	07/15/19	500.00
	REPUBLIC SERVICES #535	00001	956288	342202	07/15/19	270.00
	REPUBLIC SERVICES #535	00001	956289	342202	07/15/19	117.00
					Account Total	887.00
	Water/Sewer/Sanitation					
	REPUBLIC SERVICES #535	00001	956289	342202	07/15/19	3,412.62
	REPUBLIC SERVICES #535	00001	956292	342202	07/15/19	267.08
	REPUBLIC SERVICES #535	00001	956299	342202	07/15/19	133.54
					Account Total	3,813.24
					Department Total	4,700.24

1072	FO - West Service Center	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	REPUBLIC SERVICES #535	00001	956291	342202	07/15/19	100.15
					Account Total	100.15
					Department Total	100.15

1076	FO-Adams County Service Center	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	REPUBLIC SERVICES #535	00001	956301	342202	07/15/19	82.26
					Account Total	82.26
					Department Total	82.26

1069	FO-Animal Shelter Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Building Repair & Maint					
	COLO ANALYTICAL LABORATORY	00001	956286	342202	07/15/19	72.00
					Account Total	72.00
	Water/Sewer/Sanitation					
	REPUBLIC SERVICES #535	00001	956300	342202	07/15/19	333.84
					Account Total	333.84
					Department Total	405.84

1 General Fund	Fund	Voucher	Batch No	GL Date	Amount
Received not Vouchered Clrg					
ADAMS COUNTY COMMUNICATION CEN	00001	956337	342246	07/15/19	346,565.60
ADAMS COUNTY COMMUNICATION CEN	00001	956337	342246	07/15/19	46,500.50
ADAMSON POLICE PRODUCTS	00001	956333	342246	07/15/19	318.00
ADAMSON POLICE PRODUCTS	00001	956334	342246	07/15/19	207.00
ADAMSON POLICE PRODUCTS	00001	956335	342246	07/15/19	85.00
ADAMSON POLICE PRODUCTS	00001	956462	342333	07/16/19	25.00
ALLIED UNIVERSAL SECURITY SERV	00001	956332	342246	07/15/19	21,120.40
ALLIED UNIVERSAL SECURITY SERV	00001	956603	342462	07/17/19	3,862.80
ARMORED KNIGHTS INC	00001	956331	342246	07/15/19	339.42
ARMORED KNIGHTS INC	00001	956331	342246	07/15/19	339.42
ARMORED KNIGHTS INC	00001	956331	342246	07/15/19	339.42
ARMORED KNIGHTS INC	00001	956331	342246	07/15/19	339.42
ARMORED KNIGHTS INC	00001	956331	342246	07/15/19	339.42
ARMORED KNIGHTS INC	00001	956331	342246	07/15/19	339.42
BIG PAULIE PRODUCTIONS LLC	00001	956516	342411	07/17/19	7,000.00
BIG PAULIE PRODUCTIONS LLC	00001	956516	342411	07/17/19	500.00
BIG PAULIE PRODUCTIONS LLC	00001	956517	342411	07/17/19	10,000.00
BIG PAULIE PRODUCTIONS LLC	00001	956518	342411	07/17/19	20,000.00
BIG PAULIE PRODUCTIONS LLC	00001	956519	342411	07/17/19	15,000.00
BIG PAULIE PRODUCTIONS LLC	00001	956719	342676	07/19/19	16,750.00
CHP METRO NORTH LLC	00001	956468	342333	07/16/19	1,050.00
CODE 4 SECURITY SERVICES LLC	00001	956340	342246	07/15/19	2,832.00
COHEN MILSTEIN SELLERS & TOLL	00001	956711	342669	07/19/19	708.75
COMMUNITY REACH CENTER	00001	956383	342246	07/15/19	31,428.26
DENOVO VENTURES LLC	00001	956466	342333	07/16/19	2,940.00
EL RODEO NIGHT CLUB LLC	00001	956461	342333	07/16/19	17,500.00
FEDERAL RESOURCES SUPPLY COMPA	00001	956345	342246	07/15/19	35,158.32
G SQUARED DESIGN LLC	00001	956717	342676	07/19/19	24,315.78
GABLEHOUSE GRANBERG LLC	00001	956604	342462	07/17/19	1,904.00
GALLS LLC	00001	956350	342246	07/15/19	83.18
GALLS LLC	00001	956351	342246	07/15/19	19.31
GALLS LLC	00001	956352	342246	07/15/19	719.83
GALLS LLC	00001	956353	342246	07/15/19	116.22
GALLS LLC	00001	956354	342246	07/15/19	263.18
GALLS LLC	00001	956355	342246	07/15/19	41.59

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	GALLS LLC	00001	956356	342246	07/15/19	436.56
	GALLS LLC	00001	956357	342246	07/15/19	153.91
	GALLS LLC	00001	956360	342246	07/15/19	39.95
	GALLS LLC	00001	956362	342246	07/15/19	10.50
	GALLS LLC	00001	956363	342246	07/15/19	45.13
	GALLS LLC	00001	956364	342246	07/15/19	124.77
	GALLS LLC	00001	956365	342246	07/15/19	143.80
	GALLS LLC	00001	956366	342246	07/15/19	59.16
	GALLS LLC	00001	956366	342246	07/15/19	780.00
	GALLS LLC	00001	956367	342246	07/15/19	117.49
	GALLS LLC	00001	956368	342246	07/15/19	506.50
	GALLS LLC	00001	956369	342246	07/15/19	83.18
	GROUNDS SERVICE COMPANY	00001	956602	342462	07/17/19	519.00
	IDEXX DISTRIBUTION INC	00001	956613	342462	07/17/19	288.00
	IDEXX DISTRIBUTION INC	00001	956613	342462	07/17/19	247.60
	JOHN DEERE COMPANY	00001	956370	342246	07/15/19	11,219.13
	JOHN DEERE COMPANY	00001	956370	342246	07/15/19	14,736.01
	KORBY LANDSCAPE LLC	00001	956384	342246	07/15/19	1,369.92
	KORBY LANDSCAPE LLC	00001	956384	342246	07/15/19	913.28
	KORBY LANDSCAPE LLC	00001	956384	342246	07/15/19	1,124.03
	KORBY LANDSCAPE LLC	00001	956384	342246	07/15/19	1,171.56
	KORBY LANDSCAPE LLC	00001	956384	342246	07/15/19	517.16
	KORBY LANDSCAPE LLC	00001	956384	342246	07/15/19	509.41
	KORBY LANDSCAPE LLC	00001	956384	342246	07/15/19	836.03
	KORBY LANDSCAPE LLC	00001	956384	342246	07/15/19	1,589.41
	MGT OF AMERICA INC	00001	956385	342246	07/15/19	8,025.00
	MGT OF AMERICA INC	00001	956601	342462	07/17/19	2,675.00
	MICHELSON FOUND ANIMALS FOUNDA	00001	956614	342462	07/17/19	1,787.00
	MWI VETERINARY SUPPLY CO	00001	956607	342462	07/17/19	206.30
	MWI VETERINARY SUPPLY CO	00001	956608	342462	07/17/19	137.20
	MWI VETERINARY SUPPLY CO	00001	956609	342462	07/17/19	236.13
	MWI VETERINARY SUPPLY CO	00001	956610	342462	07/17/19	114.01
	MWI VETERINARY SUPPLY CO	00001	956611	342462	07/17/19	120.94
	MWI VETERINARY SUPPLY CO	00001	956612	342462	07/17/19	1,302.91
	NCS PEARSON INC	00001	956392	342246	07/15/19	642.00
	OLD VINE PINNACLE ASSOCIATES	00001	956467	342333	07/16/19	800.00

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	ONENECK IT SOLUTIONS LLC	00001	956469	342333	07/16/19	6,609.92
	OUTDOOR PROMOTIONS OF COLORADO	00001	956389	342246	07/15/19	600.00
	OUTDOOR PROMOTIONS OF COLORADO	00001	956391	342246	07/15/19	3,215.00
	PATTERSON VETERINARY SUPPLY IN	00001	956605	342462	07/17/19	18.73
	REGROUP	00001	956393	342246	07/15/19	6,427.00
	REPUBLIC NATIONAL DISTRIBUTING	00001	956395	342246	07/15/19	182.69
	SHERMAN & HOWARD LLC	00001	956463	342333	07/16/19	3,931.25
	SOUTHWESTERN PAINTING	00001	956396	342246	07/15/19	6,000.00
	SOUTHWESTERN PAINTING	00001	956397	342246	07/15/19	528.00
	SOUTHWESTERN PAINTING	00001	956399	342246	07/15/19	25,000.00
	SOUTHWESTERN PAINTING	00001	956401	342246	07/15/19	924.00
	STATE OF COLORADO	00001	956464	342333	07/16/19	2,137.70
	STATE OF COLORADO	00001	956464	342333	07/16/19	259.70
	STATE OF COLORADO	00001	956465	342333	07/16/19	5,961.76
	STATE OF COLORADO	00001	956713	342669	07/19/19	5,856.96
	SUMMIT FOOD SERVICE LLC	00001	956407	342246	07/15/19	4,997.37
	SUMMIT FOOD SERVICE LLC	00001	956409	342246	07/15/19	28,153.22
	SUMMIT FOOD SERVICE LLC	00001	956410	342246	07/15/19	3,537.33
	SUMMIT FOOD SERVICE LLC	00001	956412	342246	07/15/19	28,186.07
	SYSTEMS GROUP	00001	956402	342246	07/15/19	200.00
	TOWERS PAINTING	00001	956414	342246	07/15/19	725.00
	TYGRETT DEBRA R	00001	956415	342246	07/15/19	272.00
	WAGNER RENTS	00001	956416	342246	07/15/19	1,413.56
	WRIGHTWAY INDUSTRIES INC	00001	956606	342462	07/17/19	769.77
					Account Total	798,546.25
					Department Total	798,546.25

5	Golf Course Enterprise Fund	Fund	Voucher	Batch No	GL Date	Amount
	Vendor Fee Sales Tax - State					
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	2,258.64
					Account Total	2,258.64
					Department Total	2,258.64

5026	Golf Course- Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Contract Employment					
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	25,489.22
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	3,036.51
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	7,487.57
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	966.12
					Account Total	36,979.42
	Gas & Electricity					
	XCEL ENERGY	00005	956237	342113	07/12/19	101.81
					Account Total	101.81
	Grounds Maintenance					
	ALPINE ARBORISTS PRO TREE CARE	00005	956230	342113	07/12/19	8,830.00
	GOLF & SPORT SOLUTIONS	00005	956233	342113	07/12/19	1,949.50
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	193.77
					Account Total	10,973.27
	Other Repair & Maint					
	ACUITY SPECIALTY PRODUCTS INC	00005	956229	342113	07/12/19	138.11
					Account Total	138.11
	Repair & Maint Supplies					
	ALSCO AMERICAN INDUSTRIAL	00005	956231	342113	07/12/19	49.67
	ALSCO AMERICAN INDUSTRIAL	00005	956232	342113	07/12/19	47.76
	GRAINGER	00005	956234	342113	07/12/19	76.08
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	265.56
					Account Total	439.07
	Vehicle Parts & Supplies					
	INTERSTATE BATTERY OF ROCKIES	00005	956235	342113	07/12/19	258.75
					Account Total	258.75
					Department Total	48,890.43

5021	Golf Course- Pro Shop	Fund	Voucher	Batch No	GL Date	Amount
	Advertising					
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	3,000.00
					Account Total	3,000.00
	Building Repair & Maint					
	PRO LIFT DOORS OF BRIGHTON	00005	956236	342113	07/12/19	2,700.00
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	340.00
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	475.00
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	380.00
					Account Total	3,895.00
	Contract Employment					
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	22,345.20
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	2,697.40
					Account Total	25,042.60
	Gas & Electricity					
	XCEL ENERGY	00005	956237	342113	07/12/19	383.79
					Account Total	383.79
	Golf Carts					
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	1,050.00
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	944.00
					Account Total	1,994.00
	Golf Merchandise					
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	105.61
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	2,994.27
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	2,024.68
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	846.45
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	1,736.35
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	285.00
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	185.55
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	1,153.54
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	195.00
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	649.60
					Account Total	10,176.05
	Janitorial Services					
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	647.53

5021	Golf Course- Pro Shop	Fund	Voucher	Batch No	GL Date	Amount
					Account Total	647.53
	Operating Supplies					
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	47.61
					Account Total	47.61
	Other Professional Serv					
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	326.27
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	351.52
					Account Total	677.79
	Postage & Freight					
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	6.30
					Account Total	6.30
	Repair & Maint Supplies					
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	1,465.68
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	19.27
					Account Total	1,484.95
	Security Service					
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	647.50
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	740.00
					Account Total	1,387.50
	Telephone					
	PROFESSIONAL RECREATION MGMT I	00005	956185	342085	07/12/19	518.93
					Account Total	518.93
	Water/Sewer/Sanitation					
	PROFESSIONAL RECREATION MGMT I	00005	956515	342408	07/17/19	660.91
					Account Total	660.91
					Department Total	49,922.96

9252	GF- Admin/Org Support	Fund	Voucher	Batch No	GL Date	Amount
	Consultant Services					
	SEKI SHINSUKE	00001	956228	342112	07/12/19	4,000.00
					Account Total	4,000.00
					Department Total	4,000.00

1079	Human Services Center	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	REPUBLIC SERVICES #535	00001	956294	342202	07/15/19	1,001.53
					Account Total	1,001.53
					Department Total	1,001.53

935119	HHS Grant	Fund	Voucher	Batch No	GL Date	Amount
	Subscrip/Publications					
	NULINX INTERNATIONAL	00031	956318	342236	07/15/19	675.75
	NULINX INTERNATIONAL	00031	956318	342236	07/15/19	119.25
					Account Total	795.00
	Telephone					
	CENTURY LINK	00031	956316	342236	07/15/19	178.69
	CENTURY LINK	00031	956317	342236	07/15/19	129.13
					Account Total	307.82
					Department Total	1,102.82

8613	Insurance - UHC EPO Medical	Fund	Voucher	Batch No	GL Date	Amount
	Claims					
	UNITED HEALTH CARE INSURANCE C	00019	956710	342662	07/19/19	91,000.82
					Account Total	91,000.82
	POCR Fee					
	UNITED STATES TREASURY	00019	956184	342084	07/12/19	3,322.76
					Account Total	3,322.76
					Department Total	94,323.58

19	Insurance Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	COLO FRAME & SUSPENSION	00019	956618	342462	07/17/19	3,824.42
	COLO FRAME & SUSPENSION	00019	956619	342462	07/17/19	951.22
	COLO FRAME & SUSPENSION	00019	956648	342462	07/18/19	4,747.14
	FIT SOLDIERS FITNESS BOOT CAMP	00019	956344	342246	07/15/19	3,090.00
	THRIVE AT HOME NUTRITION LLC	00019	956586	342427	07/17/19	363.84
					Account Total	12,976.62
					Department Total	12,976.62

8614	Insurance- Delta Dental	Fund	Voucher	Batch No	GL Date	Amount
	Self-Insurance Claims					
	DELTA DENTAL OF COLO	00019	956227	342104	07/12/19	13,906.88
	DELTA DENTAL OF COLO	00019	956227	342104	07/12/19	185.00
					Account Total	14,091.88
					Department Total	14,091.88

8611	Insurance- Property/Casualty	Fund	Voucher	Batch No	GL Date	Amount
	General Liab - Other than Prop					
	KILLMER LANE & NEWMAN LLP COLT	00019	956193	342087	07/12/19	250,000.00
					Account Total	250,000.00
					Department Total	250,000.00

1058	IT Network/Telecom	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	COMMUNICATION CONSTRUCTION & E	00001	956238	342116	07/12/19	1,134.50
	COMMUNICATION CONSTRUCTION & E	00001	956240	342118	07/12/19	3,660.00
	UTILITY NOTIFICATION CENTER OF	00001	956239	342116	07/12/19	239.98
	UTILITY NOTIFICATION CENTER OF	00001	956241	342118	07/12/19	201.64
					Account Total	5,236.12
	Telephone					
	TDS TELECOM	00001	956306	342226	07/15/19	893.49
	WINDSTREAM COMMUNICATIONS	00001	956307	342226	07/15/19	1,882.65
					Account Total	2,776.14
					Department Total	8,012.26

1081	Long Range Strategic Planning	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	CITY OF BRIGHTON	00001	956176	341954	07/11/19	8,333.99
					Account Total	8,333.99
					Department Total	8,333.99

27	Open Space Projects Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	STREAM DESIGN LLC	00027	956349	342246	07/15/19	3,263.49
					Account Total	3,263.49
					Department Total	3,263.49

6202	Open Space Tax- Grants	Fund	Voucher	Batch No	GL Date	Amount
	Grants to Other Instit					
	COMMERCE CITY CITY OF	00028	956531	342417	07/17/19	250,804.00
					Account Total	250,804.00
					Department Total	250,804.00

3128	Park 1200-HS	Fund	Voucher	Batch No	GL Date	Amount
	Art Collection					
	DLR GROUP	00004	956179	341963	07/11/19	2,685.00
					Account Total	2,685.00
					Department Total	2,685.00

5010	PKS- Fair	Fund	Voucher	Batch No	GL Date	Amount
	Event Services					
	AIRGAS USA LLC	00001	956372	342249	07/15/19	164.42
					Account Total	164.42
	Fair Expenses-General					
	BALDWIN MARY	00001	956489	342347	07/16/19	150.00
	CHRISTIAN VICKI	00001	956403	342250	07/15/19	150.00
	COLOR CORRAL	00001	956303	342207	07/15/19	3,811.96
	CRAMER STEPHEN S	00001	956394	342250	07/15/19	150.00
	ELLIOTT MARIA ANGELICA	00001	956408	342250	07/15/19	150.00
	FEY TOM E	00001	956411	342250	07/15/19	150.00
	GARNETT BARARA	00001	956405	342250	07/15/19	150.00
	HARROLD PAMELA	00001	956398	342250	07/15/19	150.00
	HETTINGER KATHLEEN S	00001	956400	342250	07/15/19	150.00
	JOHNSON KAREN	00001	956386	342250	07/15/19	150.00
	JONES TYLER JANE	00001	956388	342250	07/15/19	150.00
	MACKEY BRIANNA L	00001	956390	342250	07/15/19	150.00
	OCHSNER CAITLYN	00001	956533	342417	07/17/19	2,000.00
	TRUMBLE COLE	00001	956490	342347	07/16/19	100.00
					Account Total	7,561.96
	Operating Supplies					
	ADMIT ONE PRODUCTS	00001	956371	342249	07/15/19	1,271.24
					Account Total	1,271.24
	Other Professional Serv					
	CYR RENEE MICHELE	00001	956358	342248	07/15/19	770.00
	FINNING DENISE M	00001	956359	342248	07/15/19	770.00
					Account Total	1,540.00
	Regional Park Rentals					
	ADAMS 12 FIVE STAR SCHOOLS	00001	956635	342540	07/18/19	400.00
	BALLMAN DEB	00001	956373	342249	07/15/19	100.00
	BUNN BILL	00001	956374	342249	07/15/19	75.00
	CAAP	00001	956637	342540	07/18/19	400.00
	CERVANTES LIZETH	00001	956375	342249	07/15/19	75.00
	CHATMAN THERESA	00001	956376	342249	07/15/19	75.00
	GUERRERO CHARRITO	00001	956377	342249	07/15/19	75.00

5010	PKS- Fair	Fund	Voucher	Batch No	GL Date	Amount
	PADILLA ELIDIA	00001	956378	342249	07/15/19	75.00
	QUIROZ CINDY	00001	956379	342249	07/15/19	500.00
	RMFMA	00001	956534	342417	07/17/19	500.00
	YSLAS CHERYL	00001	956380	342249	07/15/19	75.00
					Account Total	2,350.00
					Department Total	12,887.62

5015	PKS- Grounds Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Repair & Maint Supplies					
	ATCO INTERNATIONAL	00001	956636	342540	07/18/19	230.00
					Account Total	230.00
	Water/Sewer/Sanitation					
	CULLIGAN	00001	956638	342540	07/18/19	217.00
	UNITED SITE SERVICES	00001	956645	342540	07/18/19	2,159.67
					Account Total	2,376.67
					Department Total	2,606.67

5016	PKS- Trail Ranger Patrol	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	NORTH WASHINGTON ST WATER & SA	00001	956639	342540	07/18/19	16,521.59
	NORTH WASHINGTON ST WATER & SA	00001	956640	342540	07/18/19	3,279.73
	UNITED SITE SERVICES	00001	956535	342417	07/17/19	514.62
	UNITED SITE SERVICES	00001	956641	342540	07/18/19	437.70
	UNITED SITE SERVICES	00001	956642	342540	07/18/19	204.12
	UNITED SITE SERVICES	00001	956643	342540	07/18/19	3,010.72
	UNITED SITE SERVICES	00001	956644	342540	07/18/19	389.52
					Account Total	24,358.00
					Department Total	24,358.00

1089	PLN- Boards & Commissions	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	DOMENICO JOSEPH	00001	956314	342228	07/15/19	65.00
	DUPRIEST JOHN FIELDEN	00001	956315	342228	07/15/19	65.00
	FOREST SEAN	00001	956310	342228	07/15/19	65.00
	GARNER, ROSIE	00001	956311	342228	07/15/19	65.00
	HERRERA, AARON	00001	956308	342228	07/15/19	65.00
	PLAKORUS DAVID	00001	956309	342228	07/15/19	65.00
	RICHARDSON SHARON	00001	956313	342228	07/15/19	65.00
	THOMPSON GREGORY PAUL	00001	956312	342228	07/15/19	65.00
					Account Total	520.00
					Department Total	520.00

7	Stormwater Utility Fund	Fund	Voucher	Batch No	GL Date	Amount
	Suspense - Misc. Clearing					
	CHESTELSON JULIAN B AND	00007	5387	342399	07/17/19	51.21
					Account Total	51.21
					Department Total	51.21

2011	SHF- Admin Services Division	Fund	Voucher	Batch No	GL Date	Amount
	Concealed Handgun Permit Fees					
	KRUS DANIEL HARRISON	00001	956199	342093	07/12/19	100.00
					Account Total	100.00
	Other Professional Serv					
	PSYCHOLOGICAL DIMENSIONS	00001	956203	342093	07/12/19	450.00
					Account Total	450.00
					Department Total	550.00

2015	SHF- Civil Section	Fund	Voucher	Batch No	GL Date	Amount
	Sheriff's Fees					
	ABC LEGAL SERVICES	00001	956261	342122	07/12/19	19.00
	ADKINS SANDRA J	00001	956271	342122	07/12/19	139.00
	BALL FRANK J	00001	956256	342122	07/12/19	19.00
	COLORADO LEGAL SERVICES	00001	956247	342122	07/12/19	19.00
	DAWSON ROBERT	00001	956273	342122	07/12/19	19.00
	DIVINE HOMES DENVER LLC	00001	956248	342122	07/12/19	66.00
	EZ MESSENGER	00001	956254	342122	07/12/19	19.00
	FRANCY LAW FIRM, PLLC	00001	956258	342122	07/12/19	19.00
	FRANCY LAW FIRM, PLLC	00001	956259	342122	07/12/19	19.00
	FRANCY LAW FIRM, PLLC	00001	956260	342122	07/12/19	19.00
	HOLST AND BOETTCHER	00001	956257	342122	07/12/19	19.00
	MCKEE DORA ANN	00001	956270	342122	07/12/19	19.00
	MIDLAND FUNDING LLC	00001	956263	342122	07/12/19	19.00
	MONCADA LAURA	00001	956282	342122	07/12/19	66.00
	MOORE LAW GROUP APC	00001	956255	342122	07/12/19	19.00
	NELSON AND KENNARD	00001	956264	342122	07/12/19	19.00
	PROVEST LITIGATION SERVICES	00001	956262	342122	07/12/19	19.00
	QUINTERO-RUIZ MARTIN ALEJANDRO	00001	956274	342122	07/12/19	19.00
	SALAPICH NELSON PAMELA	00001	956272	342122	07/12/19	19.00
	SPECIALIZED ATTORNEY SERVICES	00001	956267	342122	07/12/19	19.00
	STENGER AND STENGER	00001	956252	342122	07/12/19	19.00
	STENGER AND STENGER	00001	956253	342122	07/12/19	19.00
	STOKES AND WOLF	00001	956249	342122	07/12/19	19.00
	THE JOHNSON LAW OFFICE	00001	956266	342122	07/12/19	19.00
	URIBE LESLIE	00001	956265	342122	07/12/19	19.00
	VARGO MYERS JANSON PC	00001	956250	342122	07/12/19	19.00
	WADSWORTH WARNER CONRARDY	00001	956251	342122	07/12/19	19.00
	WENZEL DANIELLA NICHOLE	00001	956268	342122	07/12/19	19.00
					Account Total	746.00
					Department Total	746.00

2075	SHF- Commissary Fund	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	METRO TRANSPORTATION PLANNING	00001	956202	342093	07/12/19	2,283.35
					Account Total	2,283.35
					Department Total	2,283.35

2016	SHF- Detective Division	Fund	Voucher	Batch No	GL Date	Amount
	Other Communications					
	CENTURY LINK	00001	956197	342093	07/12/19	88.99
					Account Total	88.99
	Other Professional Serv					
	COLO BUREAU OF INVESTIGATION	00001	956198	342093	07/12/19	330.00
					Account Total	330.00
					Department Total	418.99

2071	SHF- Detention Facility	Fund	Voucher	Batch No	GL Date	Amount
	Medical Services					
	CENTURA HEALTH	00001	956196	342093	07/12/19	600.00
					Account Total	600.00
	Operating Supplies					
	SUMMIT FOOD SERVICE LLC	00001	956204	342093	07/12/19	61.37
	SUMMIT FOOD SERVICE LLC	00001	956205	342093	07/12/19	221.00
					Account Total	282.37
					Department Total	882.37

2010	SHF- MIS Unit	Fund	Voucher	Batch No	GL Date	Amount
	Maintenance Contracts					
	TYLER TECHNOLOGIES INC	00001	955973	341699	07/09/19	760.27
	TYLER TECHNOLOGIES INC	00001	955974	341699	07/09/19	4,093.88
					Account Total	4,854.15
					Department Total	4,854.15

2005	SHF- TAC Section	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	NORTHGLENN AMBULANCE	00001	956200	342093	07/12/19	676.20
	NORTHGLENN AMBULANCE	00001	956201	342093	07/12/19	386.40
					Account Total	1,062.60
	Traffic Fines					
	ARMENDIAZ AVITA	00001	956194	342093	07/12/19	10.00
	CARPENTER MATTHEW MICHAEL	00001	956195	342093	07/12/19	123.00
					Account Total	133.00
					Department Total	1,195.60

3019	Transportation Admin/Org	Fund	Voucher	Batch No	GL Date	Amount
	Payments To Cities-Sales Taxes					
	ARVADA CITY OF	00013	956520	342415	07/17/19	11,486.85
	AURORA CITY OF	00013	956521	342415	07/17/19	249,456.37
	BENNETT TOWN OF	00013	956522	342415	07/17/19	8,791.69
	BRIGHTON CITY OF	00013	956523	342415	07/17/19	136,122.92
	COMMERCE CITY CITY OF	00013	956524	342415	07/17/19	141,152.07
	FEDERAL HEIGHTS CITY OF	00013	956525	342415	07/17/19	29,689.81
	NORTHGLENN CITY OF	00013	956526	342415	07/17/19	82,734.81
	THORNTON CITY OF	00013	956527	342415	07/17/19	288,419.94
	WESTMINSTER CITY OF	00013	956528	342415	07/17/19	166,105.73
					Account Total	1,113,960.19
					Department Total	1,113,960.19

4316	Wastewater Treatment Plant	Fund	Voucher	Batch No	GL Date	Amount
	Laboratory Analysis					
	COLO ANALYTICAL LABORATORY	00043	956435	342102	07/12/19	26.00
	COLO ANALYTICAL LABORATORY	00043	956629	342465	07/17/19	26.00
					Account Total	52.00
					Department Total	52.00

97500	WIOA YOUTH OLDER	Fund	Voucher	Batch No	GL Date	Amount
	Supp Svcs-Incentives					
	CERCENDA CARINA	00035	956593	342400	07/17/19	60.00
	HERNANDEZ BADENA EVANGELINA	00035	956504	342400	07/17/19	50.00
	ORTIZ ROJAS EMILY S	00035	956506	342400	07/17/19	40.00
	SANCHEZ KIMBERLY	00035	956594	342400	07/17/19	20.00
	SMITH KAIYA	00035	956509	342400	07/17/19	40.00
					Account Total	210.00
					Department Total	210.00

Grand Total	**3,355,486.27**

County of Adams

Net Warrant by Fund Summary

Fund Number	Fund Description	Amount
1	General Fund	1,523,897.74
4	Capital Facilities Fund	1,875,574.84
5	Golf Course Enterprise Fund	4,148.82
13	Road & Bridge Fund	214,255.95
19	Insurance Fund	138,913.66
25	Waste Management Fund	31,152.65
43	Colorado Air & Space Port	5,348.14
		3,793,291.80

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00005417	628019	BIG PAULIE PRODUCTIONS LLC	07/23/19	10,500.00
00005418	373974	HOLMES DAWN B	07/23/19	8,200.00
00005419	104910	SAUNDERS CONSTRUCTION INC	07/23/19	1,155,084.07
00739524	31359	ARAPAHOE COUNTY SHERIFF CIVIL	07/23/19	40.00
00739525	31359	ARAPAHOE COUNTY SHERIFF CIVIL	07/23/19	42.50
00739526	43744	AUTOMATED BUILDING SOLUTIONS I	07/23/19	2,550.00
00739528	13160	BRIGHTON CITY OF (WATER)	07/23/19	14,391.33
00739529	13160	BRIGHTON CITY OF (WATER)	07/23/19	4,658.33
00739531	52783	CENTER FOR EDUCATION & EMPLOYM	07/23/19	124.95
00739532	852482	CLEARWAY ENERGY GROUP LLC	07/23/19	1,187.34
00739533	209334	COLO NATURAL GAS INC	07/23/19	85.22
00739535	252174	COLORADO COMMUNITY MEDIA	07/23/19	20.88
00739536	48089	COMCAST BUSINESS	07/23/19	2,100.00
00739538	96739	CUMMINS ROCKY MOUNTAIN	07/23/19	1,332.80
00739539	315529	DENVER COUNTY SHERIFF	07/23/19	48.20
00739542	101591	ET TECHNOLOGIES INC	07/23/19	1,873.50
00739543	13454	FEDERAL EXPRESS CO	07/23/19	200.07
00739546	8721	HILL & ROBBINS	07/23/19	1,221.25
00739547	418327	IC CHAMBERS LP	07/23/19	6,838.90
00739548	13565	INTERMOUNTAIN REA	07/23/19	1,563.24
00739549	13565	INTERMOUNTAIN REA	07/23/19	169.29
00739550	49039	I70 PUBLISHING CO INC	07/23/19	46.20
00739551	535598	JACHIMIAK PETERSON LLC	07/23/19	26,871.92
00739552	13903	JEFFERSON COUNTY SHERIFF	07/23/19	95.50
00739553	454772	JEFFERSON COUNTY TREASURER	07/23/19	24.00
00739555	13906	LARIMER COUNTY SHERIFF	07/23/19	25.40
00739556	8801432	MESA COUNTY	07/23/19	1,400.00
00739557	73648	METROWEST NEWSPAPERS	07/23/19	55.44
00739559	430098	REPUBLIC SERVICES #535	07/23/19	1,752.99
00739561	255505	SHERMAN & HOWARD LLC	07/23/19	850.00
00739562	13932	SOUTH ADAMS WATER & SANITATION	07/23/19	588.35
00739563	13932	SOUTH ADAMS WATER & SANITATION	07/23/19	419.90
00739564	13932	SOUTH ADAMS WATER & SANITATION	07/23/19	705.29
00739565	13932	SOUTH ADAMS WATER & SANITATION	07/23/19	25.20
00739566	13932	SOUTH ADAMS WATER & SANITATION	07/23/19	46.97
00739567	13932	SOUTH ADAMS WATER & SANITATION	07/23/19	46.97

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739568	13932	SOUTH ADAMS WATER & SANITATION	07/23/19	1,402.91
00739569	13932	SOUTH ADAMS WATER & SANITATION	07/23/19	4,563.34
00739570	227044	SOUTHWESTERN PAINTING	07/23/19	3,549.00
00739571	35108	STEVENS KOENIG REPORTING	07/23/19	1,124.40
00739572	1007	UNITED POWER (UNION REA)	07/23/19	143.68
00739594	544338	WESTAR REAL PROPERTY SERVICES	07/23/19	13,598.25
00739595	13822	XCEL ENERGY	07/23/19	459.21
00739596	13822	XCEL ENERGY	07/23/19	4,594.88
00739606	378168	ZOETIS US LLC	07/23/19	311.80
00739608	91631	ADAMSON POLICE PRODUCTS	07/25/19	10,249.31
00739609	433987	ADCO DISTRICT ATTORNEY'S OFFIC	07/25/19	393.81
00739610	383698	ALLIED UNIVERSAL SECURITY SERV	07/25/19	3,476.52
00739612	43744	AUTOMATED BUILDING SOLUTIONS I	07/25/19	4,855.00
00739613	40942	BI INCORPORATED	07/25/19	7,008.16
00739614	347304	BRANDED IMAGE APPAREL	07/25/19	6,226.00
00739615	888876	BUA ERIC	07/25/19	100.00
00739617	9902	CHEMATOX LABORATORY INC	07/25/19	2,752.00
00739618	43659	CINTAS FIRST AID & SAFETY	07/25/19	189.41
00739619	460842	COLO INFORMATION SHARING CONSO	07/25/19	683.37
00739620	2157	COLO OCCUPATIONAL MEDICINE PHY	07/25/19	814.00
00739621	13049	COMMUNITY REACH CENTER	07/25/19	52,773.08
00739622	304520	DELL PREFERRED ACCOUNT	07/25/19	12,383.20
00739624	671123	FOUND MY KEYS	07/25/19	1,684.00
00739625	12689	GALLS LLC	07/25/19	33,221.08
00739626	218667	GARCIA SILVIANO	07/25/19	1,100.00
00739629	14991	HELTON & WILLIAMSEN PC	07/25/19	1,760.86
00739630	350168	HOFFER MICHELLE L	07/25/19	200.00
00739632	77611	KD SERVICE GROUP	07/25/19	1,240.61
00739633	40395	KUMAR & ASSOCIATES INC	07/25/19	2,359.25
00739635	11496	L L JOHNSON DIST	07/25/19	150.00
00739637	255462	MORINE SHELLY	07/25/19	75.00
00739638	13591	MWI VETERINARY SUPPLY CO	07/25/19	640.52
00739639	192059	POINT SPORTS/ERGOMED	07/25/19	1,980.00
00739640	44148	PRO FORCE LAW ENFORCEMENT	07/25/19	104.12
00739641	725956	PRUDENTIAL OVERALL SUPPLY	07/25/19	55.28
00739643	886264	REAMS MEGAN	07/25/19	115.00

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739644	64382	REDDY ICE CORPORATION	07/25/19	9,910.00
00739645	472626	SAFEWARE INC	07/25/19	2,996.67
00739646	227044	SOUTHWESTERN PAINTING	07/25/19	13,226.00
00739647	599714	SUMMIT FOOD SERVICE LLC	07/25/19	32,509.23
00739649	37005	TOSHIBA BUSINESS SOLUTIONS	07/25/19	1,421.25
00739650	7189	TOSHIBA FINANCIAL SERVICES	07/25/19	5,387.26
00739651	666214	TYGRETT DEBRA R	07/25/19	694.00
00739652	300982	UNITED SITE SERVICES	07/25/19	518.87
00739653	28617	VERIZON WIRELESS	07/25/19	3,472.30
00739654	80279	VERIZON WIRELESS	07/25/19	564.21
00739655	79537	WAVELENGTH COMMERCIAL COMMUNIC	07/25/19	548.00
00739656	13822	XCEL ENERGY	07/25/19	935.95
00739657	13822	XCEL ENERGY	07/25/19	18.81
00739658	44930	U S POSTAL SERVICE	07/25/19	30,172.14
			Fund Total	**1,523,897.74**

4 Capital Facilities Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00005420	104910	SAUNDERS CONSTRUCTION INC	07/23/19	1,874,474.84
00739634	40395	KUMAR & ASSOCIATES INC	07/25/19	1,100.00
			Fund Total	**1,875,574.84**

5 Golf Course Enterprise Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739607	1087	ACUITY SPECIALTY PRODUCTS INC	07/25/19	163.68
00739611	12012	ALSCO AMERICAN INDUSTRIAL	07/25/19	95.52
00739616	13206	C P S DISTRIBUTORS INC	07/25/19	243.67
00739623	13404	E & G TERMINAL INC	07/25/19	392.98
00739627	160270	GOLF & SPORT SOLUTIONS	07/25/19	1,903.78
00739628	804964	GRAINGER	07/25/19	453.56
00739636	11496	L L JOHNSON DIST	07/25/19	666.63
00739648	47140	TORO NSN	07/25/19	229.00
			Fund Total	**4,148.82**

13 Road & Bridge Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739522	9507	ALLIED RECYCLED AGGREGATES	07/23/19	8,367.06
00739527	8909	BRANNAN SAND & GRAVEL COMPANY	07/23/19	12,922.68
00739540	13569	ENVIROTECH SERVICES INC	07/23/19	49,621.95
00739541	534975	EP&A ENVIROTAC INC	07/23/19	58,831.25
00739544	212385	GMCO CORPORATION	07/23/19	50,786.69
00739554	506641	JK TRANSPORTS INC	07/23/19	495.00
00739573	1007	UNITED POWER (UNION REA)	07/23/19	23.16
00739574	1007	UNITED POWER (UNION REA)	07/23/19	48.65
00739575	1007	UNITED POWER (UNION REA)	07/23/19	33.00
00739576	1007	UNITED POWER (UNION REA)	07/23/19	20.00
00739577	1007	UNITED POWER (UNION REA)	07/23/19	16.50
00739578	1007	UNITED POWER (UNION REA)	07/23/19	140.29
00739579	1007	UNITED POWER (UNION REA)	07/23/19	34.00
00739580	1007	UNITED POWER (UNION REA)	07/23/19	138.92
00739581	1007	UNITED POWER (UNION REA)	07/23/19	88.49
00739582	1007	UNITED POWER (UNION REA)	07/23/19	36.00
00739583	1007	UNITED POWER (UNION REA)	07/23/19	152.38
00739584	1007	UNITED POWER (UNION REA)	07/23/19	42.60
00739585	1007	UNITED POWER (UNION REA)	07/23/19	171.87
00739586	1007	UNITED POWER (UNION REA)	07/23/19	16.50
00739587	1007	UNITED POWER (UNION REA)	07/23/19	16.50
00739588	1007	UNITED POWER (UNION REA)	07/23/19	33.00
00739589	1007	UNITED POWER (UNION REA)	07/23/19	48.65
00739591	13082	W L CONTRACTORS INC	07/23/19	6,184.27
00739597	13822	XCEL ENERGY	07/23/19	92.93
00739598	13822	XCEL ENERGY	07/23/19	107.63
00739599	13822	XCEL ENERGY	07/23/19	99.76
00739600	13822	XCEL ENERGY	07/23/19	294.26
00739601	13822	XCEL ENERGY	07/23/19	65.00
00739602	13822	XCEL ENERGY	07/23/19	20,684.91
00739603	13822	XCEL ENERGY	07/23/19	4,490.64
00739604	13822	XCEL ENERGY	07/23/19	108.46
00739605	13822	XCEL ENERGY	07/23/19	42.95
			Fund Total	**214,255.95**

19 Insurance Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739523	133729	ALLSTATE INSURANCE CO	07/23/19	8,218.71
00739530	419839	CAREHERE LLC	07/23/19	84,185.77
00739534	2157	COLO OCCUPATIONAL MEDICINE PHY	07/23/19	796.00
00739545	515095	HAYS COMPANIES	07/23/19	26,050.28
00739560	13880	SHERER AUTO PARTS	07/23/19	325.00
00739592	13082	W L CONTRACTORS INC	07/23/19	17,018.95
00739593	377265	WEATHERCALL SERVICES LLC	07/23/19	2,318.95
			Fund Total	**138,913.66**

25 Waste Management Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739558	433702	QUANTUM WATER CONSULTING	07/23/19	16,688.28
00739642	433702	QUANTUM WATER CONSULTING	07/25/19	14,464.37
			Fund Total	**31,152.65**

43 Colorado Air & Space Port

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00739521	887751	AIR METHODS CORP	07/23/19	2,609.05
00739537	255001	COPYCO QUALITY PRINTING INC	07/23/19	129.96
00739590	80279	VERIZON WIRELESS	07/23/19	500.13
00739631	204737	JVIATION INC	07/25/19	2,109.00
			Fund Total	**5,348.14**

Grand Total	**3,793,291.80**

2051	ANS - Administration	Fund	Voucher	Batch No	GL Date	Amount
	Animal Control/Shelter					
	BUA ERIC	00001	956843	342862	07/23/19	100.00
	REAMS MEGAN	00001	956842	342862	07/23/19	115.00
					Account Total	215.00
					Department Total	215.00

1024	Budget Office	Fund	Voucher	Batch No	GL Date	Amount
	Education & Training					
	MESA COUNTY	00001	956850	342876	07/23/19	1,400.00
					Account Total	1,400.00
					Department Total	1,400.00

4	Capital Facilities Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	KUMAR & ASSOCIATES INC	00004	957073	342987	07/24/19	1,100.00
	SAUNDERS CONSTRUCTION INC	00004	956709	342661	07/19/19	957,068.89
	SAUNDERS CONSTRUCTION INC	00004	956845	342857	07/23/19	1,016,062.52
					Account Total	1,974,231.41
	Retainages Payable					
	SAUNDERS CONSTRUCTION INC	00004	956709	342661	07/19/19	47,853.44-
	SAUNDERS CONSTRUCTION INC	00004	956845	342857	07/23/19	50,803.13-
					Account Total	98,656.57-
					Department Total	1,875,574.84

43	Colorado Air & Space Port	Fund	Voucher	Batch No	GL Date	Amount
	Office Deposits					
	AIR METHODS CORP	00043	956783	342759	07/22/19	3,109.05
					Account Total	3,109.05
	Received not Vouchered Clrg					
	JVIATION INC	00043	957099	343070	07/25/19	2,109.00
					Account Total	2,109.00
					Department Total	5,218.05

1010	Communications	Fund	Voucher	Batch No	GL Date	Amount
	Postage & Freight					
	U S POSTAL SERVICE	00001	957118	343073	07/25/19	30,172.14
					Account Total	30,172.14
					Department Total	30,172.14

1013	County Attorney	Fund	Voucher	Batch No	GL Date	Amount
	Books					
	CENTER FOR EDUCATION & EMPLOYM	00001	956548	342413	07/17/19	124.95
					Account Total	124.95
	Court Reporting Transcripts					
	STEVENS KOENIG REPORTING	00001	956544	342413	07/17/19	270.00
	STEVENS KOENIG REPORTING	00001	956545	342413	07/17/19	453.60
	STEVENS KOENIG REPORTING	00001	956546	342413	07/17/19	400.80
					Account Total	1,124.40
	Messenger/Delivery Service					
	FEDERAL EXPRESS CO	00001	956547	342413	07/17/19	200.07
					Account Total	200.07
	Other Professional Serv					
	ARAPAHOE COUNTY SHERIFF CIVIL	00001	956542	342413	07/17/19	40.00
	ARAPAHOE COUNTY SHERIFF CIVIL	00001	956543	342413	07/17/19	42.50
	COLORADO COMMUNITY MEDIA	00001	956536	342413	07/17/19	20.88
	DENVER COUNTY SHERIFF	00001	956540	342413	07/17/19	48.20
	I70 PUBLISHING CO INC	00001	956552	342413	07/17/19	23.76
	I70 PUBLISHING CO INC	00001	956553	342413	07/17/19	22.44
	JEFFERSON COUNTY SHERIFF	00001	956538	342413	07/17/19	45.50
	JEFFERSON COUNTY SHERIFF	00001	956539	342413	07/17/19	10.00
	JEFFERSON COUNTY SHERIFF	00001	956541	342413	07/17/19	40.00
	LARIMER COUNTY SHERIFF	00001	956537	342413	07/17/19	25.40
	METROWEST NEWSPAPERS	00001	956551	342413	07/17/19	55.44
					Account Total	374.12
					Department Total	1,823.54

2031	County Coroner	Fund	Voucher	Batch No	GL Date	Amount
	Medical Services					
	HOLMES DAWN B	00001	956835	342790	07/22/19	5,125.00
	HOLMES DAWN B	00001	956836	342790	07/22/19	3,075.00
					Account Total	8,200.00
					Department Total	8,200.00

1074	CA- Risk Management	Fund	Voucher	Batch No	GL Date	Amount
	Safety - Training					
	WEATHERCALL SERVICES LLC	00019	956549	342413	07/17/19	2,318.95
					Account Total	2,318.95
	Safety-Drug & Al Test/Med Cert					
	COLO OCCUPATIONAL MEDICINE PHY	00019	956554	342413	07/17/19	796.00
					Account Total	796.00
					Department Total	3,114.95

4302	CASP Administration	Fund	Voucher	Batch No	GL Date	Amount
	Operating Supplies					
	COPYCO QUALITY PRINTING INC	00043	956785	342759	07/22/19	64.98
					Account Total	64.98
	Telephone					
	VERIZON WIRELESS	00043	956786	342759	07/22/19	460.12
					Account Total	460.12
					Department Total	525.10

4303	CASP FBO	Fund	Voucher	Batch No	GL Date	Amount
	Operating Supplies					
	COPYCO QUALITY PRINTING INC	00043	956785	342759	07/22/19	64.98
					Account Total	64.98
	Telephone					
	VERIZON WIRELESS	00043	956786	342759	07/22/19	40.01
					Account Total	40.01
					Department Total	104.99

4304	CASP Operations/Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Building Repair & Maint					
	AIR METHODS CORP	00043	956783	342759	07/22/19	500.00-
					Account Total	500.00-
					Department Total	500.00-

1051	District Attorney	Fund	Voucher	Batch No	GL Date	Amount
	Membership Dues					
	COLO INFORMATION SHARING CONSO	00001	956877	342882	07/23/19	363.37
	COLO INFORMATION SHARING CONSO	00001	956877	342882	07/23/19	320.00
					Account Total	683.37
	Witness Fees					
	ADCO DISTRICT ATTORNEY'S OFFIC	00001	956876	342882	07/23/19	42.40
	ADCO DISTRICT ATTORNEY'S OFFIC	00001	956876	342882	07/23/19	67.64
	ADCO DISTRICT ATTORNEY'S OFFIC	00001	956876	342882	07/23/19	8.07
	ADCO DISTRICT ATTORNEY'S OFFIC	00001	956876	342882	07/23/19	137.53
	ADCO DISTRICT ATTORNEY'S OFFIC	00001	956876	342882	07/23/19	65.18
	ADCO DISTRICT ATTORNEY'S OFFIC	00001	956876	342882	07/23/19	72.99
					Account Total	393.81
					Department Total	1,077.18

1091	FO - Administration	Fund	Voucher	Batch No	GL Date	Amount
	Building Rental					
	IC CHAMBERS LP	00001	956727	342695	07/19/19	6,838.90
	WESTAR REAL PROPERTY SERVICES	00001	956731	342695	07/19/19	13,598.25
					Account Total	20,437.15
	Gas & Electricity					
	Energy Cap Bill ID=9736	00001	956770	342754	07/11/19	169.29
					Account Total	169.29
					Department Total	20,606.44

1075	FO - Administration Bldg	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=9731	00001	956767	342754	07/09/19	85.22
	Energy Cap Bill ID=9733	00001	956768	342754	07/08/19	1,563.24
					Account Total	1,648.46
					Department Total	1,648.46

1060	FO - Community Corrections	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=9724	00001	956757	342754	07/03/19	4,594.88
					Account Total	4,594.88
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=9735	00001	956758	342754	07/13/19	419.90
					Account Total	419.90
					Department Total	5,014.78

1114	FO - District Attorney Bldg.	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=9732	00001	956772	342754	07/05/19	4,658.33
					Account Total	4,658.33
					Department Total	4,658.33

1077	FO - Government Center	Fund	Voucher	Batch No	GL Date	Amount
	Building Repair & Maint					
	AUTOMATED BUILDING SOLUTIONS I	00001	956735	342695	07/19/19	2,550.00
	CUMMINS ROCKY MOUNTAIN	00001	956725	342695	07/19/19	636.63
	CUMMINS ROCKY MOUNTAIN	00001	956726	342695	07/19/19	696.17
					Account Total	3,882.80
	Grounds Maintenance					
	REPUBLIC SERVICES #535	00001	956732	342695	07/19/19	540.00
					Account Total	540.00
					Department Total	4,422.80

1070	FO - Honnen/Plan&Devel/MV Ware	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=9722	00001	956760	342754	07/05/19	576.79
	Energy Cap Bill ID=9723	00001	956761	342754	07/05/19	510.35
	XCEL ENERGY	00001	956737	342695	07/19/19	459.21
					Account Total	1,546.35
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=9725	00001	956762	342754	07/13/19	25.20
	Energy Cap Bill ID=9726	00001	956763	342754	07/13/19	46.97
	Energy Cap Bill ID=9727	00001	956764	342754	07/13/19	46.97
	Energy Cap Bill ID=9729	00001	956765	342754	07/13/19	1,402.91
	SOUTH ADAMS WATER & SANITATION	00001	956736	342695	07/19/19	588.35
					Account Total	2,110.40
					Department Total	3,656.75

1071	FO - Justice Center	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=9730	00001	956766	342754	07/05/19	14,391.33
					Account Total	14,391.33
					Department Total	14,391.33

1072	FO - West Service Center	Fund	Voucher	Batch No	GL Date	Amount
	Repair & Maint Supplies					
	REPUBLIC SERVICES #535	00001	956734	342695	07/19/19	270.00
					Account Total	270.00
	Water/Sewer/Sanitation					
	REPUBLIC SERVICES #535	00001	956734	342695	07/19/19	542.38
					Account Total	542.38
					Department Total	812.38

1076	FO-Adams County Service Center	Fund	Voucher	Batch No	GL Date	Amount
	Building Repair & Maint					
	SOUTHWESTERN PAINTING	00001	956728	342695	07/19/19	3,549.00
					Account Total	3,549.00
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=9728	00001	956769	342754	07/13/19	4,563.34
	REPUBLIC SERVICES #535	00001	956729	342695	07/19/19	233.69
					Account Total	4,797.03
					Department Total	8,346.03

1069	FO-Animal Shelter Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=9734	00001	956759	342754	07/04/19	705.29
					Account Total	705.29
					Department Total	705.29

1112	FO-Sheriff HQ/Coroner Building	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	REPUBLIC SERVICES #535	00001	956730	342695	07/19/19	166.92
					Account Total	166.92
					Department Total	166.92

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	ADAMSON POLICE PRODUCTS	00001	957074	342987	07/24/19	85.00
	ADAMSON POLICE PRODUCTS	00001	957075	342987	07/24/19	129.47
	ADAMSON POLICE PRODUCTS	00001	957076	342987	07/24/19	5,595.00
	ADAMSON POLICE PRODUCTS	00001	957077	342987	07/24/19	274.85
	ADAMSON POLICE PRODUCTS	00001	957078	342987	07/24/19	431.85
	ADAMSON POLICE PRODUCTS	00001	957079	342987	07/24/19	97.99
	ADAMSON POLICE PRODUCTS	00001	957080	342987	07/24/19	531.25
	ADAMSON POLICE PRODUCTS	00001	957081	342987	07/24/19	86.40
	ADAMSON POLICE PRODUCTS	00001	957082	342987	07/24/19	2,648.75
	ADAMSON POLICE PRODUCTS	00001	957083	342987	07/24/19	368.75
	ALLIED UNIVERSAL SECURITY SERV	00001	957084	342987	07/24/19	3,476.52
	AUTOMATED BUILDING SOLUTIONS I	00001	957085	342987	07/24/19	4,855.00
	BI INCORPORATED	00001	957086	342987	07/24/19	4,012.86
	BI INCORPORATED	00001	957086	342987	07/24/19	2,995.30
	BIG PAULIE PRODUCTIONS LLC	00001	956781	342757	07/22/19	10,500.00
	CHEMATOX LABORATORY INC	00001	957088	342987	07/24/19	222.00
	CHEMATOX LABORATORY INC	00001	957088	342987	07/24/19	197.00
	CHEMATOX LABORATORY INC	00001	957089	342987	07/24/19	2,333.00
	COMMUNITY REACH CENTER	00001	957087	342987	07/24/19	52,773.08
	DELL PREFERRED ACCOUNT	00001	957090	342987	07/24/19	12,383.20
	FOUND MY KEYS	00001	957091	342987	07/24/19	580.00
	FOUND MY KEYS	00001	957092	342987	07/24/19	1,104.00
	GALLS LLC	00001	956882	342945	07/24/19	1,255.00
	GALLS LLC	00001	956883	342945	07/24/19	159.92
	GALLS LLC	00001	956884	342945	07/24/19	169.95
	GALLS LLC	00001	956885	342945	07/24/19	736.54
	GALLS LLC	00001	956886	342945	07/24/19	307.27
	GALLS LLC	00001	956887	342945	07/24/19	158.85
	GALLS LLC	00001	956888	342945	07/24/19	248.50
	GALLS LLC	00001	956889	342945	07/24/19	462.78
	GALLS LLC	00001	956891	342945	07/24/19	106.60
	GALLS LLC	00001	956892	342945	07/24/19	277.64
	GALLS LLC	00001	956893	342945	07/24/19	7,005.02
	GALLS LLC	00001	956895	342945	07/24/19	232.44
	GALLS LLC	00001	956896	342945	07/24/19	121.95

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	GALLS LLC	00001	956897	342945	07/24/19	83.18
	GALLS LLC	00001	956898	342945	07/24/19	227.88
	GALLS LLC	00001	956899	342945	07/24/19	407.49
	GALLS LLC	00001	956900	342945	07/24/19	582.62
	GALLS LLC	00001	956902	342945	07/24/19	496.86
	GALLS LLC	00001	956903	342945	07/24/19	321.16
	GALLS LLC	00001	956904	342945	07/24/19	5.25
	GALLS LLC	00001	956905	342945	07/24/19	119.95
	GALLS LLC	00001	956906	342945	07/24/19	414.11
	GALLS LLC	00001	956908	342945	07/24/19	230.83
	GALLS LLC	00001	956909	342945	07/24/19	201.68
	GALLS LLC	00001	956910	342945	07/24/19	99.99
	GALLS LLC	00001	956937	342945	07/24/19	1,162.20
	GALLS LLC	00001	956938	342945	07/24/19	380.78
	GALLS LLC	00001	956941	342945	07/24/19	108.92
	GALLS LLC	00001	956942	342945	07/24/19	41.95
	GALLS LLC	00001	956943	342945	07/24/19	113.94
	GALLS LLC	00001	956944	342945	07/24/19	60.00
	GALLS LLC	00001	956945	342945	07/24/19	578.71
	GALLS LLC	00001	956946	342945	07/24/19	160.72
	GALLS LLC	00001	956947	342945	07/24/19	40.64
	GALLS LLC	00001	956948	342945	07/24/19	196.49
	GALLS LLC	00001	956949	342945	07/24/19	13.49
	GALLS LLC	00001	956955	342956	07/24/19	89.24
	GALLS LLC	00001	956956	342956	07/24/19	199.96
	GALLS LLC	00001	956957	342956	07/24/19	136.48
	GALLS LLC	00001	956959	342956	07/24/19	189.42
	GALLS LLC	00001	956960	342956	07/24/19	144.38
	GALLS LLC	00001	956961	342956	07/24/19	108.92
	GALLS LLC	00001	956965	342956	07/24/19	274.00
	GALLS LLC	00001	956966	342956	07/24/19	323.07
	GALLS LLC	00001	956967	342956	07/24/19	293.34
	GALLS LLC	00001	956968	342956	07/24/19	123.54
	GALLS LLC	00001	956969	342956	07/24/19	120.42
	GALLS LLC	00001	956970	342956	07/24/19	117.49
	GALLS LLC	00001	956971	342956	07/24/19	151.26

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	GALLS LLC	00001	956972	342956	07/24/19	403.55
	GALLS LLC	00001	956973	342956	07/24/19	341.82
	GALLS LLC	00001	956974	342956	07/24/19	39.00
	GALLS LLC	00001	956977	342956	07/24/19	840.00
	GALLS LLC	00001	956978	342956	07/24/19	133.42
	GALLS LLC	00001	956979	342956	07/24/19	106.60
	GALLS LLC	00001	956980	342956	07/24/19	106.60
	GALLS LLC	00001	956981	342956	07/24/19	215.17
	GALLS LLC	00001	956982	342956	07/24/19	108.92
	GALLS LLC	00001	956983	342956	07/24/19	566.85
	GALLS LLC	00001	956984	342956	07/24/19	188.00
	GALLS LLC	00001	956985	342956	07/24/19	13.18
	GALLS LLC	00001	956986	342956	07/24/19	108.92
	GALLS LLC	00001	956987	342956	07/24/19	167.98
	GALLS LLC	00001	956988	342956	07/24/19	45.13
	GALLS LLC	00001	956989	342956	07/24/19	115.90
	GALLS LLC	00001	956990	342956	07/24/19	50.95
	GALLS LLC	00001	956995	342956	07/24/19	208.38
	GALLS LLC	00001	956995	342956	07/24/19	118.32
	GALLS LLC	00001	956996	342956	07/24/19	53.96
	GALLS LLC	00001	956998	342956	07/24/19	89.00
	GALLS LLC	00001	957003	342956	07/24/19	23.98
	GALLS LLC	00001	957004	342956	07/24/19	53.30
	GALLS LLC	00001	957005	342956	07/24/19	171.18
	GALLS LLC	00001	957006	342956	07/24/19	133.50
	GALLS LLC	00001	957055	342956	07/24/19	79.38
	GALLS LLC	00001	957007	342956	07/24/19	502.50
	GALLS LLC	00001	957007	342956	07/24/19	502.50
	GALLS LLC	00001	957009	342956	07/24/19	111.36
	GALLS LLC	00001	957019	342956	07/24/19	298.50
	GALLS LLC	00001	957020	342956	07/24/19	302.45
	GALLS LLC	00001	957021	342956	07/24/19	370.65
	GALLS LLC	00001	957022	342956	07/24/19	185.00
	GALLS LLC	00001	957023	342956	07/24/19	108.92
	GALLS LLC	00001	957024	342956	07/24/19	51.25
	GALLS LLC	00001	957025	342956	07/24/19	410.00

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	GALLS LLC	00001	957037	342956	07/24/19	248.22
	GALLS LLC	00001	957038	342956	07/24/19	109.98
	GALLS LLC	00001	957039	342956	07/24/19	23.98
	GALLS LLC	00001	957040	342956	07/24/19	249.54
	GALLS LLC	00001	957041	342956	07/24/19	58.95
	GALLS LLC	00001	957043	342956	07/24/19	242.03
	GALLS LLC	00001	957044	342956	07/24/19	366.86
	GALLS LLC	00001	957046	342956	07/24/19	69.95
	GALLS LLC	00001	957047	342956	07/24/19	149.50
	GALLS LLC	00001	957048	342956	07/24/19	1,211.50
	GALLS LLC	00001	957049	342956	07/24/19	136.13
	GALLS LLC	00001	957050	342956	07/24/19	124.77
	GALLS LLC	00001	957051	342956	07/24/19	99.73
	GALLS LLC	00001	957052	342956	07/24/19	344.80
	GALLS LLC	00001	957052	342956	07/24/19	57.06
	GALLS LLC	00001	957052	342956	07/24/19	113.94
	GALLS LLC	00001	957055	342956	07/24/19	70.12
	GALLS LLC	00001	957055	342956	07/24/19	299.00
	GALLS LLC	00001	957055	342956	07/24/19	149.50
	GALLS LLC	00001	957058	342956	07/24/19	196.23
	GALLS LLC	00001	957058	342956	07/24/19	129.30
	GALLS LLC	00001	957060	342956	07/24/19	192.44
	GALLS LLC	00001	957060	342956	07/24/19	28.61
	GALLS LLC	00001	957061	342956	07/24/19	958.56
	GALLS LLC	00001	957062	342956	07/24/19	113.94
	HELTON & WILLIAMSEN PC	00001	957094	342987	07/24/19	1,760.86
	HILL & ROBBINS	00001	956851	342879	07/23/19	1,221.25
	JACHIMIAK PETERSON LLC	00001	956853	342879	07/23/19	30.00
	JACHIMIAK PETERSON LLC	00001	956853	342879	07/23/19	26,841.92
	KD SERVICE GROUP	00001	957100	343070	07/25/19	170.75
	KD SERVICE GROUP	00001	957101	343070	07/25/19	375.63
	KD SERVICE GROUP	00001	957102	343070	07/25/19	694.23
	KUMAR & ASSOCIATES INC	00001	957072	342987	07/24/19	2,359.25
	MWI VETERINARY SUPPLY CO	00001	957103	343070	07/25/19	114.01
	MWI VETERINARY SUPPLY CO	00001	957104	343070	07/25/19	476.71
	MWI VETERINARY SUPPLY CO	00001	957105	343070	07/25/19	49.80

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	PRUDENTIAL OVERALL SUPPLY	00001	957106	343070	07/25/19	55.28
	REDDY ICE CORPORATION	00001	957071	342987	07/24/19	8,860.00
	REDDY ICE CORPORATION	00001	957071	342987	07/24/19	1,050.00
	SAFEWARE INC	00001	957107	343070	07/25/19	2,996.67
	SAUNDERS CONSTRUCTION INC	00001	956707	342661	07/19/19	753,923.66
	SAUNDERS CONSTRUCTION INC	00001	956841	342857	07/23/19	461,954.31
	SHERMAN & HOWARD LLC	00001	956852	342879	07/23/19	850.00
	SOUTHWESTERN PAINTING	00001	957108	343070	07/25/19	6,960.00
	SOUTHWESTERN PAINTING	00001	957109	343070	07/25/19	2,828.00
	SOUTHWESTERN PAINTING	00001	957110	343070	07/25/19	1,948.00
	SOUTHWESTERN PAINTING	00001	957111	343070	07/25/19	1,490.00
	SUMMIT FOOD SERVICE LLC	00001	957112	343070	07/25/19	27,611.79
	SUMMIT FOOD SERVICE LLC	00001	957113	343070	07/25/19	4,897.44
	TOSHIBA FINANCIAL SERVICES	00001	957114	343070	07/25/19	2,871.02
	TOSHIBA FINANCIAL SERVICES	00001	957114	343070	07/25/19	1,506.04
	TOSHIBA FINANCIAL SERVICES	00001	957114	343070	07/25/19	187.44
	TOSHIBA FINANCIAL SERVICES	00001	957114	343070	07/25/19	822.76
	TYGRETT DEBRA R	00001	957115	343070	07/25/19	347.00
	TYGRETT DEBRA R	00001	957116	343070	07/25/19	347.00
	ZOETIS US LLC	00001	956875	342879	07/23/19	188.20
	ZOETIS US LLC	00001	956875	342879	07/23/19	123.60
					Account Total	1,454,227.47
	Retainages Payable					
	SAUNDERS CONSTRUCTION INC	00001	956707	342661	07/19/19	37,696.18-
	SAUNDERS CONSTRUCTION INC	00001	956841	342857	07/23/19	23,097.72-
					Account Total	60,793.90-
					Department Total	1,393,433.57

5026	Golf Course- Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Grounds Maintenance					
	C P S DISTRIBUTORS INC	00005	956650	342549	07/18/19	167.50
	C P S DISTRIBUTORS INC	00005	956651	342549	07/18/19	76.17
	GOLF & SPORT SOLUTIONS	00005	957067	342979	07/24/19	1,903.78
	TORO NSN	00005	956658	342549	07/18/19	229.00
					Account Total	2,376.45
	Repair & Maint Supplies					
	ACUITY SPECIALTY PRODUCTS INC	00005	957065	342979	07/24/19	163.68
	ALSCO AMERICAN INDUSTRIAL	00005	956649	342549	07/18/19	47.76
	ALSCO AMERICAN INDUSTRIAL	00005	957066	342979	07/24/19	47.76
					Account Total	259.20
	Vehicle Parts & Supplies					
	E & G TERMINAL INC	00005	956652	342549	07/18/19	392.98
	GRAINGER	00005	957068	342979	07/24/19	453.56
	L L JOHNSON DIST	00005	956653	342549	07/18/19	22.80
	L L JOHNSON DIST	00005	956654	342549	07/18/19	73.79
	L L JOHNSON DIST	00005	956655	342549	07/18/19	130.10
	L L JOHNSON DIST	00005	956656	342549	07/18/19	66.74
	L L JOHNSON DIST	00005	956657	342549	07/18/19	373.20
					Account Total	1,513.17
					Department Total	4,148.82

1079	Human Services Center	Fund	Voucher	Batch No	GL Date	Amount
	Building Repair & Maint					
	ET TECHNOLOGIES INC	00001	956733	342695	07/19/19	1,873.50
					Account Total	1,873.50
					Department Total	1,873.50

19	Insurance Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	CAREHERE LLC	00019	956854	342879	07/23/19	9,269.00
	CAREHERE LLC	00019	956854	342879	07/23/19	9,342.00
	CAREHERE LLC	00019	956855	342879	07/23/19	9,269.00
	CAREHERE LLC	00019	956855	342879	07/23/19	9,342.00
	CAREHERE LLC	00019	956856	342879	07/23/19	577.11
	CAREHERE LLC	00019	956856	342879	07/23/19	5,755.62
	CAREHERE LLC	00019	956856	342879	07/23/19	2,152.29
	CAREHERE LLC	00019	956856	342879	07/23/19	18,747.94
	CAREHERE LLC	00019	956857	342879	07/23/19	269.98
	CAREHERE LLC	00019	956857	342879	07/23/19	4,175.89
	CAREHERE LLC	00019	956857	342879	07/23/19	1,028.20
	CAREHERE LLC	00019	956857	342879	07/23/19	14,256.74
	HAYS COMPANIES	00019	956858	342879	07/23/19	26,050.28
					Account Total	110,236.05
					Department Total	110,236.05

8611	Insurance- Property/Casualty	Fund	Voucher	Batch No	GL Date	Amount
	Auto Physical Damage					
	ALLSTATE INSURANCE CO	00019	956555	342413	07/17/19	8,218.71
	SHERER AUTO PARTS	00019	956550	342413	07/17/19	325.00
					Account Total	8,543.71
	Prop Claims-Under Deduct					
	W L CONTRACTORS INC	00019	956634	342539	07/18/19	17,018.95
					Account Total	17,018.95
					Department Total	25,562.66

1058	IT Network/Telecom	Fund	Voucher	Batch No	GL Date	Amount
	ISP Services					
	COMCAST BUSINESS	00001	956847	342866	07/23/19	2,100.00
					Account Total	2,100.00
					Department Total	2,100.00

1111	Parks Facilities	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	Energy Cap Bill ID=9721	00001	956771	342754	07/05/19	100.20
					Account Total	100.20
					Department Total	100.20

1015	People Services	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	JEFFERSON COUNTY TREASURER	00001	956721	342693	07/19/19	24.00
					Account Total	24.00
					Department Total	24.00

1039	Poverty Reduction	Fund	Voucher	Batch No	GL Date	Amount
	Operating Supplies					
	UNITED POWER (UNION REA)	00001	956834	342788	07/22/19	143.68
					Account Total	143.68
					Department Total	143.68

5011	PKS- Administration	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	UNITED SITE SERVICES	00001	956799	342762	07/22/19	180.00
					Account Total	180.00
					Department Total	180.00

5010	PKS- Fair	Fund	Voucher	Batch No	GL Date	Amount
	Fair Expenses-General					
	BRANDED IMAGE APPAREL	00001	956793	342762	07/22/19	2,425.00
	BRANDED IMAGE APPAREL	00001	956794	342762	07/22/19	801.00
	GARCIA SILVIANO	00001	956789	342761	07/22/19	1,100.00
					Account Total	4,326.00
	Other Communications					
	VERIZON WIRELESS	00001	956801	342762	07/22/19	564.21
					Account Total	564.21
	Regional Park Rentals					
	L L JOHNSON DIST	00001	956797	342762	07/22/19	150.00
	MORINE SHELLY	00001	956798	342762	07/22/19	75.00
					Account Total	225.00
	5K Run for Fair					
	BRANDED IMAGE APPAREL	00001	956795	342762	07/22/19	3,000.00
					Account Total	3,000.00
					Department Total	8,115.21

5012	PKS- Regional Complex	Fund	Voucher	Batch No	GL Date	Amount
	Operating Supplies					
	CINTAS FIRST AID & SAFETY	00001	956796	342762	07/22/19	189.41
					Account Total	189.41
					Department Total	189.41

5016	PKS- Trail Ranger Patrol	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	XCEL ENERGY	00001	956802	342762	07/22/19	935.95
	XCEL ENERGY	00001	956803	342762	07/22/19	18.81
					Account Total	954.76
	Water/Sewer/Sanitation					
	UNITED SITE SERVICES	00001	956800	342762	07/22/19	338.87
					Account Total	338.87
					Department Total	1,293.63

13	Road & Bridge Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	ALLIED RECYCLED AGGREGATES	00013	956859	342879	07/23/19	1,980.73
	ALLIED RECYCLED AGGREGATES	00013	956860	342879	07/23/19	6,386.33
	BRANNAN SAND & GRAVEL COMPANY	00013	956861	342879	07/23/19	679.98
	BRANNAN SAND & GRAVEL COMPANY	00013	956861	342879	07/23/19	270.60
	BRANNAN SAND & GRAVEL COMPANY	00013	956862	342879	07/23/19	11,972.10
	ENVIROTECH SERVICES INC	00013	956863	342879	07/23/19	49,621.95
	EP&A ENVIROTAC INC	00013	956864	342879	07/23/19	58,831.25
	GMCO CORPORATION	00013	956865	342879	07/23/19	8,782.77
	GMCO CORPORATION	00013	956866	342879	07/23/19	15,729.00
	GMCO CORPORATION	00013	956867	342879	07/23/19	15,729.00
	GMCO CORPORATION	00013	956868	342879	07/23/19	10,545.92
	JK TRANSPORTS INC	00013	956869	342879	07/23/19	495.00
	W L CONTRACTORS INC	00013	956874	342879	07/23/19	6,184.27
					Account Total	187,208.90
					Department Total	187,208.90

2004	Sheriff Training	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	956704	342657	07/19/19	81.01
					Account Total	81.01
	Other Professional Serv					
	WAVELENGTH COMMERCIAL COMMUNIC	00001	956720	342657	07/19/19	548.00
					Account Total	548.00
					Department Total	629.01

2008	SHF - Training Academy	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	956704	342657	07/19/19	37.38
					Account Total	37.38
	Other Professional Serv					
	HOFFER MICHELLE L	00001	956702	342657	07/19/19	200.00
					Account Total	200.00
	Uniforms & Cleaning					
	PRO FORCE LAW ENFORCEMENT	00001	956703	342657	07/19/19	104.12
					Account Total	104.12
					Department Total	341.50

2011	SHF- Admin Services Division	Fund	Voucher	Batch No	GL Date	Amount
	Other Communications					
	VERIZON WIRELESS	00001	956705	342657	07/19/19	730.41
					Account Total	730.41
	Other Professional Serv					
	COLO OCCUPATIONAL MEDICINE PHY	00001	956699	342657	07/19/19	263.00
	POINT SPORTS/ERGOMED	00001	956700	342657	07/19/19	1,980.00
	TOSHIBA BUSINESS SOLUTIONS	00001	956704	342657	07/19/19	165.27
					Account Total	2,408.27
					Department Total	3,138.68

2015	SHF- Civil Section	Fund	Voucher	Batch No	GL Date	Amount
	Other Communications					
	VERIZON WIRELESS	00001	956705	342657	07/19/19	655.42
					Account Total	655.42
					Department Total	655.42

2075	SHF- Commissary Fund	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	956704	342657	07/19/19	92.33
					Account Total	92.33
					Department Total	92.33

2016	SHF- Detective Division	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	956704	342657	07/19/19	120.02
					Account Total	120.02
					Department Total	120.02

2071	SHF- Detention Facility	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	956704	342657	07/19/19	687.26
					Account Total	687.26
	Other Communications					
	VERIZON WIRELESS	00001	956705	342657	07/19/19	371.87
					Account Total	371.87
	Other Professional Serv					
	COLO OCCUPATIONAL MEDICINE PHY	00001	956699	342657	07/19/19	551.00
					Account Total	551.00
					Department Total	1,610.13

2081	SHF- Donated Programs	Fund	Voucher	Batch No	GL Date	Amount
	Special Events					
	GALLS LLC	00001	956701	342657	07/19/19	587.50
					Account Total	587.50
					Department Total	587.50

2072	SHF- Justice Center	Fund	Voucher	Batch No	GL Date	Amount
	Other Communications					
	VERIZON WIRELESS	00001	956705	342657	07/19/19	29.36
					Account Total	29.36
					Department Total	29.36

2010	SHF- MIS Unit	Fund	Voucher	Batch No	GL Date	Amount
	Other Communications					
	VERIZON WIRELESS	00001	956705	342657	07/19/19	102.58
					Account Total	102.58
					Department Total	102.58

2017	SHF- Patrol Division	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	956704	342657	07/19/19	74.74
					Account Total	74.74
	Other Communications					
	VERIZON WIRELESS	00001	956705	342657	07/19/19	1,272.56
					Account Total	1,272.56
					Department Total	1,347.30

2018	SHF- Records/Warrants Section	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	956704	342657	07/19/19	135.56
					Account Total	135.56
	Other Communications					
	VERIZON WIRELESS	00001	956705	342657	07/19/19	40.01
					Account Total	40.01
					Department Total	175.57

2005	SHF- TAC Section	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	956704	342657	07/19/19	27.68
					Account Total	27.68
	Other Communications					
	VERIZON WIRELESS	00001	956705	342657	07/19/19	270.09
					Account Total	270.09
					Department Total	297.77

3055	Transportation Streets Program	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	UNITED POWER (UNION REA)	00013	956567	342420	07/17/19	23.16
	UNITED POWER (UNION REA)	00013	956568	342420	07/17/19	48.65
	UNITED POWER (UNION REA)	00013	956569	342420	07/17/19	33.00
	UNITED POWER (UNION REA)	00013	956570	342420	07/17/19	20.00
	UNITED POWER (UNION REA)	00013	956571	342420	07/17/19	16.50
	UNITED POWER (UNION REA)	00013	956572	342420	07/17/19	140.29
	UNITED POWER (UNION REA)	00013	956573	342420	07/17/19	34.00
	UNITED POWER (UNION REA)	00013	956574	342420	07/17/19	138.92
	UNITED POWER (UNION REA)	00013	956575	342420	07/17/19	88.49
	UNITED POWER (UNION REA)	00013	956576	342420	07/17/19	36.00
	UNITED POWER (UNION REA)	00013	956577	342420	07/17/19	152.38
	UNITED POWER (UNION REA)	00013	956578	342420	07/17/19	42.60
	UNITED POWER (UNION REA)	00013	956579	342420	07/17/19	171.87
	UNITED POWER (UNION REA)	00013	956580	342420	07/17/19	16.50
	UNITED POWER (UNION REA)	00013	956581	342420	07/17/19	16.50
	UNITED POWER (UNION REA)	00013	956582	342420	07/17/19	33.00
	UNITED POWER (UNION REA)	00013	956583	342420	07/17/19	48.65
	XCEL ENERGY	00013	956557	342420	07/17/19	92.93
	XCEL ENERGY	00013	956558	342420	07/17/19	107.63
	XCEL ENERGY	00013	956559	342420	07/17/19	99.76
	XCEL ENERGY	00013	956560	342420	07/17/19	294.26
	XCEL ENERGY	00013	956561	342420	07/17/19	65.00
	XCEL ENERGY	00013	956562	342420	07/17/19	20,684.91
	XCEL ENERGY	00013	956563	342420	07/17/19	4,490.64
	XCEL ENERGY	00013	956564	342420	07/17/19	108.46
	XCEL ENERGY	00013	956565	342420	07/17/19	42.95
					Account Total	27,047.05
					Department Total	27,047.05

25	Waste Management Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	QUANTUM WATER CONSULTING	00025	956870	342879	07/23/19	1,811.48
	QUANTUM WATER CONSULTING	00025	956871	342879	07/23/19	4,314.68
	QUANTUM WATER CONSULTING	00025	956872	342879	07/23/19	10,562.12
	QUANTUM WATER CONSULTING	00025	957117	343070	07/25/19	14,464.37
					Account Total	31,152.65
					Department Total	31,152.65

Grand Total	**3,793,291.80**

Board of County Commissioners
Minutes of Commissioners' Proceedings

Eva J. Henry - District #1
Charles "Chaz" Tedesco - District #2
Emma Pinter - District #3
Steve O'Dorisio - District #4
Mary Hodge - District #5

Tuesday
July 23, 2019
9:30 AM

1. ROLL CALL

Rollcall

Present: 5 - Commissioner Henry, Commissioner Tedesco, Commissioner Pinter, Commissioner O'Dorisio, and Commissioner Hodge

2. PLEDGE OF ALLEGIANCE

3. MOTION TO APPROVE AGENDA

A motion was made by Commissioner Pinter, seconded by Commissioner Hodge, that this Agenda be approved. The motion carried by the following vote:

Aye: 5 - Commissioner Henry, Commissioner Tedesco, Commissioner Pinter, Commissioner O'Dorisio, and Commissioner Hodge

4. AWARDS AND PRESENTATIONS

A. Proclamation of July 24-30, 2019 as PD Aerospace Week

5. PUBLIC COMMENT

A. Citizen Communication

A total of 30 minutes is allocated at this time for public comment and each speaker will be limited to 3 minutes. If there are additional requests from the public to address the Board, time will be allocated at the end of the meeting to complete public comment. The chair requests that there be no public comment on issues for which a prior public hearing has been held before this Board.

B. Elected Officials' Communication

6. CONSENT CALENDAR

A motion was made by Commissioner Hodge, seconded by Commissioner Pinter, that this Consent Calendar be approved. The motion carried by the following vote:

Aye: 5 - Commissioner Henry, Commissioner Tedesco, Commissioner Pinter, Commissioner O'Dorisio, and Commissioner Hodge

A. List of Expenditures Under the Dates of July 8-12, 2019

B. Minutes of the Commissioners' Proceedings from July 16, 2019

C. Resolution Approving the Adams County Head Start Year Five of Five Continuation Grant Application for 2019-2020
(File approved by ELT)

D. Resolution Approving the Adams County 2019 Annual Action Plan
(File approved by ELT)

E. Resolution Approving an Amendment to the Action Plan for the Neighborhood Stabilization Program for Adams County
(File approved by ELT)

F. Resolution Approving Development Agreement between Adams County and TruStile Doors, LLC
(File approved by ELT)

G. Resolution Appointing Tim Bradsby to the Workforce Development Board as a Business Sector/Healthcare Representative
(File approved by ELT)

H. Resolution Appointing William Dowling to the Workforce Development Board as a Wagner Peyser Representative
(File approved by ELT)

I. Resolution Appointing Londell Jackson to the Workforce Development Board as a Business Sector Representative
(File approved by ELT)

J. Resolution Appointing Erika Rodriguez to the Workforce Development Board as a Labor Representative
(File approved by ELT)

K. Resolution Appointing Erika Sidles to the Workforce Development Board as a Business Sector Representative
(File approved by ELT)

7. NEW BUSINESS

A. COUNTY MANAGER

1. Resolution Approving Change Order One to the Agreement between Adams County and Whitestone Construction Services for the Government Center Employee Parking Lot Drainage Repairs
(File approved by ELT)
A motion was made by Commissioner Hodge, seconded by Commissioner Pinter, that this New Business be approved. The motion carried by the following vote:

Aye: 5 - Commissioner Henry, Commissioner Tedesco, Commissioner Pinter, Commissioner O'Dorisio, and Commissioner Hodge

B. COUNTY ATTORNEY

8. ADJOURNMENT

AND SUCH OTHER MATTERS OF PUBLIC BUSINESS WHICH MAY ARISE

ADAMS COUNTY PUBLIC TRUSTEE OPERATIONAL EXPENSE FOR THE QUARTER ENDING JUNE 2019

PERSONNEL SERVICES		
Salary - Permanent		49,681.87
Salary - Regular Part Time		2,863.63
Salary - Temporary Part Time		0.00
Overtime		0.00
	TOTAL	**52,545.50**
FRINGE BENEFITS		
Medical Insurance		8,467.50
Dental Insurance		129.18
Vision Insurance		20.64
Life Insurance		84.14
Disability Compensation		402.42
Retirement (PT Match)		4,471.36
Workmen's Compensation		328.74
Fica (PT Match)		3,089.66
Mcr (PT Match)		722.58
	TOTAL	**17,716.22**
OPERATING AND MAINTENANCE		
Operating Supplies		483.52
Special Events		0.00
Releases - Postage		100.55
Envelopes & Labels		0.00
Books & Forms		0.00
Subscriptions		0.00
Publications		300.00
	TOTAL	**884.07**
CHARGES FOR SERVICES		
Office Equipment - Planned		0.00
Equipment Maint. & Rental		60.00
Office Equipment (Planned)		0.00
Business Meetings		0.00
Mileage Reimbursement		0.00
Water		0.00
Misc Expense		0.00
Petty Cash Expense		0.00
Auditing & Accounting		11,895.00
Office Rent & Storage Unit - Transferred from excess PT Fees to Escrow Holding/Rent		0.00
Telephone		391.28
IT Support		0.00
Association Dues		0.00
Consultant - Non Recurring		0.00
Re-Recordings		66.00
Other Professional Service		0.00
Education & Training		0.00
Travel & Transportation		0.00
Insurance Premiums & Bonds		0.00
Computer Supplies/Upgrades		2,453.11
	TOTAL	**14,865.39**
CAPITAL OUTLAY		
Computer Software Purchases		0.00
Computer Hardware Purchases		0.00
Office Furniture & Equipment	**TOTAL**	**0.00**
TOTAL EXPENDITURES FOR QUARTER		**86,011.18**
RECONCILIATION		
General Expense CheckBook Balance over/under		$0.00
Total of Other Check Not Written - Transferred from excess PT Fess to Escrow Holding/Rent		$0.00
Credits - credit Consultanat Non-Recurring charged to foreclosure & credt to Travel/Mileage		$0.00
Less Deposits to Postage/Misc/ Copies Acct (adj entry $51.25 & $12.97 s/b from general exp)		$64.22
Re-Recordings for the quarter		$66.00
Total Deposits to General Exp. And Payroll Accounts		$85,880.96
	TOTAL	**$86,011.18**
	OVER/SHORT	0.00

PUBLIC TRUSTEE REVENUE FOR QUARTER ENDING JUNE, 2019

FORECLOSURE REVENUE:

	Foreclosure and Withdrawal Fees	**36,853.22**
TOTAL REVENUE COLLECTED FOR FORECLOSURES		**36,853.22**

PUBLIC TRUSTEE DOCUMENTS:

3	(Certificates of Redemption @ 30.00 each)	90.00
7	(Lienor Intents to Redeem @ 50.00 each)	350.00
40	(Public Trustee Deeds @ 30.00 each)	1,200.00
TOTAL REVENUE COLLECTED FOR FORECLOSURE DOCUMENTS		**1,640.00**

PUBLIC TRUSTEE RELEASE FEES:

5,911	(Releases executed @ 15.00 each)	**88,665.00**

PUBLIC TRUSTEE TAX ESCROW FEES

0	(PT tax escrow fees @ 75.00 each)	0.00
TOTAL OF ALL PUBLIC TRUSTEE FEES COLLECTED FOR THE 2ND QUARTER, 2019		**127,158.22**

OPERATIONAL EXPENSES FOR QUARTER

Personnel Services	**52,545.50**	
Fringe Benefits	**17,716.22**	
Operating & Maintenance	**0.00**	
Charges for Services	**15,749.46**	
Capital Outlay	**0.00**	
TOTAL OPERATIONAL EXPENSES		**86,011.18**

SUMMARY OF QUARTERLY TRANSACTIONS

Total Fees Collected for the Quarter	**127,158.22**
Transfer Excess PT Fees to Escrow Holding/Rent	**0.00**
4th Qtr adjustment overpaid Treasurer	**(2,468.19)**
Total Fees Collected for the Quarter	**0.00**
Less Operational Expenses for Quarter	**86,011.18**
BALANCE:	**38,678.85**
QUARTER ENDING BALANCE:	**38,678.85**

PUBLIC TRUSTEE REVENUE FOR QUARTER ENDING JUNE, 2019

FORECLOSURE REVENUE:

Foreclosure and Withdrawal Fees

TOTAL REVENUE COLLECTED FOR FORECLOSURES

PUBLIC TRUSTEE DOCUMENTS:

3 (Certificates of Redemption @ 30.00 each)

7 (Lienor Intents to Redeem @ 50.00 each)

40 (Public Trustee Deeds @ 30.00 each)

TOTAL REVENUE COLLECTED FOR FORECLOSURE DOCUMENTS

PUBLIC TRUSTEE RELEASE FEES:

5,911 (Releases executed @ 15.00 each)

PUBLIC TRUSTEE TAX ESCROW FEES

0 (PT tax escrow fees @ 75.00 each)

TOTAL OF ALL PUBLIC TRUSTEE FEES COLLECTED FOR THE 2ND QUARTER, 2019

OPERATIONAL EXPENSES FOR QUARTER

Personnel Services	**52,545.50**
Fringe Benefits	**17,716.22**
Operating & Maintenance	**0.00**
Charges for Services	**15,749.46**
Capital Outlay	**0.00**

TOTAL OPERATIONAL EXPENSES

SUMMARY OF QUARTERLY TRANSACTIONS

Total Fees Collected for the Quarter

Transfer Excess PT Fees to Escrow Holding/Rent

4th Qtr adjustment overpaid Treasurer

Total Fees Collected for the Quarter

Less Operational Expenses for Quarter

BALANCE:

QUARTER ENDING BALANCE:

DISPOSITION OF BALANCE OF PUBLIC TRUSTEE FEES COLLECTED 2ND QUARTER, 2019

QUARTER ENDING BALANCE	38,678.85
AMOUNT DEPOSITED WITH ADAMS COUNTY TREASURER	38,678.85
TRUSTEE ESCROW FUND PER C.R.S. 38-37-104	341,705.07

ENDING QUARTER BALANCES OF PUBLIC TRUSTEE ACCOUNTS

Copies & Misc. Accts (Beg. Bal 12401.24 + revenues 1725.70 - <998.32> expenses)	13,128.62
Postage Acct (Beg. Bal 5352.74 + 1935.75 revenues - <2780.69> expenses)	4,507.80
PT Escrow Fund Acct (Beg. Bal 339564.82 + 2140.25 Interest)	341,705.07

Susan A. Orecchio upon oath duly sworn deposes and says the information contained herein above is true and correct to the best of her knowledge

Susan A. Orecchio, Adams County Public Trustee

PUBLIC TRUSTEE
COUNTY OF ADAMS COLORADO

STATE OF COLORADO>

COUNTY OF ADAMS>

The foregoing was acknowledged before me on 7-19-18 by Susan A. Orecchio as the Public Trustee of Adams County, Colorado.

Subscribed and sworn to before me this 19th day of July, 2019

My Commission Expires: April 5, 2022

Notary Public

BONNIE KOVTYNOVICH
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19984005044
MY COMMISSION EXPIRES APRIL 5, 2022

ADAMS COUNTY BOARD OF COMMISIONERS APPROVAL

Dated:_____

_____

Chairman, Adams County Board of Commissioners

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: PLN2019-00005 - Pecos Logistics Park Metropolitan District
FROM: Jill Jennings Golich, Director, Community and Economic Development
AGENCY/DEPARTMENT: Community and Economic Development
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners sets a public hearing for August 27, 2019 in order to consider case PLN2019-00005.

BACKGROUND:

The applicant is requesting a service plan for the Pecos Logistics Park Metropolitan District (District) to provide funding for construction and maintenance of public services and facilities in the proposed service area. Pursuant to Title 32, Article 1 of Colorado Revised Statutes, Metropolitan Districts, a type of Special District providing two or more services, are quasi-governmental agencies and political subdivisions of the State of Colorado organized for specific functions. Special Districts commonly include fire protection, parks and recreation, or water and sanitation services.

The proposed District will provide financing for construction of required roadway and drainage infrastructure, as well as security and fire prevention services. The service area of the proposed district will include approximately 63 acres and is located northwest of the intersection of North Pecos Street and West 56th Avenue.

Pursuant to Section 10-05-02-03-07 of the County's Development Standards, at the next regular meeting of the Board of County Commissioners (BOCC) after the Planning Commission considers the request, a date shall be set within thirty days of such meeting for a public hearing on the service plan of the proposed Special District. Staff recommends August 27, 2019 as the set date for the public hearing for case PLN2019-00005 (Pecos Logistics Park Metropolitan District).

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Community and Economic Development, County Attorney, Finance Department.

ATTACHED DOCUMENTS:

Resolution
Service Plan for Pecos Logistics Park Metropolitan District

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

RESOLUTION SETTING THE SERVICE PLAN HEARING DATE FOR PECOS LOGISTICS PARK METROPOLITAN DISTRICT (PLN2019-00005)

WHEREAS, the Adams County Community and Economic Development Department has received a service plan for the Pecos Logistics Park Metropolitan District; and,

WHEREAS, the Planning Commission heard Case # PLN2019-000005 Pecos Logistics Park Metropolitan District and recommended approval of the service plan for the Pecos Logistics Park Metropolitan District with 9 Findings of Fact and 1 Condition; and,

WHEREAS, the August 6, 2019 BOCC consent calendar item is intended to officially set the second BOCC hearing date of August 27, 2019 per Title 32, Special Districts, Special District Act of the Colorado Revised Statutes.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the hearing date for the Pecos Logistics Park Metropolitan District service plan be hereby set for August 27, 2019 at 9:30 am at the Adams County Government Center Public Hearing Room.

SERVICE PLAN

FOR

PECOS LOGISTICS PARK METROPOLITAN DISTRICT

ADAMS COUNTY, COLORADO

Prepared By
SPENCER FANE, LLP
1700 Lincoln Street, Suite 2000
Denver, CO 80203

June 26, 2019

TABLE OF CONTENTS

LIST OF EXHIBITS

I. INTRODUCTION

A. Purpose and Intent

This service plan (the "Service Plan") for the Pecos Logistics Park Metropolitan District (the "District) is for a metropolitan district organized under Title 32 of the Colorado Revised Statutes to serve the public improvement and service needs of the nearly 63-acre commercial and industrial use redevelopment to be known as the Pecos Logistics Park (the "Project"). The Project is generally located at the northwest corner of W. 56th Avenue and Pecos Street, southwest of the intersection of Interstate 25 and Interstate 76 in unincorporated Adams County. The Project is being developed by Westfield Development Company, Inc. (the "Developer"), on behalf of Pecos Logistics Park, LLLP, the sole owner of all property within the District Boundaries.

The District is an independent unit of local government, separate and distinct from the County, and except as may otherwise be provided for by State or local law or this Service Plan, its activities are subject to review by the County only insofar as they may deviate in a material way from the requirements of this Service Plan. It is intended that the District will provide a part or all of the Public Improvements necessary and appropriate for the development of the property within the Service Area.

The Public Improvements will be constructed for the use and benefit of the public, generally, and the property owners and users within the Service Area, specifically. The primary purpose of the District will be to finance the construction of these Public Improvements.

The District is also expected to manage and oversee the permitted District Activities, and to collect property taxes and other legally available revenues sufficient for the debt service requirements of Debt issued to cover the costs associated with financing, acquisition and/or construction of the Public Improvements and to perform the District Activities.

B. Need for District

There are currently no other governmental entities, including the County, located in the immediate vicinity of the District that consider it desirable, feasible or practical to undertake the planning, design, acquisition, construction, installation, relocation, redevelopment and financing of the Public Improvements needed for the Project. Formation of the District is therefore necessary in order for the Public Improvements required for the Project to be provided in the most economic manner possible.

C. Organizers and Consultants

This Service Plan has been prepared with assistance from the following entities and individuals:

Proponent and Project Developer
Westfield Development Company, Inc.
4221 Brighton Blvd.
Denver, CO 80216

Legal Counsel
Spencer Fane LLP
Matthew R. Dalton, Esq.
Thomas N. George, Esq.
1700 Lincoln Street, Suite 2000
Denver, CO 80203

Financial Advisor
Stifel, Nicolaus & Company, Inc.
Michael Lund
125 17th Street, Suite 1600
Denver, CO 80202

Engineer
HR Green
Ryan Littleton
5619 DTC Parkway Suite 1150
Greenwood Village, CO 80111

Architect
Grey Wolf Architecture
Ken Harshman
1543 Champa Street, Suite 200
Denver, CO 80202

II. DEFINITIONS

In this Service Plan, the following terms shall have the meanings indicated below, unless the context hereof clearly requires otherwise:

Alternate Service Provider: means any other governmental service provider with jurisdiction over the Public Improvements.

Approved Development Plan: means an approved and final agreement or other process or documentation established by the County or other governmental entity with jurisdiction over the applicable Public Improvements that sets forth the requirements and timing associated for construction of the Public Improvements, as may be amended from time to time.

Board: means the board of directors of the District.

Board of County Commissioners: means the Board of County Commissioners of Adams County, Colorado.

County: means Adams County, Colorado.

Debt: means general obligation bonds or other financial obligations issued by the District, which are not subject to annual appropriation, the payment of which the District has promised to impose, collect and pledge an ad valorem property tax mill levy and/or fees or charges to be charged at the time of building permit.

Debt Limitation: means the maximum amount of Debt that the District may issue, subject to the provisions of this Service Plan. Increases necessary to accomplish a refunding, reissuance or restructuring of Debt shall not count towards the Debt Limitation. The Debt Limitation may be increased pursuant to a future intergovernmental agreement with the County.

Developer: means Westfield Development Company, Inc., a Colorado corporation, and its affiliates, successors or assigns.

District Activities: means any and all functions undertaken by the District in accordance with this Service Plan and as permitted under applicable law in order to effectuate the purposes for which the District is organized, including but not limited to providing the Public Improvements and services detailed herein.

District: means the Pecos Logistics Park Metropolitan District.

District Boundaries: means the boundaries of the District as described in Exhibit A, as amended from time to time as the same is permitted hereunder.

District Boundary Map: means the map attached hereto as Exhibit A depicting the boundaries of the District.

Fees: means any rate, fee, toll, penalty or other charge imposed by the District and permitted by applicable law for services, programs, improvements, facilities, capital costs or operations costs provided by the District, or the payment of Debt, which may be adjusted by the District to account for annual budgetary needs.

Financial Plan: means the Financial Plan attached hereto as Exhibit E and further described in Section VI which describes and projects: (a) how the Public Improvements are to be financed; (b) how the Debt is expected to be incurred; (c) the estimated operating revenue derived from fees for the first budget year; and (d) proposed sources of revenue and projected expenses of the District.

Future Inclusion Area: means the area identified in Exhibit A which may be included in the District Boundaries in the future without a Service Plan Amendment, subject to the provisions of the Special District Act and this Service Plan.

Maximum Mill Levy: means the maximum number of combined mills that the District may levy for the purposes of debt service and funding District administration, operations, and maintenance, which shall not exceed a total of fifty (50) mills, except as provided in this Service Plan, imposed upon property within the then-current boundaries of the District.

Maximum Net Effective Interest Rate: means the maximum net effective interest rate applicable to any issuance of Debt, which is 18% under this Service Plan.

Maximum Underwriting Discount: means the maximum underwriter's discount applicable to any issuance of Debt, which is 3% under this Service Plan.

Preliminary Engineering Survey: means the maps shown in Exhibit D, which depict existing infrastructure and planned Public Improvements for the District.

Project: means the commercial and industrial use redevelopment to be known as the Pecos Logistics Park.

Public Improvements: means a part or all of the improvements authorized to be planned, designed, acquired, constructed, installed, relocated, redeveloped, operated, maintained and/or financed by the District, including necessary and appropriate landscaping, appurtenances and acquisition of real property to effect such improvements, as generally described in the Preliminary Engineering Survey and this Service Plan, and as are necessary to serve the future taxpayers and constituents of the Service Area as determined by the Board.

Service Area: means the property within the District Boundaries, as may be amended pursuant to the requirements of the Special District Act from time to time.

Service Plan: means this service plan for the District approved by the Board of County Commissioners, as may be amended from time to time.

Service Plan Amendment: means an amendment to the Service Plan approved by the Board of County Commissioners in accordance with the County's policies and the applicable state law.

Special District Act: means Section 32-1-101, et seq., of the Colorado Revised Statutes as amended from time to time.

State: means the State of Colorado.

Vicinity Map: means the map showing the general vicinity of the District, as represented in Exhibit B.

III. BOUNDARIES

The area within the District Boundaries includes approximately 63 acres. A legal description and map of the District Boundaries is attached hereto as Exhibit A. It is anticipated that the District's boundaries may change from time to time as it undergoes inclusions and exclusions pursuant to C.R.S. § 32-1-401, *et seq.*, and C.R.S. § 32-1-501, *et seq.*, as amended. A potential Future Inclusion Area is identified in Exhibit A. It is anticipated that this Future Inclusion Area may be included into the District Boundaries at a later date. A vicinity map depicting the District's general location is attached hereto as Exhibit B.

IV. PROPOSED LAND USE / POPULATION PROJECTION / ASSESSED VALUATION

It is currently anticipated that at full buildout the Service Area will contain approximately 1.1 million square feet of existing and proposed commercial and industrial space. It is not anticipated that the Service Area will include any residential property or uses. As shown in the Financial Plan, the current assessed valuation of the property within the District Boundaries is assumed to be $1,683,432 for purposes of this Service Plan.

Approval of this Service Plan by the County does not imply approval of the development of a specific area within the Service Area of the District, nor does it imply approval of the number of commercial or industrial units or the total site/floor area of commercial or other buildings identified in this Service Plan or any of the exhibits attached thereto.

V. DESCRIPTION OF PROPOSED POWERS, IMPROVEMENTS AND SERVICES

A. General Powers of the District / District Services

The District shall have the power and authority to acquire, construct, install, and operate and maintain the Public Improvements within and without the District Boundaries and undertake related District Activities within the Service Area, as such power and authority is described in the Special District Act, other applicable statutes, the common law and the Constitution, subject to the limitations set forth in this Service Plan. Further, the District shall have the power to provide any and all services necessary or incidental to the provision of the Public Improvements.

All Public Improvements provided by the District shall be designed and constructed in compliance with all applicable County standards, regulations, permits and other requirements.

1. Sanitation

Except as limited by the provisions of the Berkeley Water and Sanitation District Overlap Consent Resolution attached hereto as Exhibit F and an agreement between the District and Berkeley Water and Sanitation District as contemplated herein, the District shall have the power and authority to provide for the design, acquisition, installation, construction, financing, operation, and maintenance of storm or sanitary sewers, or both, flood and surface drainage improvements including but not limited to, culverts, dams, retaining walls, access ways inlets, detention ponds and paving, roadside swales and curb and gutter, wastewater lift stations, force mains and wetwell storage facilities, and all necessary or proper equipment and appurtenances incident thereto, together with all necessary, incidental and appurtenant facilities, land and easements, and all necessary extensions of and improvements to said facilities or systems.

2. Water

Except as limited by an agreement between the District and Denver Water as contemplated herein, the District shall have the power and authority to provide for the design, acquisition, installation, construction, financing of a complete potable water and non-potable irrigation water system, including but not limited to, water rights, water supply, transmission and distribution systems for domestic and other public or private purposes, together with all necessary and proper water rights, equipment and appurtenances incident thereto which may include, but shall not be limited to, transmission lines, distribution mains and laterals, storage facilities, land and easements, together with extensions of and improvements to said systems.

3. Streets

The District shall have the power and authority to provide for the design, acquisition, installation, construction, financing, operation, and maintenance of street and roadway improvements, including but not limited to curbs, gutters, culverts, storm sewers and other drainage facilities, detention ponds, retaining walls and appurtenances, as well as sidewalks, bridges, parking facilities, paving, lighting, grading, landscaping, under grounding of public utilities, snow removal equipment, or tunnels and other street improvements, together with all necessary, incidental, and appurtenant facilities, land and easements together with extension of and improvements to said facilities.

4. Traffic and Safety Controls

The District shall have the power and authority to provide for the design, acquisition, installation, construction, financing, operation, and maintenance of traffic and safety protection facilities and services through traffic and safety controls and devices on arterial streets and highways, as well as other facilities and improvements including but not limited to, signalization at intersections, traffic signs, area identification signs, directional assistance, and driver information signs, together with all necessary, incidental, and appurtenant facilities, land easements, together with extensions of and improvements to said facilities.

5. Park and Recreation

The District shall not have the power and authority to provide for park and recreation facilities or services.

6. Transportation

The District shall have the power and authority to provide for the design, acquisition, installation, construction, financing, operation, and maintenance of public transportation system improvements, including transportation equipment, park and ride facilities and parking lots, parking structures, roofs, covers, and facilities, including structures for repair, operations and maintenance of such facilities, together with all necessary, incidental and appurtenant facilities, land and easements, and all necessary extensions of and improvements to said facilities or systems.

7. Television Relay and Translation

The District shall have the power and authority to provide for the design, acquisition, construction, completion, installation, financing, and/or operation and maintenance of television relay and translation facilities, including but not limited to cable television and communication facilities, together with all necessary, incidental and appurtenant facilities, land and easements, and all necessary extensions of and improvements to said facilities.

8. Mosquito and Pest Control

The District shall have the power and authority to provide for the design, acquisition, installation, construction, financing, operation, and maintenance of systems and methods for the elimination and control of mosquitoes, rodents and other pests.

9. Security

The District shall have the power and authority to provide security services within the boundaries of the District, subject to the limitations set forth in C.R.S. § 32-1-1004(7), as amended; provided, in no way are this power and authority intended to limit or supplant the responsibility and authority of law enforcement agencies (i.e., the Adams County Sheriff's Department) within the boundaries of the District. The District will consult with the Adams County Sheriff's Department prior to providing any security services within the District.

10. Covenant Enforcement

The District shall have the power and authority to provide covenant enforcement and design review services subject to the limitations set forth in C.R.S. § 32-1-1004(8), as amended.

11. Fire Protection

The District is located within the boundaries of the Adams County Fire Protection District. The District is not authorized to provide fire protection services or improvements and shall not duplicate or interfere with any fire protection services or improvements provided by the Adams County Fire Protection District; provided, the authority to plan for, design, acquire, construct, install, relocate, redevelop, finance, operate or maintain fire hydrants and related fire protection improvements incidental to and in connection with the District's other public improvement and service powers authorized or described herein shall not be limited by this subsection.

12. Additional Powers

If, after the Service Plan is approved, the State law includes additional powers or grants new or broader powers for Title 32 districts by amendment of the Special District Act or other applicable law, to the extent permitted by law any or all such powers shall be deemed to be a part hereof and available to or to be exercised by the District upon execution of a written agreement with the County concerning the exercise of such powers. Execution and performance of such agreement by the District shall not constitute a material modification of this Service Plan by the District.

13. Funding / Compliance / Scope

The District shall be authorized to fund the District Activities from the proceeds of Debt to be issued by the District, and from all other legally available revenues, including Fees. The District will construct the Public Improvements in compliance with the County's standards and requirements. The scope and specific Public Improvements to be undertaken by the District shall be determined in the discretion of the Board of Directors of the District, subject to the requirements of the County and other applicable service providers, and are anticipated to include those Public Improvements as generally set forth in Exhibits C and D.

B. Limitations of the District Powers and Service Plan Amendment

1. Operation and Maintenance

It is anticipated that all of the Public Improvements will either be dedicated to the County or an Alternative Service Provider, or will be owned, operated and maintained by the District. The annual budget(s) adopted by the District will authorize expenditures from District revenues for the District's administration and the operation and maintenance of the Public Improvements not conveyed to the County or an Alternative Service Provider. In addition to property taxes, and in order to offset the expenses of the anticipated operations and maintenance costs, the District may rely upon various other revenue sources authorized by law. These revenues may include fees, rates, tolls, penalties, or charges as authorized in Section 32-1-1001(l), C.R.S., as amended.

2. Construction Standards Limitation

Construction of all Public Improvements shall be subject to applicable ordinances, codes and regulations of the County and pursuant to the requirements of any Approved Development Plan, as well as the applicable ordinances, codes and regulations of any other governmental service provider with jurisdiction over the Public Improvements. The District will ensure that the Public Improvements to be dedicated or maintained by the District are designed and constructed in accordance with the standards and specifications of the County, as applicable, as well as the applicable standards of other governmental entities with jurisdiction over the specific Public Improvements and in accordance with any Approved Development Plan. The District will obtain approval of civil engineering plans and permits for construction and installation of Public Improvements from the County or other governmental entity with jurisdiction as necessary and appropriate.

3. Inclusions and Exclusions

The District shall be permitted to undertake inclusions and exclusions at its discretion and without further amendment to this Service Plan, so long as such inclusions are in accordance with the Special District Act. Notice of any such boundary adjustment shall be provided to the County pursuant to the requirements of the annual report required herein under Section VII. The County shall not be required to take any action to facilitate such boundary adjustments or obligations with respect to the same.

4. Debt Limitation

The District's Debt Limitation shall be $20,000,000. The obligations of the District in intergovernmental agreements concerning the funding and/or operations of the District's Public Improvements and services, for which voter approval shall be obtained to the extent required by law, will not count against the Debt Limitation. Increases necessary to accomplish a refunding, reissuance or restructuring of Debt shall also not count against the Debt Limitation. Agreements between the District and the Developer regarding advance funding, public improvement acquisition, or reimbursements, which are subject to annual appropriation, shall not be considered Debt under this Service Plan and shall not count against the Debt Limitation.

5. Service Plan Amendment Requirement

This Service Plan has been designed with sufficient flexibility to enable the District to provide required services and facilities under evolving circumstances without the need for Service Plan Amendments. Actions of the District that constitute material modifications to this Service Plan under the Special District Act shall entitle the County to all remedies available under State and local law to enjoin such actions. Any violation of the Debt Limitation or the Maximum Mill Levy without County approval, as set forth herein, shall constitute a material modification of this Service Plan.

6. Services Provided by Other Governmental Entities; Overlapping Districts

a. Berkeley Water and Sanitation District

The District is located within the boundaries of the Berkeley Water and Sanitation District. It is anticipated that sanitation and wastewater collection, transmission and/or treatment services will be provided to the Project by Berkeley Water and Sanitation District, and the Developer and/or the District and Berkeley Water and Sanitation District will enter into a sanitary sewer facilities and services agreement whereby all wastewater collection, transmission and pretreatment facilities necessary to connect the Project to Berkeley Water and Sanitation District's systems will be constructed by the Developer or the District and sewer mains will be conveyed to Berkeley Water and Sanitation District. Berkeley Water and Sanitation District is the primary provider of municipal wastewater collection and delivery services within its boundaries, and the District may not duplicate services provided by Berkeley Water and Sanitation District. Berkeley Water and Sanitation District has consented to the District's provision of water and sanitation services within overlapping territory, as evidenced by the Overlap Consent Resolution attached hereto as Exhibit F.

b. Denver Water

It is anticipated that water services will be provided to the Project by Denver Water, and the Developer and/or the District and Denver Water will enter into a water facilities and services agreement whereby all water facilities necessary to connect the Project to Denver Water's systems will be constructed by the Developer or the District and conveyed to Denver Water.

c. Adams County Fire Protection District

The District is located within the boundaries of the Adams County Fire Protection District. Fire protection services will be provided to the Project by the Adams County Fire Protection District.

d. Others

The District is located within the boundaries of the Hyland Hills Park and Recreation District and the Rangeview Library District. The District will not provide park and recreation or library services, or related improvements.

C. Preliminary Engineering Survey

A preliminary engineering survey depicting the anticipated scope of the Public Improvements which may be provided by or through the District is attached hereto as Exhibit D. A schedule of the initial estimated costs of the proposed Public Improvements is attached hereto as Exhibit C. As detailed in Exhibit C, the estimated costs of the proposed Public Improvements total approximately $10,628,882. Based on the Financial Plan detailed herein, it is anticipated the District will finance approximately 89% of the Public Improvement costs.

Actual Public Improvements costs will vary based in part upon the specific requirements and timing related to construction of the Public Improvements and other factors. Final planning and design of Public Improvements will depend on the specific matters contained in an Approved Development Plan as well as other factors, and therefore the estimates and proposed scope presented herein are conceptual in nature only. All Public Improvements will be designed in such a way as to assure that the District's facility and service standards will be compatible with those of the County and any other governmental service provider with jurisdiction over them.

VI. FINANCIAL PLAN

A. General

The District shall be authorized to provide for the District Activities from the proceeds of Debt to be issued by the District and from other legally available revenues of the District, including but not limited to an operations and maintenance mill levy and Fees. The financial plan for the District shall be to issue such Debt as the District can reasonably pay from time to time based upon the generation of the revenue sources depicted in the Financial Plan, attached hereto as Exhibit E. The Financial Plan sets forth projections currently associated with planned development within the Service Area. The timing and amounts associated with the issuance of any Debt shall be based upon the pace at which development actually progresses within the Service Area and the discretion of the District's Board. As a consequence, Debt that the District issues may be issued on a schedule and in such year or years as the District determines shall meet the needs of the Financial Plan and the District, and may be phased and altered to serve development as it occurs. The Financial Plan provides an illustration of how the Public Improvements and other services of the District may be financed; however, the final terms of Debt financing are likely to be different and shall be determined by the District, subject to the key limiting parameters established within this Service Plan. As further described in the Financial Plan, the District anticipates issuing approximately $13,555,000 of Debt, which issuance is expected to provide approximately $9,484,150 in project funds. The actual amount of Debt may increase or decrease, dependent upon the timing with respect to actual build-out and actual assessed value that is established within the District. Notwithstanding the foregoing, the District shall not be permitted to issue Debt in excess of the Debt Limitation or impose a debt service mill levy which, when combined with the District's operations and maintenance mill levy, exceeds the Maximum Mill Levy established hereunder, except as set forth herein.

It is anticipated that the District will impose a debt service mill levy of twenty (20) mills upon all taxable property within the District, beginning in the assessment year 2019 for collection in 2020. Notwithstanding the foregoing, the District may certify debt service, and operations and maintenance mill levies as necessary to cover debt service requirements and to fund District administration, operations, and maintenance in any separate or combined amounts, provided the combined mill levy does not exceed the Maximum Mill Levy, except as set forth herein.

B. Maximum Net Effective Interest Rate / Maximum Underwriting Discount

The interest rate on any Debt is expected to be the market rate at the time the Debt is issued, but shall not exceed the Maximum Net Effective Interest Rate. The underwriting discount on any Debt shall not exceed the Maximum Underwriting Discount. Debt, when issued, will comply with all relevant requirements of this Service Plan, State law and federal law as then applicable to the issuance of public securities. Interest rates and debt terms will ultimately determine, within the limitations of this Service Plan, the amounts and times of debt issuance.

C. Maximum Mill Levy

The Maximum Mill Levy authorized herein shall be the maximum combined mill levy the District is permitted to impose upon the taxable property within the District, and shall be determined as follows: the Maximum Mill Levy shall be fifty (50) mills; provided, that if on or after January 1, 2019, there are changes in the method of calculating assessed valuation or any constitutionally mandated tax credit, cut or abatement, the Maximum Mill Levy may be increased or decreased to reflect such changes, such increases or decreases to be determined by the Board in good faith (such determination to be binding and final) so that to the extent possible the actual tax revenues generated by the mill levy, as adjusted for changes occurring after January 1, 2019, are neither diminished nor enhanced as a result of such changes. For purposes of the foregoing, a change in the ratio of actual valuation shall be deemed to be a change in the method of calculating assessed valuation.

For the portion of any Debt which is equal to or less than fifty percent (50%) of the District's assessed valuation, either on the date of issuance or at any time thereafter, the mill levy to be imposed to repay such portion of Debt shall not be subject to the Maximum Mill Levy and, as a result, the mill levy may be such amount as is necessary to pay the debt service on such Debt, without limitation of rate. For purposes of the foregoing, once Debt has been determined to be equal to or less than fifty percent (50%) of the District's assessed valuation, so that the District is entitled to pledge to its payment an unlimited ad valorem mill levy, the District may provide that such Debt shall remain secured by such unlimited mill levy, inclusive of refundings of the same, notwithstanding any subsequent change in the District's Debt to assessed ratio. All Debt issued by the District must be issued in compliance with the requirements of Section 32-1-1101, C.R.S., and all other requirements of State law.

D. Debt Repayment Sources

The District may rely upon various revenue sources authorized by law including but not limited to ad valorem property taxes and the power to assess fees, rates, tolls, penalties, or charges as provided in Section 32-1-1001(1), C.R.S., as amended from time to time. The District shall have the authority to pledge revenue from its fees, rates, tolls, penalties or charges to the repayment of Debt.

E. Security for Debt

The District shall not pledge any revenue or property of the County as security for the Debt authorized in this Service Plan. Approval of this Service Plan shall not be construed as a guarantee by the County of payment of any of the District's obligations; nor shall anything in the Service Plan be construed so as to create any responsibility or liability on the part of the County in the event of default by the District in the payment of any such obligation.

F. District's Operating Costs

The estimated cost of engineering services, legal services and administrative services, together with the estimated costs of the District's organization and initial operations, are included within assumptions contained in the Financial Plan and are anticipated to be funded with any revenues legally available to the District, including Fees and property taxes.

In addition to the capital costs of the Public Improvements, the District will require operating funds for administration and to plan and cause the Public Improvements to be constructed and maintained. In the early stages of development of the Project and prior to the District's issuance of Debt, it is anticipated that such funds may be provided by the Developer through one or more advance, acquisition, and/or reimbursement agreements between the District and the Developer. The District's first year operating budget is estimated to be One Hundred Thousand Dollars ($100,000) which is anticipated to be derived from revenues of the District, including potential Developer advances. A proposed Developer Advance and Reimbursement Agreement is attached hereto as Exhibit J.

G. Debt Instrument Disclosure Requirement

Debt instruments shall be required to include the following statement: "The [debt instrument] does not constitute a debt, financial obligation or liability of the County, and the County is not liable for payment of the principal of, premium if any, and interest on the [debt instrument]".

VII. ANNUAL REPORT

The District shall be responsible for submitting an annual report to the County by June 1 of each year.

VIII. CONSOLIDATION/DISSOLUTION

The consolidation of the District with any other special district shall be subject to the approval of the County. The District will take all action necessary to dissolve pursuant to Section 32-1-701, et seq., C.R.S., as amended from time to time, at such time as it does not need to remain in existence to discharge its financial obligations or perform its services. In the event the District is

dissolved, such dissolution process will comply with the provisions of Section 32-1-701, et seq., C.R.S., as amended from time to time.

IX. INTERGOVERNMENTAL AGREEMENTS

As stated above, it is anticipated that sanitation and wastewater treatment services and water services will be provided to the Project by Berkeley Water and Sanitation District and Denver Water, respectively, and the Developer and/or the District will enter into facilities and services agreements with Berkeley Water and Sanitation District and Denver Water regarding the same. No other intergovernmental agreements are anticipated as of the date of this Service Plan.

X. ELECTION OF BOARD OF DIRECTORS

The Board of Directors of the District is anticipated to have up to five (5) directors. The initial Board of Directors will be elected from a pool of eligible electors at an organizational election held after approval of this Service Plan. Thereafter, directors may be appointed to fill vacancies and the District shall hold regular elections consistent with the provisions of the Special District Act. The number of directors may be modified by the Board of Directors of the District from time to time consistent with the provisions of the Special District Act.

XI. CONCLUSION

It is submitted that this Service Plan, as required by Section 32-1-203(2) and Section 32-1-203(2.5), C.R.S., establishes that:

A. There is sufficient existing and projected need for organized service in the area to be serviced by the District;

B. The existing service in the area to be served by the District is inadequate for present and projected needs;

C. The District is capable of providing economical and sufficient service to the area within its proposed boundaries;

D. The area to be included in the District does have, and will have, the financial ability to discharge the proposed indebtedness on a reasonable basis;

E. Adequate service is not, and will not be, available to the area through the County or other existing municipal or quasi-municipal corporations, including existing special districts, within a reasonable time and on a comparable basis;

F. The facility and service standards of the District are compatible with the facility and service standards of each county within which the special district is to be located and each municipality which is an interested party under Section 32-1-204(1), C.R.S.;

G. The proposal is in substantial compliance with a comprehensive plan adopted pursuant to Section 30-28-106, C.R.S.;

H. The proposal is in compliance with any duly adopted county, regional or state long range water quality management plan for the area; and

I. The creation of the District is in the best interests of the area proposed to be served.

Exhibit A
Legal Description and District Boundary Map

METRO DISTRICT EXHIBIT

A TRACT OF LAND LOCATED IN THE SOUTHWEST 1/4 OF SECTION 9,
TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH P.M.
WEST 56TH AVENUE AND PECOS STREET
SHEET 1 OF 1

CURVE TABLE				
CURVE	LENGTH	RADIUS	CHB	CHORD
C1	97.37'	1928.00	S70°19'45"E	97.36'

LINE TABLE		
LINE	LENGTH	BEARING
L1	58.59'	N75°02'00"W
L2	10.30'	S89°48'07"W
L3	10.00'	S00°05'00"E
L4	10.00'	N00°05'00"W
L5	30.00'	S89°48'07"W
L6	10.00'	N89°48'07"E
L7	10.00'	S89°51'16"W
L8	47.91'	S75°02'00"E
L9	86.37'	N02°21'23"E

LEGAL DESCRIPTION:

A TRACT OF LAND LOCATED IN THE SOUTHWEST ¼ OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH P.M., MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHEAST CORNER OF A PARCEL OF LAND DESCRIBED IN DEED RECORDED AT RECEPTION NO. 2018000084369 FROM WHICH THE CENTER ¼ CORNER OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH P.M. BEARS N02°55'20"E A DISTANCE OF 924.39 FEET, SAID POINT ALSO BEING ON THE WEST RIGHT-OF-WAY LINE OF PECOS STREET; THENCE ALONG THE SAID WEST RIGHT-OF-WAY LINE OF PECOS STREET THE FOLLOWING NINE (9) DESCRIBED COURSES:

1. THENCE S00°59'29"E, 297.70 FEET;
2. THENCE S00°58'57"E, 117.77 FEET;
3. THENCE S00°00'00"W, 100.17 FEET;
4. THENCE N75°02'00"W, 58.59 FEET;
5. THENCE S15°01'02"W, 134.37 FEET;
6. THENCE ALONG A CURVE TO THE RIGHT HAVING AN ARC LENGTH OF 97.37 FEET, A RADIUS OF 1928.00 FEET, A CENTRAL ANGLE OF 2°53'37", A CHORD DISTANCE OF 97.36 FEET AND WHOSE CHORD BEARS S70°19'45"E;
7. THENCE S00°00'00"W, 742.71 FEET;
8. THENCE S89°48'07"W, 10.30 FEET;
9. THENCE S00°00'00"W, 267.86 FEET TO THE INTERSECTION OF THE WEST RIGHT-OF-WAY LINE OF PECOS STREET AND THE NORTH RIGHT-OF-WAY LINE OF WEST 56TH AVENUE;

THENCE ALONG THE NORTH RIGHT-OF-WAY LINE OF WEST 56TH AVENUE THE FOLLOWING FIVE (5) COURSES:

1. THENCE S89°48'07"W, 948.20 FEET;
2. THENCE S00°05'00"E, 10.00 FEET;
3. THENCE S89°48'07"W, 271.20 FEET;
4. THENCE N00°05'00"W, 10.00 FEET;
5. THENCE S89°48'07"W, 30.00 FEET TO A POINT ON THE EAST LINE OF TEJON STREET;

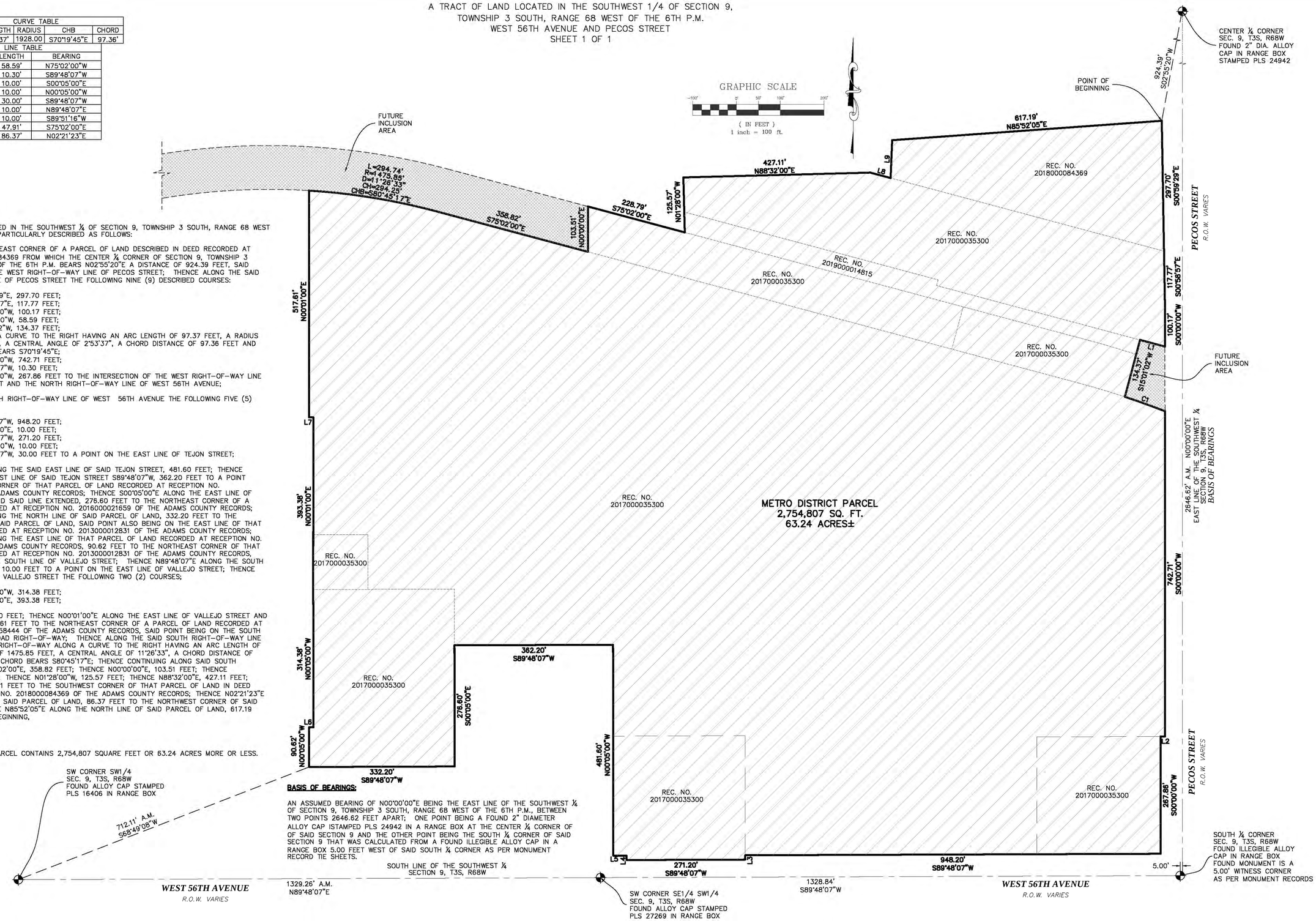
THENCE N00°05'00"W ALONG THE SAID EAST LINE OF SAID TEJON STREET, 481.60 FEET; THENCE DEPARTING FROM SAID EAST LINE OF SAID TEJON STREET S89°48'07"W, 362.20 FEET TO A POINT BEING THE NORTHWEST CORNER OF THAT PARCEL OF LAND RECORDED AT RECEPTION NO. 2012000088342 OF THE ADAMS COUNTY RECORDS; THENCE S00°05'00"E ALONG THE EAST LINE OF SAID PARCEL OF LAND AND SAID LINE EXTENDED, 276.60 FEET TO THE NORTHEAST CORNER OF A PARCEL OF LAND RECORDED AT RECEPTION NO. 2016000021659 OF THE ADAMS COUNTY RECORDS; THENCE S89°48'07"W ALONG THE NORTH LINE OF SAID PARCEL OF LAND, 332.20 FEET TO THE NORTHWEST CORNER OF SAID PARCEL OF LAND, SAID POINT ALSO BEING ON THE EAST LINE OF THAT PARCEL OF LAND RECORDED AT RECEPTION NO. 2013000012831 OF THE ADAMS COUNTY RECORDS; THENCE N00°05'00"W ALONG THE EAST LINE OF THAT PARCEL OF LAND RECORDED AT RECEPTION NO. 2013000012831 OF THE ADAMS COUNTY RECORDS, 90.62 FEET TO THE NORTHEAST CORNER OF THAT PARCEL OF LAND RECORDED AT RECEPTION NO. 2013000012831 OF THE ADAMS COUNTY RECORDS, SAID POINT BEING ON THE SOUTH LINE OF VALLEJO STREET; THENCE N89°48'07"E ALONG THE SOUTH LINE OF VALLEJO STREET, 10.00 FEET TO A POINT ON THE EAST LINE OF VALLEJO STREET; THENCE ALONG THE EAST LINE OF VALLEJO STREET THE FOLLOWING TWO (2) COURSES;

1. THENCE N00°05'00"W, 314.38 FEET;
2. THENCE N00°01'00"E, 393.38 FEET;

THENCE S89°51'16"W, 10.00 FEET; THENCE N00°01'00"E ALONG THE EAST LINE OF VALLEJO STREET AND SAID LINE EXTENDED, 517.61 FEET TO THE NORTHEAST CORNER OF A PARCEL OF LAND RECORDED AT RECEPTION NO. 2007000058444 OF THE ADAMS COUNTY RECORDS, SAID POINT BEING ON THE SOUTH LINE OF THE BNSF RAILROAD RIGHT-OF-WAY; THENCE ALONG THE SAID SOUTH RIGHT-OF-WAY LINE OF SAID BNSF RAILROAD RIGHT-OF-WAY ALONG A CURVE TO THE RIGHT HAVING AN ARC LENGTH OF 294.74 FEET, A RADIUS OF 1475.85 FEET, A CENTRAL ANGLE OF 11°26'33", A CHORD DISTANCE OF 294.25 FEET AND WHOSE CHORD BEARS S80°45'17"E; THENCE CONTINUING ALONG SAID SOUTH RIGHT-OF-WAY LINE S75°02'00"E, 358.82 FEET; THENCE N00°00'00"E, 103.51 FEET; THENCE S75°02'00"E, 228.79 FEET; THENCE N01°28'00"W, 125.57 FEET; THENCE N88°32'00"E, 427.11 FEET; THENCE S75°02'00"E, 47.91 FEET TO THE SOUTHWEST CORNER OF THAT PARCEL OF LAND IN DEED RECORDED AT RECEPTION NO. 2018000084369 OF THE ADAMS COUNTY RECORDS; THENCE N02°21'23"E ALONG THE WEST LINE OF SAID PARCEL OF LAND, 86.37 FEET TO THE NORTHWEST CORNER OF SAID PARCEL OF LAND; THENCE N85°52'05"E ALONG THE NORTH LINE OF SAID PARCEL OF LAND, 617.19 FEET TO THE POINT OF BEGINNING,

COUNTY OF ADAMS,
STATE OF COLORADO

THE ABOVE DESCRIBED PARCEL CONTAINS 2,754,807 SQUARE FEET OR 63.24 ACRES MORE OR LESS.



BASIS OF BEARINGS:

AN ASSUMED BEARING OF N00°00'00"E BEING THE EAST LINE OF THE SOUTHWEST ¼ OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH P.M., BETWEEN TWO POINTS 2646.62 FEET APART; ONE POINT BEING A FOUND 2" DIAMETER ALLOY CAP ISTAMPED PLS 24942 IN A RANGE BOX AT THE CENTER ¼ CORNER OF OF SAID SECTION 9 AND THE OTHER POINT BEING THE SOUTH ¼ CORNER OF SAID SECTION 9 THAT WAS CALCULATED FROM A FOUND ILLEGIBLE ALLOY CAP IN A RANGE BOX 5.00 FEET WEST OF SAID SOUTH ¼ CORNER AS PER MONUMENT RECORD TIE SHEETS.

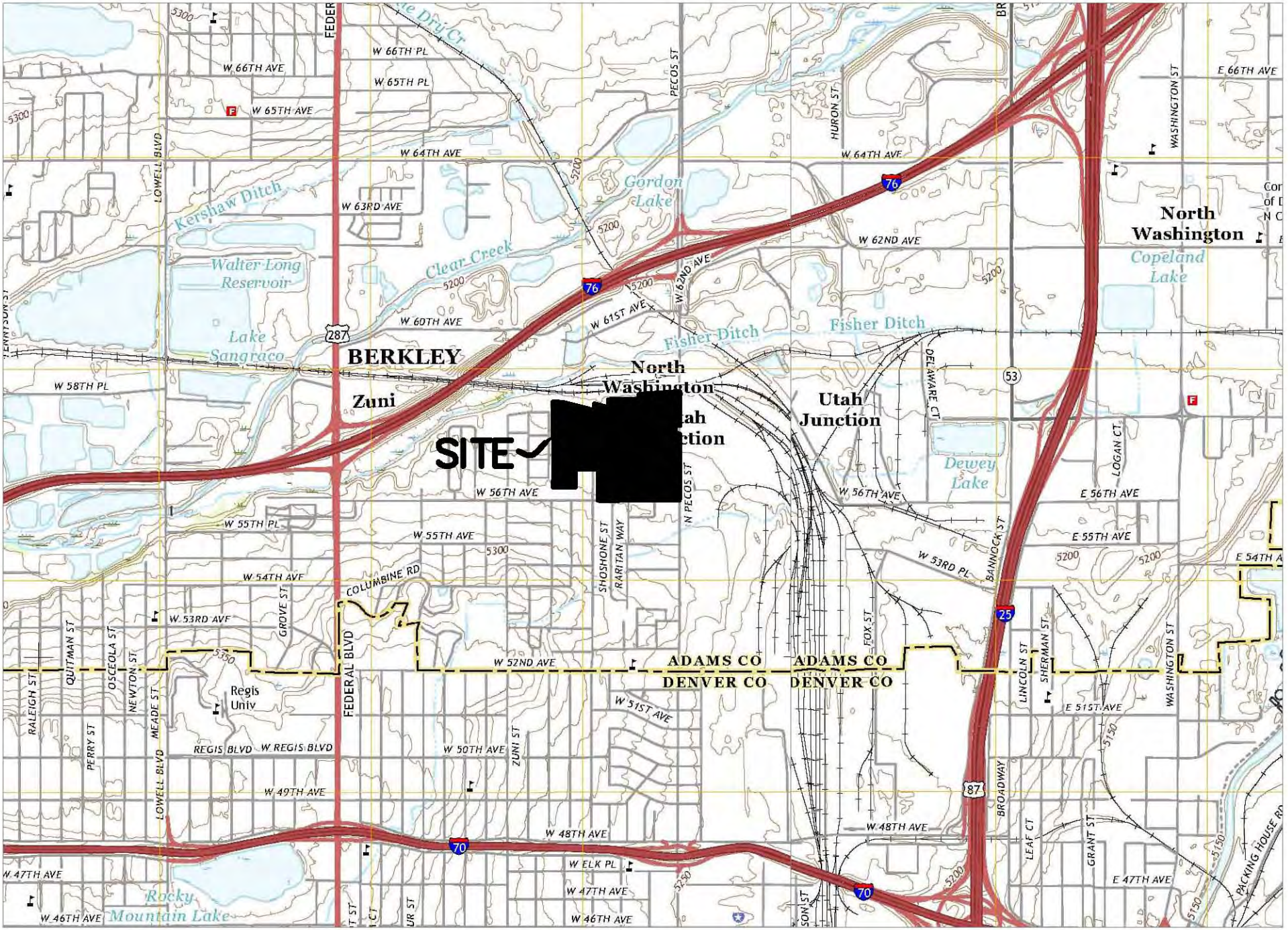
NOTE: THIS EXHIBIT IS NOT A MONUMENTED LAND SURVEY PLAT OR IMPROVEMENT SURVEY PLAT AND IS NOT TO BE RELIED UPON AS SUCH. THIS EXHIBIT IS FOR INFORMATIONAL PURPOSES ONLY.

Exhibit A Legal Description and Map

811 Know what's below. Call before you dig.

PREPARED BY: 39 NORTH ENGINEERING AND SURVEYING LLC
4495 HALE PARKWAY
SUITE 305
DENVER, COLORADO 80220
PH: 303-325-5071
EMAIL: damien.cain@39north.net

Exhibit B-1
Vicinity Map



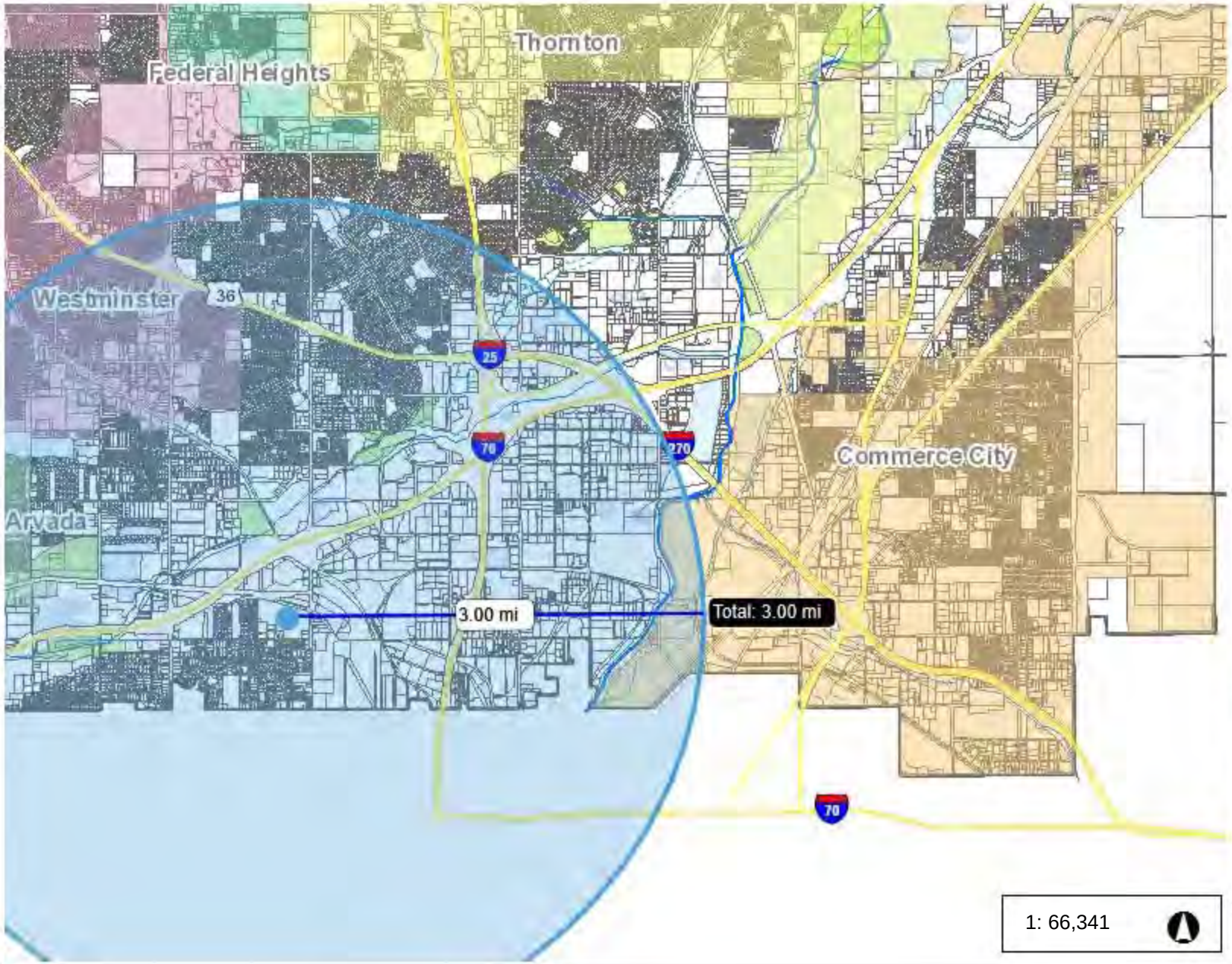
Vicinity Map
1"=2000'

N
W
E
S

Exhibit B - Vicinity Map

Exhibit B-2
3-Mile Radius Maps

Adams County Map



Legend

- Highways
- Highways (> 20,000)
  - Interstate
  - Highway
  - Tollway
- County Parks and Open Space
- Cities
  - Arvada
  - Aurora
  - Bennett
  - Brighton
  - Commerce City
  - Federal Heights
  - Lochbuie
  - Northglenn
  - Thornton
  - Westminster
- Small Lakes
- Major Lakes
- Rivers
  - Canal
  - Ditch
  - Primary Creek
  - River
  - Secondary Creek
  - Stream

1: 66,341

Notes

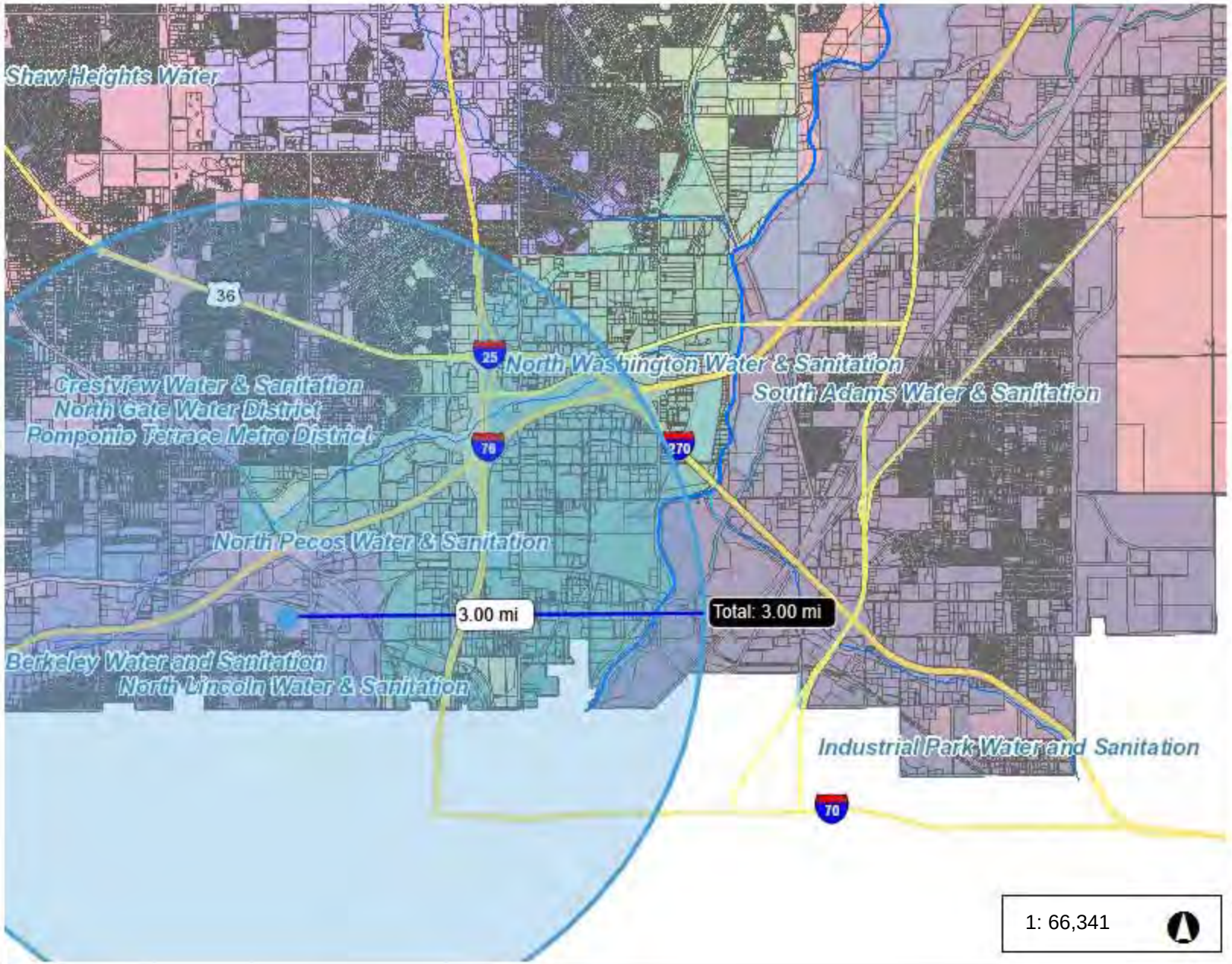
2.1 0 1.05 2.1 Miles

NAD_1983_StatePlane_Colorado_Central_FIPS_0502_Feet

This map is a user generated static output from an Internet mapping site and is for reference only. Data layers that appear on this map may or may not be accurate, current, or otherwise reliable.

THIS MAP IS NOT TO BE USED FOR NAVIGATION

Adams County Map



Legend

- Highways
- Highways (> 20,000)
  - Interstate
  - Highway
  - Tollway
- Small Lakes
- Major Lakes
- Rivers
  - Canal
  - Ditch
  - Primary Creek
  - River
  - Secondary Creek
  - Stream
- Parcels
- School District
  - 1
  - 12
  - 14
  - 26J
  - 27J
  - 28J
  - 29J
  - 31J
  - 32J
  - 50

1: 66,341

Notes

2.1 0 1.05 2.1 Miles

NAD_1983_StatePlane_Colorado_Central_FIPS_0502_Feet

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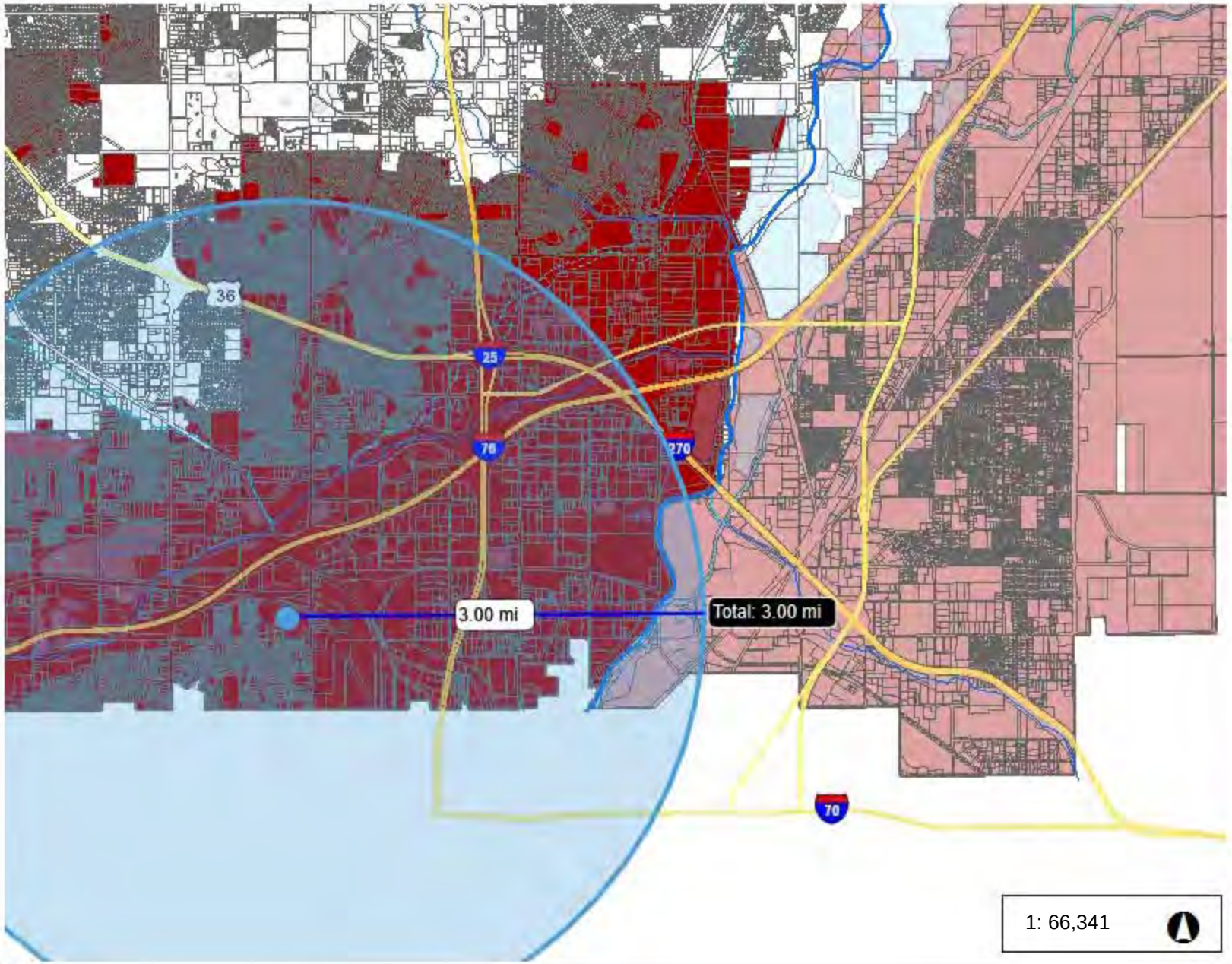
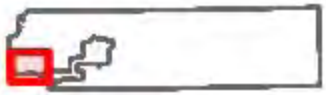
THIS MAP IS NOT TO BE USED FOR NAVIGATION

Adams County Map





Legend

- Highways
- Highways (> 20,000)
  - Interstate
  - Highway
  - Tollway
- Small Lakes
- Major Lakes
- Rivers
  - Canal
  - Ditch
  - Primary Creek
  - River
  - Secondary Creek
  - Stream
- Parcels
- Fire District
  - Adams County Fire Protection Distr
  - Bennett Fire Protection District
  - Brighton Fire Protection District
  - Byers Fire Protection District
  - Deer Trail Fire Protection District
  - North Metro Fire District
  - Sable-Altura Fire Protection District
  - South Adams County Fire District
  - Southeast Weld County Fire Protec
  - Strasburg Fire Protection District

1: 66,341

Notes

2.1 0 1.05 2.1 Miles

NAD_1983_StatePlane_Colorado_Central_FIPS_0502_Feet

This map is a user generated static output from an Internet mapping site and is for reference only. Data layers that appear on this map may or may not be accurate, current, or otherwise reliable.
THIS MAP IS NOT TO BE USED FOR NAVIGATION

Adams County Map

Legend

- Highways
- Highways (> 20,000)
  - Interstate
  - Highway
  - Tollway
- Streets (20,000 - 50,000)
  - Streets
  - Ramp
- Small Lakes
- Major Lakes
- Rivers
  - Canal
  - Ditch
  - Primary Creek
  - River
  - Secondary Creek
  - Stream
- Parcels
- Zoning
  - Municipality
  - A-1
  - A-2
  - A-3
  - AV
  - C-0
  - C-1

1: 41,917

Notes

1.3 0 0.66 1.3 Miles

NAD_1983_StatePlane_Colorado_Central_FIPS_0502_Feet

This map is a user generated static output from an Internet mapping site and is for reference only. Data layers that appear on this map may or may not be accurate, current, or otherwise reliable.

THIS MAP IS NOT TO BE USED FOR NAVIGATION

Exhibit B-3
Proposed Services

Pursuant to Section 10-05-03-03-02-04 of the Adams County Special District Guidelines and Regulations, the following is a list of services proposed to be supplied by the District provided by each of the municipalities and special districts shown on the foregoing maps in Exhibit B-2:

1. Sanitation Services. As described in greater detail elsewhere in the Service Plan, it is anticipated all sanitary sewer improvements necessary to connect the Project to Berkeley Water and Sanitation District's system will be constructed by the District. Thereafter, Berkeley Water and Sanitation District will be the primary provider of sanitary sewer services to the property within the District.

2. Water Services. As described in greater detail elsewhere in the Service Plan, it is anticipated all water improvements necessary to connect the Project to Denver Water's systems will be constructed by the District. Thereafter, Denver Water will be the primary provider of sanitary sewer services to the property within the District.

3. Ongoing Street, Traffic and Safety Controls, and Transportation Services. It is anticipated the District will provide ongoing street, traffic and safety control, and transportation services, including related stormwater management, only with respect to the operation and maintenance of internal streets and transportation improvements retained by the District. The District is not expected to provide ongoing street, traffic safety control, or transportation services with respect to any street or traffic safety control improvements conveyed to the County or other entities.

4. Security Services. The District will consult with the Adams County Sheriff's Department prior to providing any security services within the District.

5. Financing and Construction of Public Improvements. The District proposes to provide for the financing and construction of the Public Improvements described in greater detail elsewhere in this Service Plan, which Public Improvements may be associated with the ongoing provision of services by Berkeley Water and Sanitation District, Denver Water, the County and/or the Adams County Fire Protection District.

Exhibit C
Estimated Cost of Public Improvements

Exhibit C - Cost of Improvements

PECOS LOGISTICS PARK METROPOLITAN DISTRICT

Adams County, Colorado

Direct Hard Costs	**Budget**
Utilities - Water, Sanitary, Storm	3,221,626
Detention Pond	500,000
Street Lighting	209,790
Roadway Paving	337,500
Pecos St, 56th St. and Tejon Improvements	1,276,312
Traffice Signal at Pecos and Property Entrance	400,000
Landscaping and Irrigation	769,438
Xcel Overhead Conversion	750,000
Signage and Wayfinding	250,000
Total Hard Costs	**7,714,665**
Soft Costs	
Survey	100,000
Civil Design	300,000
Geotech	50,000
Soils Testing and Utility Inspections	100,000
Legal	100,000
Construction Management	506,137
Contingency	1,758,080
Total Soft Costs	**2,914,217**
Total Bond Budget	**10,628,882**

Exhibit D
Preliminary Engineering Survey

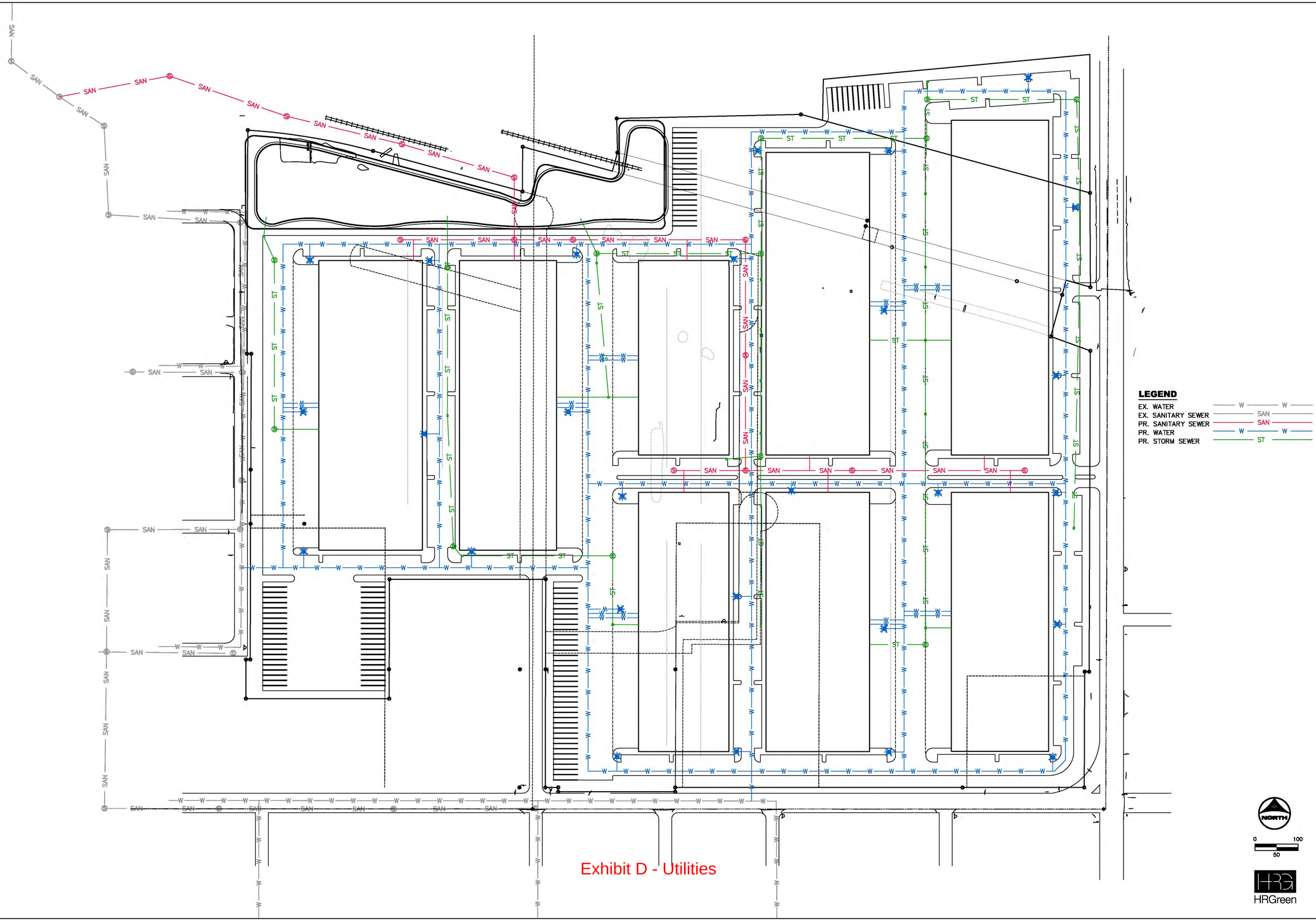
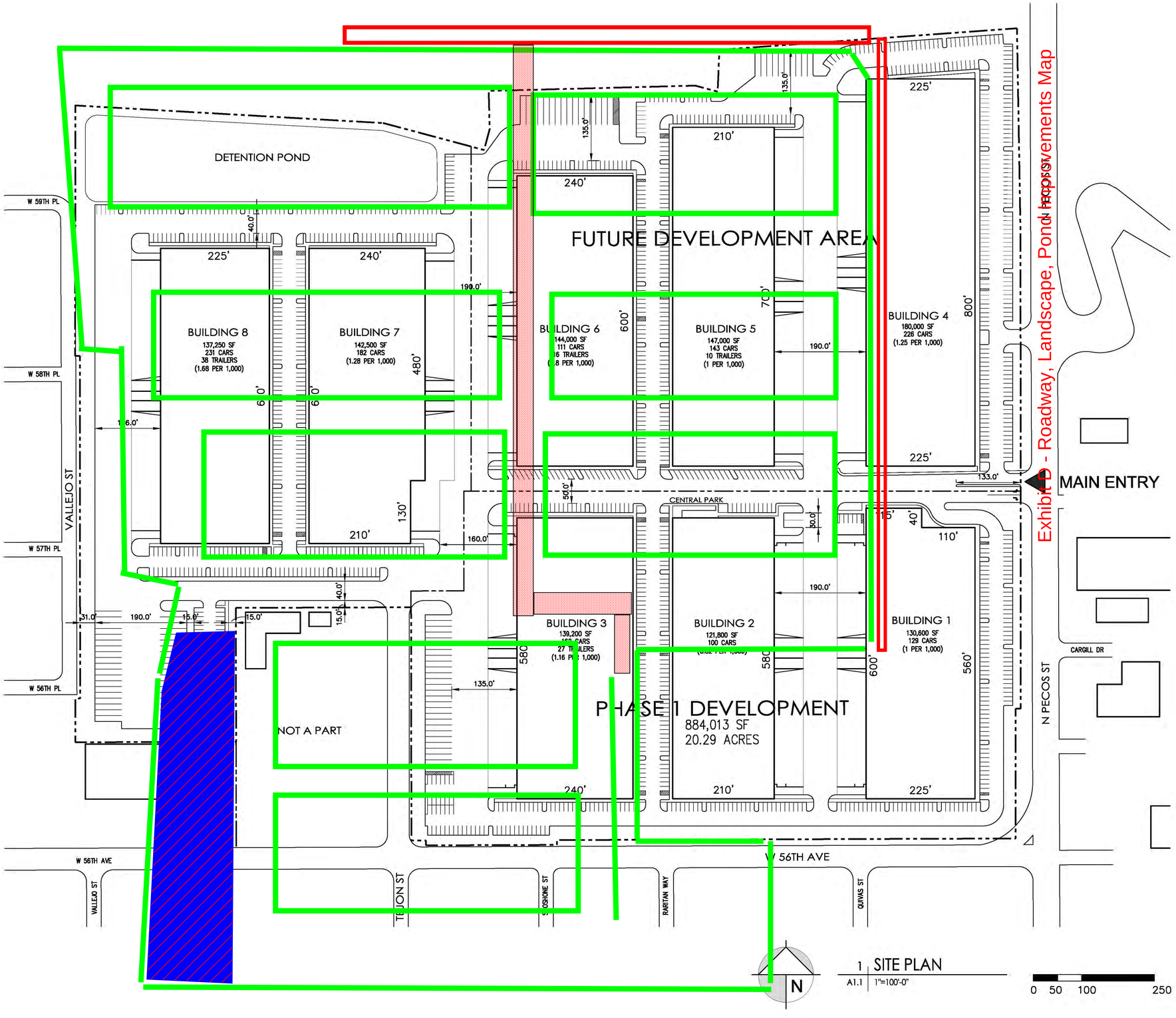


Exhibit D - Utilities



SITE DATA

PROPOSED ZONING	I–2
EXISTING LOT AREA	2,792,025 SF 64.09 AC
PHASE 1	884,013 SF=20.29 AC
FUTURE DEVELOPMENT	1,908,012=43.8 AC
BUILDING AREA	1,142,350 SF
FAR	0.41
LANDSCAPE REQ'D	10%
LANDSCAPE PROVIDED	13%
PARKING REQ'D	
WAREHOUSE	1 PER 5,000
OFFICE	1 PER 300
WHOLESALE	1 PER 900
MANUFACTURING	1 PER 1,000
PARKING PROVIDED 9x19	1,284
TRAILER PARKING 12x55	92

1 SITE PLAN
A1.1 1"=100'-0"

0 50 100 250

GREY WOLF ARCHITECTURE
ARCHITECTURE PLANNING INTERIOR DESIGN
1543 champa st. #200
denver, co 80202
phone: 303.292.9107
fax: 303.292.4297

5801 N PECOS ST
Adams County, Colorado

PROJECT NUMBER 18–495.1
DRAWN JH
CHECKED KWH

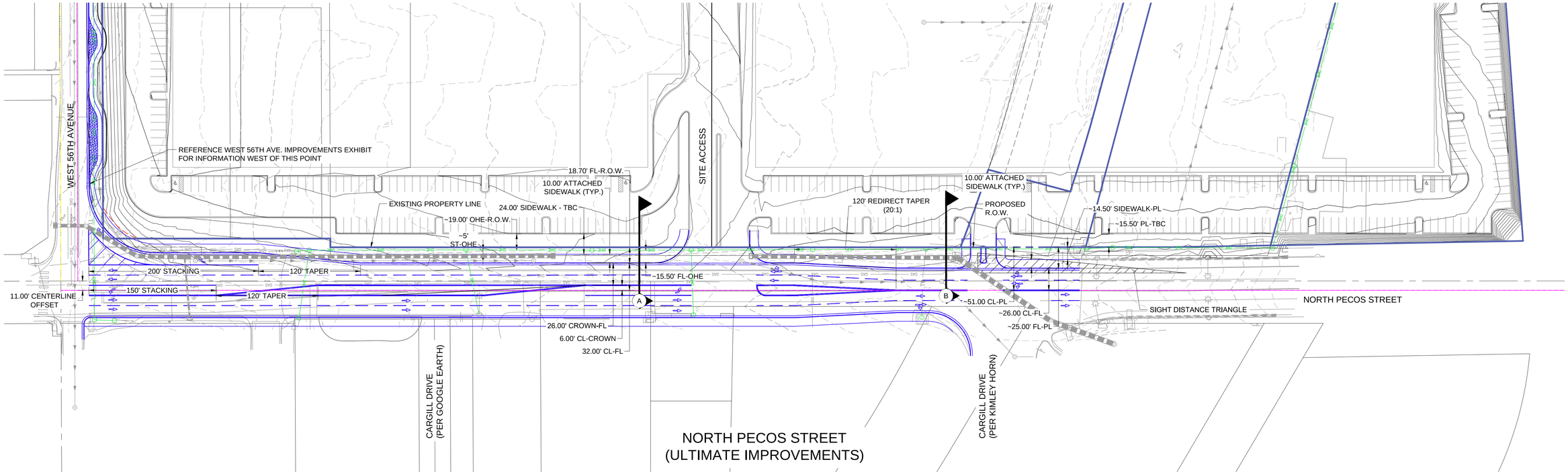
ISSUE
02.05.19 NEIGHBORHOOD

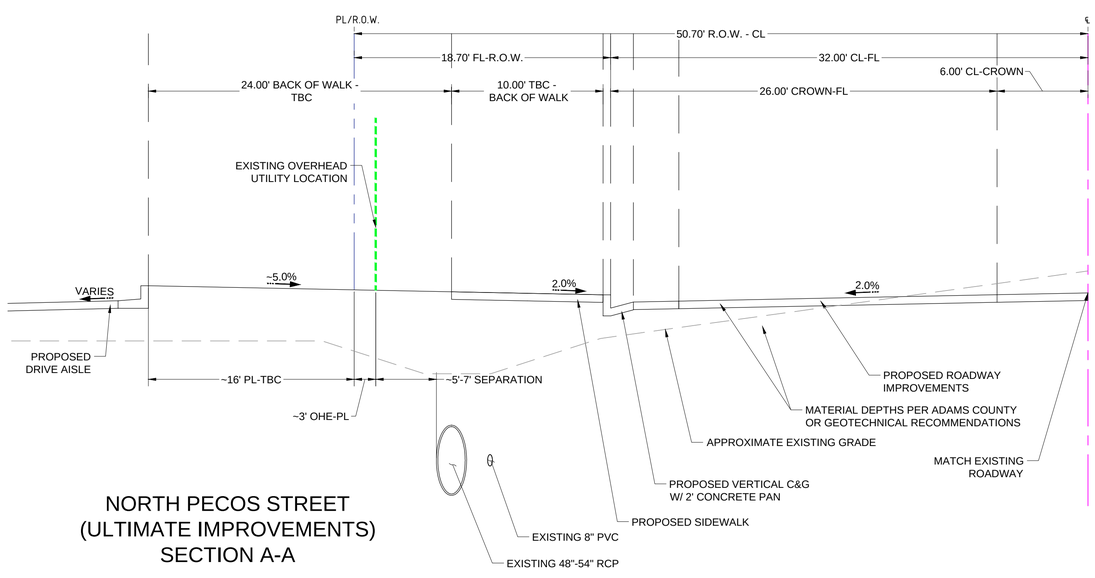
REVISIONS

SITE PLAN

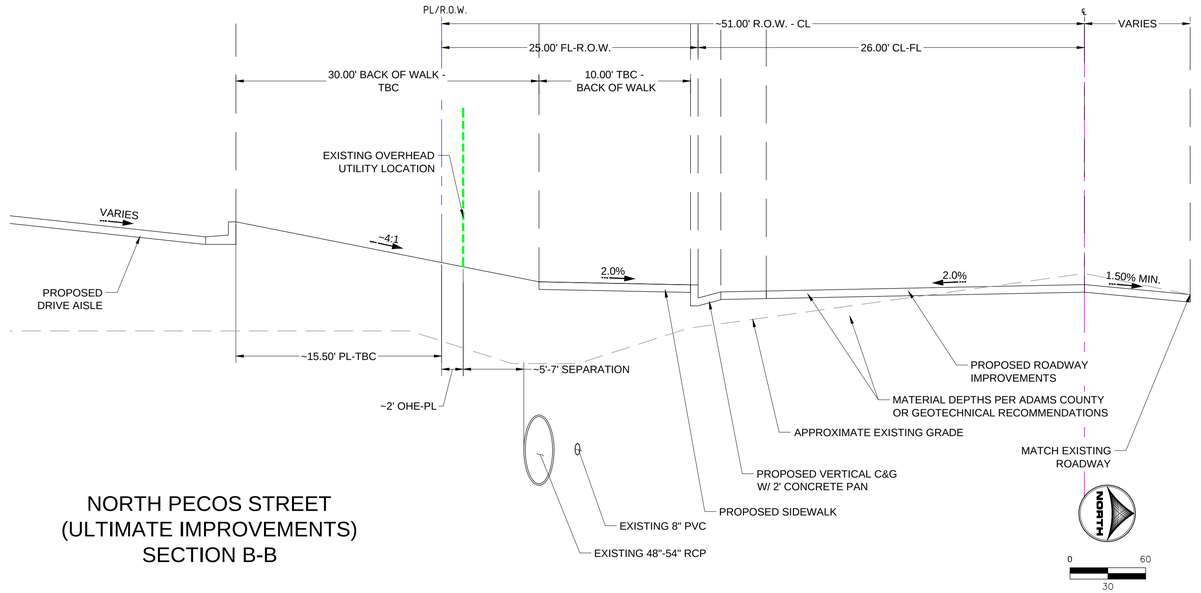
A1.1

Plot Date/Time: 02/05/19 07: 48am





NORTH PECOS STREET
(ULTIMATE IMPROVEMENTS)
SECTION A-A



NORTH PECOS STREET
(ULTIMATE IMPROVEMENTS)
SECTION B-B

DRAWN BY:	XXX	JOB DATE:	2018
APPROVED:	XXX	JOB NUMBER:	180905
CAD DATE:	3/8/2019 1:13:12 PM		
CAD FILE:	J:\2018\180905.01\CAD\Dwgs\Exhibits\Site Roadway Improvements (Overall with Sections-Revision).dwg		

BAR IS ONE INCH ON OFFICIAL DRAWINGS. 0 1"
IF NOT ONE INCH, ADJUST SCALE ACCORDINGLY.

NO.	DATE	BY	REVISION DESCRIPTION

HRGreen.com
HRGreen

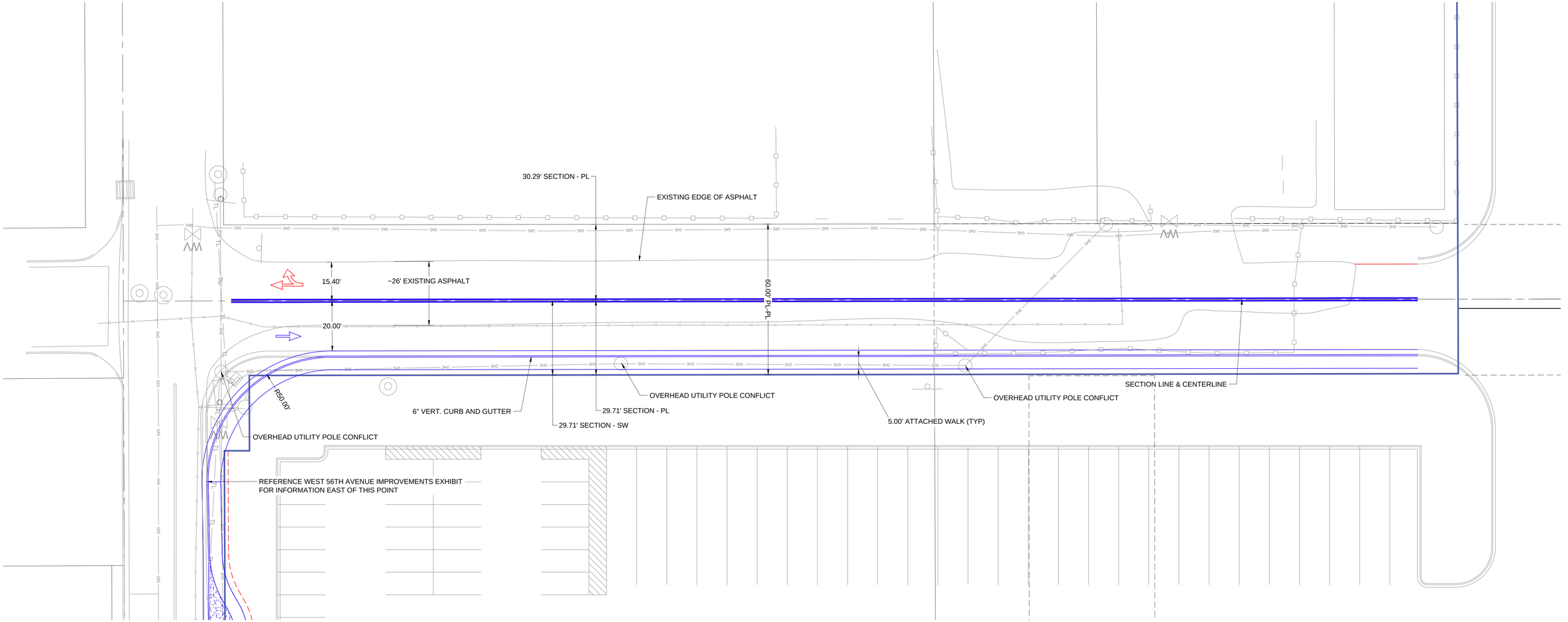
56TH AND PECOS
INDUSTRIAL DEVELOPMENT

EXHIBIT
NORTH PECOS STREET IMPROVEMENTS
(WITHOUT REDIRECT TAPER)

SHEET NO.
1 OF 1

J:\2018\180905.01\CAD\Dwgs\Exhibits\Site Roadway Improvements (Overall with Sections-Revision).dwg

Exhibit D - Improvements to Pecos St.



TEJON STREET
(INTERIM IMPROVEMENTS)

NORTH

0 20
10

DRAWN BY: XXX	JOB DATE: 2018	BAR IS ONE INCH ON OFFICIAL DRAWINGS. 0 1" IF NOT ONE INCH, ADJUST SCALE ACCORDINGLY.	
APPROVED: XXX	JOB NUMBER: 180905		
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NO.	DATE	BY	REVISION DESCRIPTION

HRGreen.com
HRGreen

56TH AND PECOS
INDUSTRIAL DEVELOPMENT

EXHIBIT
TEJON STREET IMPROVEMENTS

SHEET NO.
1 OF 1

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Exhibit D - Imrovements to Tejon St.

Exhibit E
Financial Plan

STIFEL | Public Finance

To:	Adams County (the "County")
From:	Stifel **MEMO**
Date:	April 1, 2019
Subject:	Pecos Logistics Park Metropolitan District – Underwriting Data Source and Assumptions Comment

The financial plan for Pecos Logistics Park Metropolitan District (the "District") is based on information provided by the Developer. Current property values were used along with estimates for future land and building values based on estimated development costs. Per the Developer's direction, the cash flow model assumes a 7-building industrial park that is to be completed in three phases.

Interest rates on the bond projections were derived by comparing market rates of similar projected underwritten by Stifel in the Colorado region, including RII-DII Business Improvement District. Stifel is the number one underwriter of non-rated development transactions in the country, having underwritten and sold over $1.4 billion of development bonds in 2018 (Source: Thomson Reuters).

Pecos Logistics Park Metropolitan District

(In Adams County, Colorado)

Limited Tax General Obligation Bonds

20 MILLS FOR D/S AND 5 MILLS FOR O&M

BOND ISSUANCE AMOUNT 13,555,000

	PROPERTY TAX REVENUE SUMMARY FOR DEBT SERVICE						Current Interest Bonds Series 2020 Debt Service[5]									PROPERTY TAX REVENUE SUMMARY FOR O&M					TOTAL PROPERTY TAX SUMMARY	
Collection Year	Assessed Value	D/S Mill Levy	Prop Tax Revenue	SO Tax[1]	Collection Fees[2]	Net Revenues	Principal	Coupon	Interest	CAPI	D/S Reserve Fund[(4)]	Net Debt Service	Annual Surplus	Cumulative Surplus	Coverage %	O&M Mill Levy	Prop Tax Revenue	SO Tax[1]	Collection Fees[2]	Net Revenues	Est. Combined Mill Levy	Prop Tax. Rev
6/1/2020																						
2020	1,683,432		-	-	-	-	-	6.00%	406,650	(406,650)	(3,061)	(3,061)	-	-			-	-	-	-	0.00	-
2021	2,188,563	20	43,771	3,064	(703)	46,133	-	6.00%	813,300	(813,300)	(6,122)	(6,122)	46,133	46,133		5	10,943	766	(176)	11,533	25.00	57,666
2022	15,803,003	20	316,060	22,124	(5,073)	333,112	-	6.00%	813,300	(813,300)	(6,122)	(6,122)	333,112	379,244		5	79,015	5,531	(1,268)	83,278	25.00	416,389
2023	22,226,449	20	444,529	31,117	(7,135)	468,511	-	6.00%	813,300	(406,650)	(6,122)	400,529	61,861	441,106	1.15	5	111,132	7,779	(1,784)	117,128	25.00	585,639
2024	33,128,427	20	662,569	46,380	(10,634)	698,314	-	6.00%	813,300	-	(6,122)	807,179	(114,986)	326,120	0.86	5	165,642	11,595	(2,659)	174,579	25.00	872,893
2025	41,808,721	20	836,174	58,532	(13,421)	881,286	65,000	6.00%	813,300	-	(6,122)	872,179	2,986	329,106	1.00	5	209,044	14,633	(3,355)	220,322	25.00	1,101,608
2026	45,989,594	20	919,792	64,385	(14,763)	969,415	160,000	6.00%	809,400	-	(6,122)	963,279	15	329,120	1.00	5	229,948	16,096	(3,691)	242,354	25.00	1,211,768
2027	45,989,594	20	919,792	64,385	(14,763)	969,415	165,000	6.00%	799,800	-	(6,122)	958,679	4,615	333,735	1.00	5	229,948	16,096	(3,691)	242,354	25.00	1,211,768
2028	46,909,385	20	938,188	65,673	(15,058)	988,803	195,000	6.00%	789,900	-	(6,122)	978,779	3,903	337,638	1.00	5	234,547	16,418	(3,764)	247,201	25.00	1,236,004
2029	46,909,385	20	938,188	65,673	(15,058)	988,803	210,000	6.00%	778,200	-	(6,122)	982,079	603	338,241	1.00	5	234,547	16,418	(3,764)	247,201	25.00	1,236,004
2030	47,847,573	20	956,951	66,987	(15,359)	1,008,579	240,000	6.00%	765,600	-	(6,122)	999,479	2,979	341,220	1.00	5	239,238	16,747	(3,840)	252,145	25.00	1,260,724
2031	47,847,573	20	956,951	66,987	(15,359)	1,008,579	255,000	6.00%	751,200	-	(6,122)	1,000,079	2,379	343,599	1.00	5	239,238	16,747	(3,840)	252,145	25.00	1,260,724
2032	48,804,525	20	976,090	68,326	(15,666)	1,028,751	290,000	6.00%	735,900	-	(6,122)	1,019,779	2,851	346,449	1.00	5	244,023	17,082	(3,917)	257,188	25.00	1,285,938
2033	48,804,525	20	976,090	68,326	(15,666)	1,028,751	310,000	6.00%	718,500	-	(6,122)	1,022,379	251	346,700	1.00	5	244,023	17,082	(3,917)	257,188	25.00	1,285,938
2034	49,780,615	20	995,612	69,693	(15,980)	1,049,326	345,000	6.00%	699,900	-	(6,122)	1,038,779	4,426	351,126	1.00	5	248,903	17,423	(3,995)	262,331	25.00	1,311,657
2035	49,780,615	20	995,612	69,693	(15,980)	1,049,326	365,000	6.00%	679,200	-	(6,122)	1,038,079	5,126	356,251	1.00	5	248,903	17,423	(3,995)	262,331	25.00	1,311,657
2036	50,776,227	20	1,015,525	71,087	(16,299)	1,070,312	410,000	6.00%	657,300	-	(6,122)	1,061,179	3,012	359,263	1.00	5	253,881	17,772	(4,075)	267,578	25.00	1,337,890
2037	50,776,227	20	1,015,525	71,087	(16,299)	1,070,312	435,000	6.00%	632,700	-	(6,122)	1,061,579	2,612	361,875	1.00	5	253,881	17,772	(4,075)	267,578	25.00	1,337,890
2038	51,791,752	20	1,035,835	72,508	(16,625)	1,091,718	480,000	6.00%	606,600	-	(6,122)	1,080,479	5,118	366,994	1.00	5	258,959	18,127	(4,156)	272,930	25.00	1,364,648
2039	51,791,752	20	1,035,835	72,508	(16,625)	1,091,718	510,000	6.00%	577,800	-	(6,122)	1,081,679	3,918	370,912	1.00	5	258,959	18,127	(4,156)	272,930	25.00	1,364,648
2040	52,827,587	20	1,056,552	73,959	(16,958)	1,113,553	565,000	6.00%	547,200	-	(6,122)	1,106,079	1,353	372,265	1.00	5	264,138	18,490	(4,239)	278,388	25.00	1,391,941
2041	52,827,587	20	1,056,552	73,959	(16,958)	1,113,553	600,000	6.00%	513,300	-	(6,122)	1,107,179	253	372,517	1.00	5	264,138	18,490	(4,239)	278,388	25.00	1,391,941
2042	53,884,139	20	1,077,683	75,438	(17,297)	1,135,824	655,000	6.00%	477,300	-	(6,122)	1,126,179	3,524	376,041	1.00	5	269,421	18,859	(4,324)	283,956	25.00	1,419,780
2043	53,884,139	20	1,077,683	75,438	(17,297)	1,135,824	695,000	6.00%	438,000	-	(6,122)	1,126,879	2,824	378,865	1.00	5	269,421	18,859	(4,324)	283,956	25.00	1,419,780
2044	54,961,821	20	1,099,236	76,947	(17,643)	1,158,540	760,000	6.00%	396,300	-	(6,122)	1,150,179	2,240	381,105	1.00	5	274,809	19,237	(4,411)	289,635	25.00	1,448,175
2045	54,961,821	20	1,099,236	76,947	(17,643)	1,158,540	805,000	6.00%	350,700	-	(6,122)	1,149,579	2,840	383,945	1.00	5	274,809	19,237	(4,411)	289,635	25.00	1,448,175
2046	56,061,058	20	1,121,221	78,485	(17,996)	1,181,711	875,000	6.00%	302,400	-	(6,122)	1,171,279	4,311	388,256	1.00	5	280,305	19,621	(4,499)	295,428	25.00	1,477,139
2047	56,061,058	20	1,121,221	78,485	(17,996)	1,181,711	930,000	6.00%	249,900	-	(6,122)	1,173,779	1,811	390,068	1.00	5	280,305	19,621	(4,499)	295,428	25.00	1,477,139
2048	57,182,279	20	1,143,646	80,055	(18,356)	1,205,345	1,010,000	6.00%	194,100	-	(6,122)	1,197,979	1,245	391,313	1.00	5	285,911	20,014	(4,589)	301,336	25.00	1,506,682
2049	57,182,279	20	1,143,646	80,055	(18,356)	1,205,345	1,070,000	6.00%	133,500	-	(6,122)	1,197,379	1,845	393,158	1.00	5	285,911	20,014	(4,589)	301,336	25.00	1,506,682
2050	58,325,925	20	1,166,518	81,656	(18,723)	1,229,452	1,155,000	6.00%	69,300	-	(1,230,422)	(6,122)	5,152	398,310	1.00	5	291,630	20,414	(4,681)	307,363	25.00	1,536,815
Total:							13,555,000		18,147,150	(2,439,900)		27,851,244	398,310									

Notes:

(1) Estimated SO Tax : 7.00%

(2) Estimated Collection Fees: 1.50%

(4) DSRF - Requirement: 1,224,300

Estimate Int Earnings: 0.50%

(5) Debt Service Notes:

a.. Preliminary and subject to change.

b. Interest rate assumptions are based on current market conditions and similar credits.

c. Issuer's actual results may differ, and Stifel makes no commitment to underwrite at these levels.

d. Costs of issuance and underwriter's discount are estimates for discussion purposes.

Sources of Funds	*Series 2020*
Bond Proceeds	13,555,000
Total	13,555,000
Uses of Funds	
Construction Fund	9,484,150
Capitalized Interest Fund	2,439,900
Debt Service Reserve Fund	1,224,300
Cost of Issuance	406,650
Total	13,555,000

STIFEL

Pecos Logistics Park Metropolitan District

(In Adams County, Colorado)

Limited Tax General Obligation Bonds

Biennial AV Growth After Buildout				2%
RAW LAND				
	Current	**Less Phase I & II**		**Less Phase III**
Acres	66.3	27.5	27.5	0
Assessment Year	2019	2020	2021	2022
Collection Year	2020	2021	2022	2023
Market Value	5,804,936	7,546,770	16,171,650	-
MV per Land SF	2.01	6.3	13.5	13.5
Assessment Ratio	29%	29%	29%	29%
Total AV	1,683,432	2,188,563	4,689,779	-

BTS				
	RSF	Acres (Per Site Plan)	Permit Date	Completion Date
Phase I	271,688	15.9	2020	2021
Phase II	391,600	22.9	2020	2021
Phase III	471,000	27.5	2022	2023

	PHASE I			**PHASE II**			**PHASE III**			**COMBINED TOTAL**	
	Building NRA:	**271,688**		**Building NRA:**	**391,600**		**Building NRA:**	**471,000**		**Building NRA:**	**1,134,288**
	Acres of Land:	**15.9**		**Acres of Land:**	**22.9**		**Acres of Land:**	**27.5**		**Acres of Land:**	**66.3**
	Permit Date:	**2020**		**Permit Date:**	**2020**		**Permit Date:**	**2022**			
	Comletion Date:	**2021**		**Comletion Date:**	**2021**		**Comletion Date**	**2023**			
Assessment Year	Collection Year	Market Value	MV per NRA[1]	Total Assessed Value	Market Value	MV per NRA[1]	Total Assessed Value	Market Value	MV per NRA[1]	Total Assessed Value	Market Value	Total Assessed Value
2019	2020	-	-	-	-	-	-	-	-	-	5,804,936	1,683,432
2020	2021	-	-	-	-	-	-	-	-	-	7,546,770	2,188,563
2021	2022	15,696,774	57.78	4,552,065	22,624,690	57.78	6,561,160	-	-	-	54,493,114	15,803,003
2022	2023	31,393,548	115.55	9,104,129	45,249,380	115.55	13,122,320	-	-	-	76,642,928	22,226,449
2023	2024	34,531,545	127.10	10,014,148	49,772,360	127.10	14,433,984	29,932,050	63.55	8,680,295	114,235,955	33,128,427
2024	2025	34,531,545	127.10	10,014,148	49,772,360	127.10	14,433,984	59,864,100	127.10	17,360,589	144,168,005	41,808,721
2025	2026	37,984,699	139.81	11,015,563	54,749,596	139.81	15,877,383	65,850,510	139.81	19,096,648	158,584,805	45,989,594
2026	2027	37,984,699	139.81	11,015,563	54,749,596	139.81	15,877,383	65,850,510	139.81	19,096,648	158,584,805	45,989,594
2027	2028	38,744,393	142.61	11,235,874	55,844,588	142.61	16,194,930	67,167,520	142.61	19,478,581	161,756,501	46,909,385
2028	2029	38,744,393	142.61	11,235,874	55,844,588	142.61	16,194,930	67,167,520	142.61	19,478,581	161,756,501	46,909,385
2029	2030	39,519,281	145.46	11,460,592	56,961,480	145.46	16,518,829	68,510,871	145.46	19,868,152	164,991,631	47,847,573
2030	2031	39,519,281	145.46	11,460,592	56,961,480	145.46	16,518,829	68,510,871	145.46	19,868,152	164,991,631	47,847,573
2031	2032	40,309,667	148.37	11,689,803	58,100,709	148.37	16,849,206	69,881,088	148.37	20,265,516	168,291,464	48,804,525
2032	2033	40,309,667	148.37	11,689,803	58,100,709	148.37	16,849,206	69,881,088	148.37	20,265,516	168,291,464	48,804,525
2033	2034	41,115,860	151.33	11,923,599	59,262,723	151.33	17,186,190	71,278,710	151.33	20,670,826	171,657,293	49,780,615
2034	2035	41,115,860	151.33	11,923,599	59,262,723	151.33	17,186,190	71,278,710	151.33	20,670,826	171,657,293	49,780,615
2035	2036	41,938,177	154.36	12,162,071	60,447,978	154.36	17,529,914	72,704,284	154.36	21,084,242	175,090,439	50,776,227
2036	2037	41,938,177	154.36	12,162,071	60,447,978	154.36	17,529,914	72,704,284	154.36	21,084,242	175,090,439	50,776,227
2037	2038	42,776,941	157.45	12,405,313	61,656,937	157.45	17,880,512	74,158,370	157.45	21,505,927	178,592,248	51,791,752
2038	2039	42,776,941	157.45	12,405,313	61,656,937	157.45	17,880,512	74,158,370	157.45	21,505,927	178,592,248	51,791,752
2039	2040	43,632,480	160.60	12,653,419	62,890,076	160.60	18,238,122	75,641,537	160.60	21,936,046	182,164,093	52,827,587
2040	2041	43,632,480	160.60	12,653,419	62,890,076	160.60	18,238,122	75,641,537	160.60	21,936,046	182,164,093	52,827,587
2041	2042	44,505,129	163.81	12,906,487	64,147,878	163.81	18,602,885	77,154,368	163.81	22,374,767	185,807,375	53,884,139
2042	2043	44,505,129	163.81	12,906,487	64,147,878	163.81	18,602,885	77,154,368	163.81	22,374,767	185,807,375	53,884,139
2043	2044	45,395,232	167.09	13,164,617	65,430,835	167.09	18,974,942	78,697,455	167.09	22,822,262	189,523,522	54,961,821
2044	2045	45,395,232	167.09	13,164,617	65,430,835	167.09	18,974,942	78,697,455	167.09	22,822,262	189,523,522	54,961,821
2045	2046	46,303,136	170.43	13,427,910	66,739,452	170.43	19,354,441	80,271,404	170.43	23,278,707	193,313,993	56,061,058
2046	2047	46,303,136	170.43	13,427,910	66,739,452	170.43	19,354,441	80,271,404	170.43	23,278,707	193,313,993	56,061,058
2047	2048	47,229,199	173.84	13,696,468	68,074,241	173.84	19,741,530	81,876,832	173.84	23,744,281	197,180,273	57,182,279
2048	2049	47,229,199	173.84	13,696,468	68,074,241	173.84	19,741,530	81,876,832	173.84	23,744,281	197,180,273	57,182,279
2049	2050	48,173,783	177.31	13,970,397	69,435,726	177.31	20,136,361	83,514,369	177.31	24,219,167	201,123,878	58,325,925
2050	2051	48,173,783	177.31	13,970,397	69,435,726	177.31	20,136,361	83,514,369	177.31	24,219,167	201,123,878	58,325,925
2051	2052	49,137,259	180.86	14,249,805	70,824,440	180.86	20,539,088	85,184,656	180.86	24,703,550	205,146,356	59,492,443
2052	2053	49,137,259	180.86	14,249,805	70,824,440	180.86	20,539,088	85,184,656	180.86	24,703,550	205,146,356	59,492,443
2053	2054	50,120,004	184.48	14,534,801	72,240,929	184.48	20,949,869	86,888,349	184.48	25,197,621	209,249,283	60,682,292
2054	2055	50,120,004	184.48	14,534,801	72,240,929	184.48	20,949,869	86,888,349	184.48	25,197,621	209,249,283	60,682,292
2055	2056	51,122,404	188.17	14,825,497	73,685,748	188.17	21,368,867	88,626,116	188.17	25,701,574	213,434,268	61,895,938
2056	2057	51,122,404	188.17	14,825,497	73,685,748	188.17	21,368,867	88,626,116	188.17	25,701,574	213,434,268	61,895,938

[1] Provided by the Developer

STIFEL

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Pecos Logistics Park Metropolitan District
Limited Tax General Obligation Bonds, Series 2020

SOURCES AND USES OF FUNDS

Pecos Logistics Park Metropolitan District
Limited Tax General Obligation Bonds, Series 2020

Dated Date	06/01/2020
Delivery Date	06/01/2020

Sources:	
Bond Proceeds:	
Par Amount	13,555,000.00
	13,555,000.00

Uses:	
Project Fund Deposits:	
Project Fund	9,484,150.00
Other Fund Deposits:	
Debt Service Reserve Fund	1,224,300.00
Capitalized Interest Fund	2,439,900.00
	3,664,200.00
Delivery Date Expenses:	
Cost of Issuance	406,650.00
	13,555,000.00

Notes:
1. Preliminary and subject to change.
2. Interest rate assumptions are based on current market conditions and similar credits.
3. Issuer's actual results may differ, and Stifel makes no commitment to underwrite at these levels.
4. Costs of issuance and underwriter's discount are estimates for discussion purposes.

BOND PRICING

Pecos Logistics Park Metropolitan District
Limited Tax General Obligation Bonds, Series 2020

Bond Component	Maturity Date	Amount	Rate	Yield	Price
Term Bond:					
	12/01/2050	13,555,000	6.000%	6.000%	100.000
		13,555,000			

Dated Date	06/01/2020	
Delivery Date	06/01/2020	
First Coupon	12/01/2020	
Par Amount	13,555,000.00	
Original Issue Discount		
Production	13,555,000.00	100.000000%
Underwriter's Discount		
Purchase Price	13,555,000.00	100.000000%
Accrued Interest		
Net Proceeds	13,555,000.00	

Notes:
1. Preliminary and subject to change.
2. Interest rate assumptions are based on current market conditions and similar credits.
3. Issuer's actual results may differ, and Stifel makes no commitment to underwrite at these levels.
4. Costs of issuance and underwriter's discount are estimates for discussion purposes.

BOND DEBT SERVICE

Pecos Logistics Park Metropolitan District
Limited Tax General Obligation Bonds, Series 2020

Period Ending	Principal	Coupon	Interest	Debt Service
12/01/2020			406,650	406,650
12/01/2021			813,300	813,300
12/01/2022			813,300	813,300
12/01/2023			813,300	813,300
12/01/2024			813,300	813,300
12/01/2025	65,000	6.000%	813,300	878,300
12/01/2026	160,000	6.000%	809,400	969,400
12/01/2027	165,000	6.000%	799,800	964,800
12/01/2028	195,000	6.000%	789,900	984,900
12/01/2029	210,000	6.000%	778,200	988,200
12/01/2030	240,000	6.000%	765,600	1,005,600
12/01/2031	255,000	6.000%	751,200	1,006,200
12/01/2032	290,000	6.000%	735,900	1,025,900
12/01/2033	310,000	6.000%	718,500	1,028,500
12/01/2034	345,000	6.000%	699,900	1,044,900
12/01/2035	365,000	6.000%	679,200	1,044,200
12/01/2036	410,000	6.000%	657,300	1,067,300
12/01/2037	435,000	6.000%	632,700	1,067,700
12/01/2038	480,000	6.000%	606,600	1,086,600
12/01/2039	510,000	6.000%	577,800	1,087,800
12/01/2040	565,000	6.000%	547,200	1,112,200
12/01/2041	600,000	6.000%	513,300	1,113,300
12/01/2042	655,000	6.000%	477,300	1,132,300
12/01/2043	695,000	6.000%	438,000	1,133,000
12/01/2044	760,000	6.000%	396,300	1,156,300
12/01/2045	805,000	6.000%	350,700	1,155,700
12/01/2046	875,000	6.000%	302,400	1,177,400
12/01/2047	930,000	6.000%	249,900	1,179,900
12/01/2048	1,010,000	6.000%	194,100	1,204,100
12/01/2049	1,070,000	6.000%	133,500	1,203,500
12/01/2050	1,155,000	6.000%	69,300	1,224,300
	13,555,000		18,147,150	31,702,150

Notes:
1. Preliminary and subject to change.
2. Interest rate assumptions are based on current market conditions and similar credits.
3. Issuer's actual results may differ, and Stifel makes no commitment to underwrite at these levels.
4. Costs of issuance and underwriter's discount are estimates for discussion purposes.

BOND SUMMARY STATISTICS

Pecos Logistics Park Metropolitan District
Limited Tax General Obligation Bonds, Series 2020

Dated Date	06/01/2020
Delivery Date	06/01/2020
Last Maturity	12/01/2050
Arbitrage Yield	6.000000%
True Interest Cost (TIC)	6.000000%
Net Interest Cost (NIC)	6.000000%
All-In TIC	6.259384%
Average Coupon	6.000000%
Average Life (years)	22.313
Duration of Issue (years)	12.190
Par Amount	13,555,000.00
Bond Proceeds	13,555,000.00
Total Interest	18,147,150.00
Net Interest	18,147,150.00
Total Debt Service	31,702,150.00
Maximum Annual Debt Service	1,224,300.00
Average Annual Debt Service	1,039,414.75
Underwriter's Fees (per $1000)	
Average Takedown	
Other Fee	
Total Underwriter's Discount	
Bid Price	100.000000

Bond Component	Par Value	Price	Average Coupon	Average Life	PV of 1 bp change
Term Bond	13,555,000.00	100.000	6.000%	22.313	18,977.00
	13,555,000.00			22.313	18,977.00

	TIC	All-In TIC	Arbitrage Yield
Par Value	13,555,000.00	13,555,000.00	13,555,000.00
+ Accrued Interest			
+ Premium (Discount)			
- Underwriter's Discount			
- Cost of Issuance Expense		-406,650.00	
- Other Amounts			
Target Value	13,555,000.00	13,148,350.00	13,555,000.00
Target Date	06/01/2020	06/01/2020	06/01/2020
Yield	6.000000%	6.259384%	6.000000%

BOND SUMMARY STATISTICS

Pecos Logistics Park Metropolitan District
Limited Tax General Obligation Bonds, Series 2020

Notes:
1. Preliminary and subject to change.
2. Interest rate assumptions are based on current market conditions and similar credits.
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4. Costs of issuance and underwriter's discount are estimates for discussion purposes.

GENERAL INFORMATION EXCLUSION DISCLOSURE

Pecos Logistics Park Metropolitan District
Limited Tax General Obligation Bonds, Series 2020

Stifel, Nicolaus & Company, Incorporated ('Stifel') has prepared the attached materials. Such material consists of factual or general information (as defined in the SEC's Municipal Advisor Rule). Stifel is not hereby providing a municipal entity or obligated person with any advice or making any recommendation as to action concerning the structure, timing or terms of any issuance of municipal securities or municipal financial products. To the extent that Stifel provides any alternatives, options, calculations or examples in the attached information, such information is not intended to express any view that the municipal entity or obligated person could achieve particular results in any municipal securities transaction, and those alternatives, options, calculations or examples do not constitute a recommendation that any municipal issuer or obligated person should effect any municipal securities transaction. Stifel is acting in its own interests, is not acting as your municipal advisor and does not owe a fiduciary duty pursuant to Section 15B of the Securities Exchange Act of 1934, as amended, to the municipal entity or obligated party with respect to the information and materials contained in this communication.

Stifel is providing information and is declaring to the proposed municipal issuer and any obligated person that it has done so within the regulatory framework of MSRB Rule G-23 as an underwriter (by definition also including the role of placement agent) and not as a financial advisor, as defined therein, with respect to the referenced proposed issuance of municipal securities. The primary role of Stifel, as an underwriter, is to purchase securities for resale to investors in an arm's- length commercial transaction. Serving in the role of underwriter, Stifel has financial and other interests that differ from those of the issuer. The issuer should consult with its own financial and/or municipal, legal, accounting, tax and other advisors, as applicable, to the extent it deems appropriate.

These materials have been prepared by Stifel for the client or potential client to whom such materials are directly addressed and delivered for discussion purposes only. All terms and conditions are subject to further discussion and negotiation. Stifel does not express any view as to whether financing options presented in these materials are achievable or will be available at the time of any contemplated transaction. These materials do not constitute an offer or solicitation to sell or purchase any securities and are not a commitment by Stifel to provide or arrange any financing for any transaction or to purchase any security in connection therewith and may not relied upon as an indication that such an offer will be provided in the future. Where indicated, this presentation may contain information derived from sources other than Stifel. While we believe such information to be accurate and complete, Stifel does not guarantee the accuracy of this information. This material is based on information currently available to Stifel or its sources and is subject to change without notice. Stifel does not provide accounting, tax or legal advice; however, you should be aware that any proposed indicative transaction could have accounting, tax, legal or other implications that should be discussed with your advisors and /or counsel as you deem appropriate.

Notes:
1. Preliminary and subject to change.
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Exhibit F
Overlapping Mill Levies and Indebtedness; Similar District Comparison

Pursuant to Section 10-05-03-03-02-02 of the Adams County Special District Guidelines and Regulations, a list of all mill levies currently imposed within the proposed District, a list of all overlapping bonded indebtedness, and a list of mill levies and other fees for districts supplying similar services for a similar market located in the region are provided below.

Overlapping Mill Levies

Entity	Mill Levy
Rangeview Library District	3.666
Berkeley Water & Sanitation District	3.374
Adams County Fire Protection District	16.650
Adams County	26.864
Hyland Hills Park & Recreation	5.413
RTD	0.000
SD 50	66.514
Urban Drainage South Platte	0.094
Urban Drainage & Flood Control	0.726
TOTAL	136.378

Overlapping Bonded Indebtedness

Entity	Debt*
Rangeview Library District	$39,139,981-
Berkeley Water & Sanitation District	-
Adams County Fire Protection District	$2,619,537
Adams County	$194,418,412
Hyland Hills Park & Recreation	$6,225,000
RTD	0.000
SD 50	$64,515,000
Urban Drainage South Platte	-
Urban Drainage & Flood Control	-

*according to Adams County 2017 Comprehensive Financial Report (2017 Audit)

Mill Levies and Other Fees for Districts Supplying Similar Services

District	Total Mill Levy	Fees	Jurisdiction	Property Type
(proposed) Pecos Logistics Park Metropolitan District	25.000 (exp. 2019)	-	Adams County	Commercial Only
Compark Business Campus Metropolitan District	42.275	-	Douglas County	Commercial Only
Denver Rock Drill Metropolitan District	50.000 (exp. 2019)	-	Denver	Commercial Only
Hurley Place Commercial Metropolitan District	50.000 (exp. 2019)	-	Denver	Commercial Only
Midtown Metropolitan District	30.000	-	Denver	Commercial Only
Foxfield Metropolitan District No. 1	40.000 (2017 levy)	-	Arapahoe	Commercial Only

Exhibit G
List of Property Owners and Adjacent Owners

Pursuant to Section 10-05-03-03-02-07 of the Adams County Special District Guidelines and Regulations, a list of property owners and adjacent property owners follows.

Property Owner (sole owner):
Pecos Logistics Park, LLLP
4221 Brighton Blvd.
Denver CO 80216

Adjacent Owners:

ADJACENT OWNER NAME	PROPERTY ADDRESS
ALPINE LUMBER COMPANY	5800 PECOS ST
ESP VENTURES LLC	5750 PECOS ST
CASTILLO THEODORE G	5686 PECOS ST
MONTEFERRANTE ASSET MANAGEMENT LLC	5680 PECOS ST
STEWART JAMES	5678 PECOS ST
WHITE DIANE E	5650 PECOS ST
MONTEFERRANTE ASSET MANAGEMENT LLC	5680 PECOS STREET
RINGSBY TERMINALS INC	5610 PECOS ST
HENDERSON RODNEY W	5676 PECOS ST
AMAR INC	5595 PECOS ST
BK ENTERPRISES LLC	5555 PECOS ST
TRUJILLO WILLIE RAYMOND AND TRUJILLO ORALIA ARA	5584 QUIVAS ST
SANCHEZ ABRAHAM AND SANCHEZ MARIA R	5585 QUIVAS ST
PACHECO TANIA B DELGADO	1722 W 56TH AVE
LOPEZ ARTURO JR	1742 W 56TH AVE
PAIZ DARRIN P AND PAIZ TRACIE L	1762 W 56TH AVE
GONZALES FRANCES R	5582 RARITAN WAY
APMANN AARON	5573 RARITAN WAY
RODRIGUEZ PETE F AND DURAN BONNIE A	5570 SHOSHONE ST
SWEENEY GRISEL AND SWEENEY MATHEW	5581 SHOSHONE ST
PACHECO DEBBIE KAY	1950 W 56TH AVE
OLGUIN DOROTHY AND VASQUEZ SALVADOR H	1960 W 56TH AVE
CSWM PROPERTIES LLC	5671 TEJON ST

MANN PROPERTIES LTD	2151 W 56TH AVE
NEVAREZ MARCELO GUTIERREZ	2201 W 56TH AVE
ORTIZ ERASMO AND ORTIZ MARIA	2200 W 56TH PL
CLAYPOOL DAVID	2201 W 56TH PL
MC BAIN HELEN J	2220 W 57TH PL
FALLER DEBRA JEAN	2201 W 57TH PL
SUAZO BOBBY	2210 W 58TH PL
SALAZAR PETE AND SALAZAR STELLA C	2211 W 58TH PL
DIETZ ERIC	2230 W 59TH PL
PATRICK DEWEY R AND PATRICK RHONDA A	2211 W 59TH PL

*information obtained from Adams County Assessor June 25, 2019

Exhibit H
Proof of Ownership

Electronically Recorded RECEPTION#: 2018000094949,
11/27/2018 at 2:51 PM, 1 OF 7,
REC: $43.00 DocStamp: $4,071.21
TD Pgs: 2 Stan Martin, Adams County, CO.

E-RECORDED

When recorded return to:
Fox Rothschild LLP
1225 17th Street, Suite 2200
Denver, CO 80202
Attn: Michael Friedman, Esq.

State Documentary Fee
Date
$ 4071.21

SPECIAL WARRANTY DEED

[Statutory Form - C.R.S. § 38-30-115]

Rocky Mountain Prestress, LLC, a Colorado limited liability company ("Grantor"), whose street address is 5801 Pecos Street, Denver, CO 80221, for Ten and 00/100 Dollars ($10.00) and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, hereby sells and conveys to Pecos Logistics Park, LLLP, a Colorado limited liability limited partnership, whose street address is 4221 Brighton Boulevard, Denver, CO 80216, the real property in the County of Adams and State of Colorado described on Exhibit A attached hereto and made a part hereof, with all its appurtenances, and warrants the title to the same against all persons claiming under Grantor, subject to the matters set forth on Exhibit B attached hereto and made a part hereof.

The street address for the foregoing property is: 5801 Pecos Street, Denver, CO 80221.

Signed as of this 27th day of November, 2018.

SIGNATURES ON FOLLOWING PAGES

Land Title

705726030

E-RECORDED

When recorded return to:
Fox Rothschild LLP
1225 17th Street, Suite 2200
Denver, CO 80202
Attn: Michael Friedman, Esq.

State Documentary Fee
Date
$ 4071.21

SPECIAL WARRANTY DEED
[Statutory Form - C.R.S. § 38-30-115]

Rocky Mountain Prestress, LLC, a Colorado limited liability company ("Grantor"), whose street address is 5801 Pecos Street, Denver, CO 80221, for Ten and 00/100 Dollars ($10.00) and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, hereby sells and conveys to Pecos Logistics Park, LLLP, a Colorado limited liability limited partnership, whose street address is 4221 Brighton Boulevard, Denver, CO 80216, the real property in the County of Adams and State of Colorado described on Exhibit A attached hereto and made a part hereof, with all its appurtenances, and warrants the title to the same against all persons claiming under Grantor, subject to the matters set forth on Exhibit B attached hereto and made a part hereof.

The street address for the foregoing property is: 5801 Pecos Street, Denver, CO 80221.

Signed as of this 27th day of November, 2018.

SIGNATURES ON FOLLOWING PAGES

Land Title

705726630

Rocky Mountain Prestress, LLC,
a Colorado limited liability company

By: _____
Name: V. David Holsteen
Title: General Manager

By: _____
Name Travis W. Gillmore
Title: Manager

STATE OF COLORADO)
) ss.
CITY AND COUNTY OF DENVER)

The foregoing instrument was acknowledged before me this 19th day of November, 2018, by V. David Holsteen as General Manager of Rocky Mountain Prestress, LLC, a Colorado limited liability company.

Witness my hand and official seal.

My commission expires: 10/30/2021

DEBRA L MAHURON
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19874124698
MY COMMISSION EXPIRES 10/30/2021

_____
Notary Public

STATE OF COLORADO)
) ss.
CITY AND COUNTY OF DENVER)

The foregoing instrument was acknowledged before me this 19th day of November, 2018, by Travis W. Gillmore as Manager of Rocky Mountain Prestress, LLC, a Colorado limited liability company.

Witness my hand and official seal.

My commission expires: 10/30/2021

DEBRA L MAHURON
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19874124698
MY COMMISSION EXPIRES 10/30/2021

_____
Notary Public

EXHIBIT A
TO
SPECIAL WARRANTY DEED

LEGAL DESCRIPTION
(see attached)

PARCEL A:

LOT 1, BLOCK 1, PRESTRESSED - CON SUBDIVISION SECOND FILING, AS AMENDED BY PRESTRESSED-CON SUBDIVISION SECOND FILING - PLAT CORRECTION NO. 1, ACCORDING TO THE PLAT THEREOF RECORDED NOVEMBER 15, 2018 UNDER RECEPTION NO. 2018000092478, COUNTY OF ADAMS, STATE OF COLORADO, EXCEPT THAT PART DESCRIBED AS EXHIBIT "A" IN DEED RECORDED AUGUST 18, 2009 UNDER RECEPTION NO. 2009000061475.

PARCEL C:

THAT PART OF THE SOUTHWEST 1/4 OF THE SOUTHWEST 1/4 OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO, MORE PARTICULARLY DESCRIBED AS FOLLOWS:

COMMENCING AT A POINT 664.4 FEET EAST AND 660.0 FEET NORTH OF THE SOUTHWEST CORNER OF SAID SECTION;
THENCE EAST 10 FEET TO THE POINT OF BEGINNING;
THENCE CONTINUING EAST 125 FEET;
THENCE NORTH 125 FEET;
THENCE WEST 125 FEET;
THENCE SOUTH 125 FEET TO THE POINT OF BEGINNING.

PARCEL D:

LOTS 1 AND 2 INCLUSIVE, BLOCK 1, PRESTRESSED - CON SUBDIVISION, COUNTY OF ADAMS, STATE OF COLORADO.

PARCEL E:

LOT 2, BLOCK 1, FELCH SUBDIVISION, COUNTY OF ADAMS, STATE OF COLORADO.

PARCEL F:

THAT PART OF THE EAST ONE-HALF OF THE SOUTHWEST ONE-QUARTER OF SECTION 9, TOWNSHIP 3
SOUTH, RANGE 68 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO, MORE
PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE SOUTHWEST CORNER OF THE SOUTHEAST QUARTER OF THE SOUTHWEST QUARTER OF SAID SECTION 9, THENCE EAST ALONG SAID SECTION LINE 60 FEET;
THENCE NORTH 40 FEET TO THE TRUE POINT OF BEGINNING;
THENCE NORTH 10 FEET;
THENCE WEST 30 FEET;
THENCE NORTH 308 FEET;
THENCE EAST 302.2 FEET;
THENCE SOUTH 318 FEET;
THENCE WEST 95 FEET;
THENCE NORTH 145 FEET;
THENCE WEST 110 FEET;
THENCE SOUTH 145 FEET;
THENCE WEST 67.20 FEET TO THE TRUE POINT OF BEGINNING.
EXCEPT THE NORTH 35 FEET THEREOF AND EXCEPT THE EAST 1 FOOT THEREOF DESCRIBED IN
DEED RECORDED AUGUST 31, 1978 IN BOOK 2270 AT PAGE 387.

NOTE: THIS LEGAL DESCRIPTION FOR PARCEL F IS THE SAME AS THE LEGAL DESCRIPTION REFERENCED IN THE PERSONAL REPRESENTATIVES DEED RECORDED ON AUGUST 8, 2000 AT RECEPTION NO. C0698515 IN BOOK 6216 AT PAGE 002-003, BUT WITH A CORRECTION TO THE SCRIVENERS ERRORS CONTAINED IN SUCH DEED THAT (I) INCORRECTLY LISTED THE RANGE AS "RANGE 58 WEST", (II) INCORRECTLY STATED THE SIXTH CALL AS "THENCE EAST 202.2 FEET" AND (III) INCORRECTLY LISTED THE LAST CALL AS "THENCE WEST 07.20 FEET TO THE TRUE POINT OF BEGINNING".

PARCEL G:

A PARCEL OF LAND IN THE SOUTHEAST 1/4 OF THE SOUTHWEST 1/4 OF SECTION 9, TOWNSHIP 3
SOUTH, RANGE 68 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO, MORE
PARTICULARLY DESCRIBED AS FOLLOWS:
COMMENCING AT THE SOUTHWEST CORNER OF THE SOUTHEAST 1/4 OF THE SOUTHWEST 1/4 OF
SAID SECTION 9, THENCE EAST ALONG THE SOUTH SECTION LINE, 127.20 FEET;
THENCE NORTH 40 FEET TO THE TRUE POINT OF BEGINNING;
THENCE NORTH 145 FEET;
THENCE EAST 110 FEET;
THENCE SOUTH 145 FEET
THENCE WEST 110 FEET TO THE POINT OF BEGINNING.

NOTE: THIS LEGAL DESCRIPTION FOR PARCEL G IS THE SAME AS THE LEGAL DESCRIPTION REFERENCED IN THE PERSONAL REPRESENTATIVES DEED RECORDED ON AUGUST 8, 2000 AT RECEPTION NO. C0698515 IN BOOK 6216 AT

PAGE 002-003, BUT WITH A CORRECTION TO THE SCRIVENERS ERRORS CONTAINED IN SUCH DEED THAT INCORRECTLY STATED THE FIRST CALL AS "THENCE EAST ALONG THE SOUTH SECTION LINE, 187.20 FEET."

EXHIBIT B
TO
SPECIAL WARRANTY DEED

TITLE EXCEPTIONS

1. TAXES FOR THE YEAR 2018, A LIEN NOT YET DUE AND PAYABLE.

2. WATER RIGHTS, CLAIMS OR TITLE TO WATER.

3. RIGHT OF THE PROPRIETOR OF A VEIN OR LODE TO EXTRACT AND REMOVE HIS ORE THEREFROM, SHOULD THE SAME BE FOUND TO PENETRATE OR INTERSECT THE PREMISES HEREBY GRANTED, AND A RIGHT OF WAY FOR DITCHES OR CANALS CONSTRUCTED BY THE AUTHORITY OF THE UNITED STATES, AS RESERVED IN UNITED STATES PATENT RECORDED AUGUST 21, 1897 IN BOOK A67 AT PAGE 272.

4. TERMS, CONDITIONS, PROVISIONS, BURDENS AND OBLIGATIONS AS SET FORTH IN RESOLUTION OF COMMISSIONERS RECORDED AUGUST 21, 1957 IN BOOK 670 AT PAGE 517 AND MARCH 19, 1958 IN BOOK 702 AT PAGE 107.

5. EASEMENT GRANTED TO PUBLIC SERVICE COMPANY OF COLORADO, FOR GAS PIPELINES, AND INCIDENTAL PURPOSES, BY INSTRUMENT RECORDED JULY 01, 1959, IN BOOK 786 AT PAGE 562.

6. RESERVATION OF RIGHTS-OF-WAY OR EASEMENTS FOR THE CONTINUED USE OF EXISTING SEWER, GAS, WATER OR SIMILAR PIPE LINES AND APPURTENANCES AND FOR ELECTRIC, TELEPHONE AND SIMILAR LINES AND APPURTENANCES WITHIN THE VACATED RIGHTS OF WAY OF TEJON STREET, RARITAN STREET AND PINKARD DRIVE, BY THE BOARD OF COUNTY COMMISSIONERS, COUNTY OF ADAMS, AS SET FORTH IN RESOLUTION RECORDED JUNE 15, 1970 IN BOOK 1605 AT PAGE 266.

7. RESERVATION OF RIGHTS-OF-WAY OR EASEMENTS FOR THE CONTINUED USE OF EXISTING SEWER, GAS, WATER OR SIMILAR PIPE LINES AND APPURTENANCES AND FOR ELECTRIC, TELEPHONE AND SIMILAR LINES AND APPURTENANCES WITHIN THE VACATED RIGHTS OF WAY OF A PORTION OF RARITAN STREET NORTH OF W. 56TH AVENUE, BY THE BOARD OF COUNTY COMMISSIONERS, COUNTY OF ADAMS, AS SET FORTH IN RESOLUTION RECORDED APRIL 28, 1971 IN BOOK 1689 AT PAGE 483 , AND CORRECTION RECORDED JULY 14, 1971 IN BOOK 1714 AT PAGE 369.

8. TERMS, CONDITIONS, PROVISIONS, BURDENS AND OBLIGATIONS AS SET FORTH IN DEVELOPMENT AGREEMENT RECORDED APRIL 16, 1974 IN BOOK 1924 AT PAGE 492.

9. EASEMENTS, CONDITIONS, COVENANTS, RESTRICTIONS, RESERVATIONS AND NOTES ON THE PLAT OF FELCH SUBDIVISION RECORDED APRIL 16, 1974 UNDER RECEPTION NO. 37717. AFFIDAVIT OF CORRECTION RECORDED JULY 16, 1974 IN BOOK 1942 AT PAGE 492.

10. RESERVATION OF RIGHTS-OF-WAY OR EASEMENTS FOR THE CONTINUED USE OF EXISTING SEWER, GAS, WATER OR SIMILAR PIPE LINES AND APPURTENANCES AND FOR ELECTRIC, TELEPHONE AND SIMILAR LINES AND APPURTENANCES WITHIN THE VACATED RIGHTS OF WAY OF A PORTION OF WEST 56TH PLACE AND RARITAN STREET, BY THE BOARD OF COUNTY COMMISSIONERS, COUNTY OF ADAMS, AS SET FORTH IN RESOLUTION RECORDED FEBRUARY 10, 1981 IN BOOK 2530 AT PAGE 336.

11. EASEMENTS, CONDITIONS, COVENANTS, RESTRICTIONS, RESERVATIONS AND NOTES ON THE PLAT OF PRESTRESSED - CON SUBDIVISION RECORDED AUGUST 05, 1981 UNDER RECEPTION NO. 336911.

12. TERMS, CONDITIONS, PROVISIONS, BURDENS AND OBLIGATIONS AS SET FORTH IN DEVELOPMENT AGREEMENT RECORDED AUGUST 18, 1981 IN BOOK 2579 AT PAGE 800.

13. TERMS, CONDITIONS, PROVISIONS, BURDENS, OBLIGATIONS AND EASEMENTS AS SET FORTH AND GRANTED IN PRIVATE WAY LICENSE RECORDED SEPTEMBER 28, 1982 IN BOOK 2681 AT PAGE 765.

14. TERMS, CONDITIONS, PROVISIONS, BURDENS, OBLIGATIONS AND EASEMENTS AS SET FORTH AND GRANTED IN RIGHT OF WAY AGREEMENT RECORDED JUNE 19, 1984 IN BOOK 2885 AT PAGE 841.

15. TERMS, CONDITIONS, PROVISIONS, BURDENS, OBLIGATIONS AND EASEMENTS AS SET FORTH AND GRANTED IN UTILITY EASEMENT FOR WATER LINE, SANITARY SEWER AND STORM SEWER RECORDED DECEMBER 10, 1987 IN BOOK 3397 AT PAGE 485.

Electronically Recorded RECEPTION#: 2019000040235,
5/28/2019 at 2:25 PM, 1 OF 7,
REC: $43.00 DocStamp: $598.23
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

When recorded return to:
Fox Rothschild LLP
1225 17th Street, Suite 2200
Denver, CO 80202
Attn: Michael Friedman, Esq.

Doc Fee $598.23

SPECIAL WARRANTY DEED
[Statutory Form – C.R.S. § 38-30-115]

Rocky Mountain Prestress, LLC, a Colorado limited liability company ("Grantor"), whose street address is 5801 Pecos Street, Denver, CO 80221, for Ten and 00/100 Dollars ($10.00) and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, hereby sells and conveys to Pecos Logistics Park, LLLP, a Colorado limited liability limited partnership, whose street address is 4221 Brighton Boulevard, Denver, CO 80216, the real property in the County of Adams and State of Colorado described on Exhibit A attached hereto and made a part hereof, with all its appurtenances, and warrants the title to the same against all persons claiming under Grantor, subject to the matters set forth on Exhibit B attached hereto and made a part hereof.

The street address for the foregoing property is: Vacant Land.

Signed as of this 28th day of May, 2019.

Land Title
GUARANTEE COMPANY

70603098.1

Electronically Recorded RECEPTION#: 2019000040235,
5/28/2019 at 2:25 PM, 2 OF 7,
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

Rocky Mountain Prestress, LLC,
a Colorado limited liability company

By:_____
Name: V. David Holsteen
Title: General Manager

STATE OF COLORADO)
) ss.
CITY AND COUNTY OF DENVER)

The foregoing instrument was acknowledged before me this 16 day of May, 2019, by V. David Holsteen as General Manager of Rocky Mountain Prestress, LLC, a Colorado limited liability company.

Witness my hand and official seal.

My commission expires: 8-29-21

_____
Notary Public

THOMAS J BLAKE
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19874017358
My Commission Expires August 29, 2021

Electronically Recorded RECEPTION#: 2019000040235,
5/28/2019 at 2:25 PM, 3 OF 7,
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

EXHIBIT A
TO
SPECIAL WARRANTY DEED

LEGAL DESCRIPTION

PARCEL B:
LOT 1, BLOCK 2, PRESTRESSED - CON SUBDIVISION SECOND FILING, AS AMENDED BY PRESTRESSED-CON SUBDIVISION SECOND FILING - PLAT CORRECTION NO. 1, ACCORDING TO THE PLAT THEREOF RECORDED NOVEMBER 15, 2018 UNDER RECEPTION NO. 2018000092478, COUNTY OF ADAMS, STATE OF COLORADO, EXCEPT THAT PART DESCRIBED AS EXHIBIT "B" IN DEED RECORDED AUGUST 18, 2009 UNDER RECEPTION NO. 2009000061475.

PARCEL H:
A PARCEL OF LAND LOCATED IN THE SOUTHWEST 1/4 OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO, MORE PARTICULARLY DESCRIBED AS FOLLOWS: ALL THAT PORTION OF THE BURLINGTON NORTHERN AND SANTA FE RAILWAY COMPANY'S (FORMERLY COLORADO AND SOUTHERN RAILWAY COMPANY) 100.0 FOOT WIDE BRANCH LINE RIGHT OF WAY, BEING 50.0 FEET WIDE ON EACH SIDE OF SAID RAILWAY COMPANY'S MAIN TRACK CENTERLINE, AS ORIGINALLY LOCATED AND CONSTRUCTED UPON, OVER, AND ACROSS THOSE LANDS CONVEYED TO SAID RAILWAY COMPANY BY DEED RECORDED AUGUST 15, 1870 IN BOOK 28 AT PAGE 266, RECORDS OF ARAPAHOE COUNTY, COLORADO AND SITUATED IN THE SW1/4 OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE SIXTH PRINCIPAL MERIDIAN, ADAMS COUNTY, COLORADO BOUNDED ON THE EASTERLY SIDE BY A LINE DRAWN AT RIGHT ANGLES TO SAID MAIN TRACK CENTERLINE DISTANT 545.0 FEET WESTERLY OF THE CENTERLINE OF PECOS STREET, AS MEASURED ALONG A LINE DRAWN PARALLEL WITH AND DISTANT 50.0 FEET SOUTHERLY OF, AS MEASURED AT RIGHT ANGLES FROM SAID MAIN TRACK CENTERLINE, AND BOUNDED ON THE WESTERLY SIDE BY A LINE DRAWN PARALLEL WITH THE EAST LINE OF SAID SW1/4 OF SECTION 9 AND DISTANT 1,405.0 FEET WESTERLY OF SAID CENTERLINE OF PECOS STREET, AS MEASURED ALONG SAID LINE DRAWN PARALLEL WITH AND DISTANT 50.0 FEET SOUTHERLY OF, AS MEASURED AT RIGHT ANGLES FROM SAID MAIN TRACK CENTERLINE.

PARCEL I:
A PARCEL OF LAND LYING IN THE SOUTHWEST 1/4 OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH P.M., COUNTY OF ADAMS, STATE OF COLORADO, DESCRIBED AS FOLLOWS:
BEING THAT PORTION OF THAT CERTAIN 12 ACRE TRACT OF LAND DESCRIBED IN DEED DATED AUGUST 15, 1870 TO THE COLORADO CENTRAL RAILROAD COMPANY, RECORDED AUGUST 15, 1870 IN BOOK 28 AT PAGE 266, RECORDS OF

ARAPAHOE COUNTY, BOUNDED WESTERLY BY THE EASTERLY BOUNDARY OF THAT CERTAIN PARCEL OF LAND DESCRIBED IN DEED DATED FEBRUARY 24, 1998 FROM THE BURLINGTON NORTHERN AND SANTA FE RAILROAD COMPANY TO ANT, LLC, RECORDED DECEMBER 10, 1999 IN BOOK 5978 AT PAGE 846, RECORDS OF ADAMS COUNTY AND BOUNDED EASTERLY BY THE WESTERLY BOUNDARY OF THAT CERTAIN 0.215 ACRE PARCEL OF LAND DESCRIBED IN DEED DATED SEPTEMBER 11, 2009 FROM BNSF RAILWAY COMPANY TO ADAMS COUNTY, COLORADO RECORDED SEPTEMBER 16, 2009 AT RECEPTION NO. 2009000069014, RECORDS OF ADAMS COUNTY.

Electronically Recorded RECEPTION#: 2019000040235,
5/28/2019 at 2:25 PM, 5 OF 7,
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

EXHIBIT B
TO
SPECIAL WARRANTY DEED

TITLE EXCEPTIONS

1. TAXES FOR THE YEAR 2019, A LIEN NOT YET DUE AND PAYABLE.

2. RIGHT OF THE PROPRIETOR OF A VEIN OR LODE TO EXTRACT AND REMOVE HIS ORE THEREFROM, SHOULD THE SAME BE FOUND TO PENETRATE OR INTERSECT THE PREMISES HEREBY GRANTED, AND A RIGHT OF WAY FOR DITCHES OR CANALS CONSTRUCTED BY THE AUTHORITY OF THE UNITED STATES, AS RESERVED IN UNITED STATES PATENT RECORDED AUGUST 21, 1897 IN BOOK A67 AT PAGE 272.

3. TERMS, CONDITIONS, PROVISIONS, BURDENS AND OBLIGATIONS AS SET FORTH IN RESOLUTION OF COMMISSIONERS RECORDED AUGUST 21, 1957 IN BOOK 670 AT PAGE 517 AND MARCH 19, 1958 IN BOOK 702 AT PAGE 107.

4. EASEMENT GRANTED TO PUBLIC SERVICE COMPANY OF COLORADO, FOR GAS PIPELINES, AND INCIDENTAL PURPOSES, BY INSTRUMENT RECORDED JULY 01, 1959, IN BOOK 786 AT PAGE 562.

5. RESERVATION OF RIGHTS-OF-WAY OR EASEMENTS FOR THE CONTINUED USE OF EXISTING SEWER, GAS, WATER OR SIMILAR PIPE LINES AND APPURTENANCES AND FOR ELECTRIC, TELEPHONE AND SIMILAR LINES AND APPURTENANCES WITHIN THE VACATED RIGHTS OF WAY OF TEJON STREET, RARITAN STREET AND PINKARD DRIVE, BY THE BOARD OF COUNTY COMMISSIONERS, COUNTY OF ADAMS, AS SET FORTH IN RESOLUTION RECORDED JUNE 15, 1970 IN BOOK 1605 AT PAGE 266.

6. RESERVATION OF RIGHTS-OF-WAY OR EASEMENTS FOR THE CONTINUED USE OF EXISTING SEWER, GAS, WATER OR SIMILAR PIPE LINES AND APPURTENANCES AND FOR ELECTRIC, TELEPHONE AND SIMILAR LINES AND APPURTENANCES WITHIN THE VACATED RIGHTS OF WAY OF A PORTION OF RARITAN STREET NORTH OF W. 56TH AVENUE, BY THE BOARD OF COUNTY COMMISSIONERS, COUNTY OF ADAMS, AS SET FORTH IN RESOLUTION RECORDED APRIL 28, 1971 IN BOOK 1689 AT PAGE 483, AND CORRECTION RECORDED JULY 14, 1971 IN BOOK 1714 AT PAGE 369.

7. TERMS, CONDITIONS, PROVISIONS, BURDENS AND OBLIGATIONS AS SET FORTH IN DEVELOPMENT AGREEMENT RECORDED AUGUST 18, 1981 IN BOOK 2579 AT PAGE 800.

8. TERMS, CONDITIONS, PROVISIONS, BURDENS, OBLIGATIONS AND EASEMENTS AS SET FORTH AND GRANTED IN PRIVATE WAY LICENSE RECORDED SEPTEMBER 28, 1982 IN BOOK 2681 AT PAGE 765.

9. TERMS, CONDITIONS, PROVISIONS, BURDENS, OBLIGATIONS AND EASEMENTS AS SET FORTH AND GRANTED IN RIGHT OF WAY AGREEMENT RECORDED JUNE 19, 1984 IN BOOK 2885 AT PAGE 841.

10. TERMS, CONDITIONS, PROVISIONS, BURDENS, OBLIGATIONS AND EASEMENTS AS SET FORTH AND GRANTED IN UTILITY EASEMENT FOR WATER LINE, SANITARY SEWER AND STORM SEWER RECORDED DECEMBER 10, 1987 IN BOOK 3397 AT PAGE 485.

11. TERMS, PROVISIONS AND CONDITIONS OF RESERVATION OF ALL COAL, OIL, GAS, CASING HEAD GAS AND ALL ORES AND MINERALS OF EVERY KIND AND NATURE, AS RESERVED IN INSTRUMENT RECORDED DECEMBER 10, 1999, IN BOOK 5978 AT PAGE 846 AND CORRECTION QUITCLAIM DEED RECORDED APRIL 17, 2002 UNDER RECEPTION NO. C0956732, AND ANY AND ALL ASSIGNMENTS THEREOF OR INTERESTS THEREIN, EXCEPT EASEMENTS OR RIGHTS REFERRED TO IN QUITCLAIM DEED FROM BNSF RAILWAY COMPANY, A DELAWARE CORPORATION RELEASING CERTAIN EASEMENTS RECORDED MARCH 14, 2019 UNDER RECEPTION NO. 2019000018468 AND TERMINATION OF BNSF EASEMENTS RECORDED MARCH 14, 2019 UNDER RECEPTION NO. 2019000018720.

12. TERMS, PROVISIONS AND CONDITIONS OF RESERVATION OF ALL COAL, OIL, GAS, CASING-HEAD GAS AND ALL ORES AND MINERALS OF EVERY KIND AND NATURE INCLUDING SAND AND GRAVEL, AND OTHER MINERAL RIGHTS AS RESERVED IN INSTRUMENT RECORDED JULY 22, 2014, UNDER RECEPTION NO. 2014000048098, AND ANY AND ALL ASSIGNMENTS THEREOF OR INTERESTS THEREIN.

13. TERMS, CONDITIONS, PROVISIONS, BURDENS, OBLIGATIONS AND EASEMENTS AS SET FORTH AND RESERVED IN QUITCLAIM DEED FROM BNSF RAILWAY COMPANY TO ROCKY MOUNTAIN PRESTRESS, LLC RECORDED JULY 22, 2014 UNDER RECEPTION NO. 2014000048098, EXCEPT EASEMENTS OR RIGHTS REFERRED TO IN QUITCLAIM DEED FROM BNSF RAILWAY COMPANY, A DELAWARE CORPORATION RELEASING CERTAIN EASEMENTS RECORDED MARCH 14, 2019 UNDER RECEPTION NO. 2019000018468 AND TERMINATION OF BNSF EASEMENTS RECORDED MARCH 14, 2019 UNDER RECEPTION NO. 2019000018720.

14. ANY FACTS, RIGHTS, INTERESTS OR CLAIMS WHICH MAY EXIST OR ARISE BY REASON OF THE FOLLOWING FACTS SHOWN ON ALTA/NSPS LAND TITLE SURVEY DATED NOVEMBER 16, 2018 PREPARED BY NV5, INC., JOB #223518-0000060.00:

A. A FENCE CROSSING PARCEL H BUT NOT ALONG THE PROPERTY LINE. (AFFECTS PARCEL H)

F. UTILITY LINES CROSSING PARCELS H AND I, BUT NOT WITHIN RECORDED EASEMENTS. (AFFECTS PARCELS H AND I)

G. POSSIBLE ENCROACHMENT OF A BUILDING ONTO THE LAND ADJACENT TO THE SOUTH. (AFFECTS PARCEL B)

15. TERMS, CONDITIONS, PROVISIONS, BURDENS, OBLIGATIONS AND EASEMENTS AS SET FORTH AND GRANTED IN ACCESS EASEMENT DEED RECORDED FEBRUARY 28, 2019 UNDER RECEPTION NO. 2019000014868.

Electronically Recorded RECEPTION#: 2019000040238,
5/28/2019 at 2:25 PM, 1 OF 5,
REC: $33.00 DocStamp: $75.07
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

When recorded return to:
Fox Rothschild LLP
1225 17th Street, Suite 2200
Denver, CO 80202
Attn: Michael Friedman, Esq.

Doc Fee $75.07

BARGAIN AND SALE DEED
[Statutory Form - C.R.S. § 38-30-115]

ROCKY MOUNTAIN PRESTRESS, LLC, a Colorado limited liability company ("Grantor"), whose street address is 5801 Pecos Street, Denver, CO 80221, for the consideration of Ten Dollars ($10.00), in hand paid, and other good and valuable consideration, hereby sells and conveys to Pecos Logistics Park, LLLP, a Colorado limited liability limited partnership ("Grantee") , whose street address is 4221 Brighton Boulevard, Denver, CO 80216, the following real property in the County of Adams and State of Colorado, to wit:

the real property described in Exhibit A attached hereto and made a part hereof (the "Property"),

with all its appurtenances.

Grantor makes no warranties, express or implied, with respect to title to the Property.

The Property subject to the following covenants, conditions and restrictions, which Grantee, by the acceptance of this Deed, covenants for itself, its successors and assigns, faithfully to keep, observe and perform:

(a) Railroad Proximity.

(i) Grantee acknowledges that the property abutting the Westerly boundary line of the Property is dedicated and used for railroad purposes, that railroad operations may create noise, vibrations, emissions, fumes and odors twenty-four (24) hours a day, and that the amount, nature and intensity of railroad operations may increase or change (collectively, the "Permitted Effects"). Grantee accepts the Property subject to the existence of the Permitted Effects. By acceptance of the Property, Grantee agrees that, at Grantee's sole cost and expense, as part of the development of the Property, Grantee shall design and install and/or construct and thereafter maintain improvements to reduce or limit the Permitted Effects and to comply with all governmental requirements, if any, which may be imposed as a condition to the development and use of the Property because of the Permitted Effects.

(ii) Grantee shall not, and hereby waives all rights to, (A) institute legal proceedings against Grantor to reduce or lessen the Permitted Effects, and (B) directly or indirectly participate in petition drives, lobbying efforts or other

activities seeking the enactment of federal, state or local laws or ordinances to reduce or lessen the Permitted Effects. Any party breaching such covenant shall reimburse Grantor for all costs incurred by Grantor to comply with any such orders, laws or ordinances, including, without limitation, attorney fees and court costs.

(iii) If Grantee sells or leases all or any portion of the Property, Grantee shall require all purchasers and tenants to acknowledge the location of the railroad operations abutting the Property and the existence of the Permitted Effects, and to agree in writing, for the benefit of Grantor, to comply with the above covenants.

(b) Restriction on Use. The Property must not be used for (i) residential, (ii) lodgings or accommodations (including, without limitation, hotels, motels, boarding houses, dormitories, hospitals, nursing homes, or retirement centers), or (iii) educational or child-care facilities (including, without limitation, schools, kindergartens or day-care centers).

The street address for the foregoing property is Vacant Land.

Signed this 28th day of May, 2019.

Rocky Mountain Prestress, LLC,
a Colorado limited liability company

By: _____
Name: V. David Holsteen
Title: General Manager

STATE OF COLORADO)
) ss.
CITY AND COUNTY OF DENVER)

The foregoing instrument was acknowledged before me this 16 day of May, 2019, by V. David Holsteen as General Manager of Rocky Mountain Prestress, LLC, a Colorado limited liability company.
Witness my hand and official seal.

My commission expires: 8-29-21

_____
Notary Public

THOMAS J BLAKE
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19874017358
My Commission Expires August 29, 2021

Electronically Recorded RECEPTION#: 2019000040238,
5/28/2019 at 2:25 PM, 3 OF 5,
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

Grantee hereby accepts this Deed and agrees for itself, its successors and assigns, to be bound by the covenants set forth herein.

Dated as of this 28th day of May, 2019.

Pecos Logistics Park, LLLP
a Colorado limited liability limited partnership

By: Its General Partner,
Westfield-Pecos General Partner, LLC,
a Colorado limited liability company

By KM
Name: Kevin McClintock
Title: Manager

STATE OF Colorado)
) ss.
COUNTY OF Denver)

The foregoing instrument was acknowledged before me this 22nd day of May, 2019, by Kevin McClintock as Manager of Westfield-Pecos General Partner, LLC, a Colorado limited liability company, the General Partner of Pecos Logistics Park, LLLP, a Colorado limited liability limited partnership.

Witness my hand and official seal.

My commission expires: 3/31/2020

JUDITH C. BREGMAN
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19994024873
MY COMMISSION EXPIRES MARCH 31, 2020

Notary Public

Electronically Recorded RECEPTION#: 2019000040238,
5/28/2019 at 2:25 PM, 4 OF 5,
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

EXHIBIT A
TO
BARGAIN AND SALE DEED

(Legal Description)

A PARCEL OF LAND BEING A PORTION OF LAND IN WARRANTY DEED RECORDED AUGUST 21, 1906 IN BOOK 16 AT PAGE **514** IN THE RECORDS OF THE ADAMS COUNTY CLERK & RECORDER'S OFFICE, STATE OF COLORADO, SITUATED IN THE EAST ONE-HALF OF THE SOUTHWEST ONE-QUARTER OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, MORE PARTICULARLY DESCRIBED AS FOLLOWS: BASIS OF BEARINGS: ALL BEARINGS ARE GRID BEARINGS OF THE COLORADO STATE PLANE COORDINATE SYSTEM, NORTH ZONE, NORTH AMERICAN DATUM OF 1983 (2011). THE BASIS OF BEARINGS IS THE EAST LINE OF THE SOUTHWEST ONE-QUARTER OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH PRINCIPAL MERIDIAN. THE NORTH POINT OF SAID LINE IS A FOUND 2-INCH ALUMINUM CAP STAMPED "JACOBS ENGINEERING 2016 PLS 24942". THE SOUTH POINT OF SAID LINE IS A FOUND 2 1/2-INCH ALUMINUM CAP STAMPED CAP STAMPED "W.C. 5.00 2016 PLS 37601" IN A RANGE BOX MARKED "SURVEY". THE WITNESS CORNER IS 5.00 FEET WEST OF AND ON LINE TO THE WEST 1/16 CORNER OF SAID SECTION 9. THE MEASURED BEARING BETWEEN SAID POINTS IS SOUTH 00° 02' 51" WEST A DISTANCE OF 2,646.62 FEET. HOWEVER, THE BASIS BEARINGS HAS BEEN ROTATED COUNTERCLOCKWISE 00° 02' 51" TO MATCH THE BASIS OF BEARINGS USED ON THE PLAT PRESTRESSED-CON SUBDIVISION, SECOND FILING, RECORDED AT SURVEY DEPOSIT FILE NO. 14, MAP NO. 765, AUGUST 5, 1981 UNDER RECEPTION NO. B336912 IN THE RECORDS OF SAID COUNTY. THE BASIS OF BEARINGS ON THIS AND THE REFERENCE PLAT IS NORTH 00° 00' 00" EAST COMMENCING AT THE SOUTH POINT OF THE BASIS OF BEARINGS;

THENCE NORTH 00° 00'00" EAST A DISTANCE OF 1,163.68 ALONG THE EAST LINE OF THE SW1/4 OF SAID SECTION 9;

THENCE NORTH 90° 00' 00"WEST A DISTANCE OF 30.00 FEET TO A POINT ON THE WEST RIGHT-OF WAY LINE OF NORTH PECOS STREET, ALSO BEING THE SOUTHEAST CORNER OF A PARCEL OF LAND RECORDED AUGUST 11, 2009 UNDER RECEPTION NO. 2009000059721 AND THE NORTHEAST CORNER OF A PARCEL OF LAND RECORDED SEPTEMBER 16, 2009 UNDER RECEPTION NO. 2009000069014 IN THE RECORDS OF SAID COUNTY;

THENCE ON A NON-TANGENT ARC TO THE LEFT, ON THE COMMON BOUNDARY BETWEEN SAID PARCELS AT RECEPTION NUMBERS 2009000059721 AND 2009000069014, HAVING A RADIUS OF 2028.00 FEET, A CENTRAL ANGLE OF 02° 15' 24" AND AN ARC LENGTH OF 79.88 FEET. THE CHORD OF SAID CURVE BEARS NORTH 70° 48' 21" WEST A DISTANCE OF 79.87 FEET TO THE SOUTHWEST CORNER OF SAID

PARCEL AT RECEPTION NO. 2009000059721 AND THE NORTHWEST CORNER OF SAID PARCEL RECEPTION NUMBER 2009000069014 AND THE POINT OF BEGINNING:

THENCE CONTINUING ON A NON-TANGENT ARC TO THE LEFT, ON THE NORTH LINE OF A PARCEL OF LAND DESCRIBED AS PARCEL "I" IN RECEPTION NUMBER 2017000035300 ON APRIL 24, 2017 IN THE RECORDS OF SAID COUNTY, HAVING A RADIUS OF 2028.00 FEET, A CENTRAL ANGLE OF 03°05'57" AND AN ARC LENGTH OF 109.70 FEET, THE CHORD OF SAID CURVE BEARS NORTH 73°29'01" WEST A DISTANCE OF 109.68 FEET;
THENCE CONTINUING ALONG THE NORTH LINE OF SAID PARCEL "I" NORTH 75°02'00" WEST A DISTANCE OF 300.28 FEET TO THE NORTHWEST CORNER OF SAID PARCEL "I";
THENCE NORTH 75°02'00" WEST A DISTANCE OF 657.94 FEET ALONG THE NORTH LINE OF A PARCEL OF LAND DESCRIBED AS PARCEL "H" IN RECEPTION NUMBER 2017000035300 ON APRIL 24, 2017 IN THE RECORDS OF SAID COUNTY;
THENCE DEPARTING SAID NORTH LINE OF PARCEL "H" NORTH 01°28'00" WEST A DISTANCE OF 46.67 FEET TO THE SOUTHWEST CORNER OF A PARCEL OF LAND DESCRIBED AS PARCEL "B" IN RECEPTION NUMBER 2017000035300 ON APRIL 24, 2017 IN THE RECORDS OF SAID COUNTY;
THENCE ALONG SAID SOUTH LINE OF PARCEL "B" SOUTH 75°02'00" EAST A DISTANCE OF 600.00 FEET;
THENCE CONTINUING ALONG SAID SOUTH LINE OF PARCEL "B" SOUTH 14°58'00" WEST A DISTANCE OF 13.50 FEET;
THENCE CONTINUING ALONG SAID SOUTH LINE OF PARCEL "B" SOUTH 75°02'00" EAST A DISTANCE OF 481.10 FEET TO THE NORTHWEST CORNER OF SAID PARCEL AT RECEPTION NUMBER 2009000059721;
THENCE DEPARTING SAID SOUTH LINE OF PARCEL "B" SOUTH 15°01'04" WEST A DISTANCE OF 34.23 FEET ALONG THE WEST LINE OF SAID PARCEL AT RECEPTION NUMBER 2009000059721 TO THE POINT OF BEGINNING.

12425752_3

Electronically Recorded RECEPTION#: 2019000040236,
5/28/2019 at 2:25 PM, 1 OF 7,
REC: $43.00 DocStamp: $214.13
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

When recorded return to:
Fox Rothschild LLP
1225 17th Street, Suite 2200
Denver, CO 80202
Attn: Michael Friedman, Esq.

Doc Fee $214.14

SPECIAL WARRANTY DEED
[Statutory Form - C.R.S. § 38-30-115]

Rocky Mountain Prestress, LLC, a Colorado limited liability company ("Grantor"), whose street address is 5801 Pecos Street, Denver, CO 80221, for Ten and 00/100 Dollars ($10.00) and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, hereby sells and conveys to Pecos Logistics Park, LLLP, a Colorado limited liability limited partnership, whose street address is 4221 Brighton Boulevard, Denver, CO 80216, the real property in the County of Adams and State of Colorado described on Exhibit A attached hereto and made a part hereof, with all its appurtenances, and warrants the title to the same against all persons claiming under Grantor, subject to the matters set forth on Exhibit B attached hereto and made a part hereof.

The Property subject to the following covenants, conditions and restrictions, which Grantee, by the acceptance of this Deed, covenants for itself, its successors and assigns, faithfully to keep, observe and perform:

(a) Restriction on Use. The Property must not be used for (i) residential, (ii) lodgings or accommodations (including, without limitation, hotels, motels, boarding houses, dormitories, hospitals, nursing homes, or retirement centers), or (iii) educational or child-care facilities (including, without limitation, schools, kindergartens or day-care centers).

(b) Railroad Proximity.

(i) Grantee acknowledges that the property abutting the Northerly and Westerly boundary line of the Property is dedicated and used for railroad purposes, that railroad operations may create noise, vibrations, emissions, fumes and odors twenty-four (24) hours a day, and that the amount, nature and intensity of railroad operations may increase or change (collectively, the "Permitted Effects"). Grantee accepts the Property subject to the existence of the Permitted Effects. By acceptance of the Property, Grantee agrees that, at Grantee's sole cost and expense, as part of the development of the Property, Grantee shall design and install and/or construct and thereafter maintain improvements to reduce or limit the Permitted Effects and to comply with all governmental requirements, if any, which may be imposed as a condition to the development and use of the Property because of the Permitted Effects.

(ii) Grantee shall not, and hereby waives all rights to, (A) institute legal proceedings against Grantor to reduce or lessen the Permitted Effects, and (B) directly or indirectly participate in

petition drives, lobbying efforts or other activities seeking the enactment of federal, state or local laws or ordinances to reduce or lessen the Permitted Effects. Any party breaching such covenant shall reimburse Grantor for all costs incurred by Grantor to comply with any such orders, laws or ordinances, including, without limitation, attorney fees and court costs.

(iii) If Grantee sells or leases all or any portion of the Property, Grantee shall require all purchasers and tenants to acknowledge the location of the railroad operations abutting the Property and the existence of the Permitted Effects, and to agree in writing, for the benefit of Grantor, to comply with the above covenants.

The street address for the foregoing property is 5855 Pecos Street, Denver, CO 80221.

Signed as of this 28th day of May, 2019.

SIGNATURES ON FOLLOWING PAGES

Electronically Recorded RECEPTION#: 2019000040236,
5/28/2019 at 2:25 PM, 3 OF 7,
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

Rocky Mountain Prestress, LLC,
a Colorado limited liability company

By: _____
Name: V. David Holsteen
Title: General Manager

STATE OF COLORADO)
) ss.
CITY AND COUNTY OF DENVER)

The foregoing instrument was acknowledged before me this 16 day of May, 2019, by V. David Holsteen as General Manager of Rocky Mountain Prestress, LLC, a Colorado limited liability company.

Witness my hand and official seal.

My commission expires: 8-29-21

_____
Notary Public

THOMAS J BLAKE
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19874017358
My Commission Expires August 29, 2021

Electronically Recorded RECEPTION#: 2019000040236,
5/28/2019 at 2:25 PM, 4 OF 7,
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

Grantee hereby accepts this Deed and agrees for itself, its successors and assigns, to be bound by the covenants set forth herein.

Dated as of this 28th day of May, 2019.

Pecos Logistics Park, LLLP
a Colorado limited liability limited partnership

By: Its General Partner,
Westfield-Pecos General Partner, LLC,
a Colorado limited liability company

By KM
Name: Kevin McClintock
Title: Manager

STATE OF Colorado)
) ss.
COUNTY OF Denver)

The foregoing instrument was acknowledged before me this 22nd day of May, 2019, by Kevin McClintock as Manager of Westfield-Pecos General Partner, LLC, a Colorado limited liability company, the General Partner of Pecos Logistics Park, LLLP, a Colorado limited liability limited partnership.

Witness my hand and official seal.

My commission expires: 3/31/2020

Notary Public

JUDITH C. BREGMAN
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19994024873
MY COMMISSION EXPIRES MARCH 31, 2020

Electronically Recorded RECEPTION#: 2019000040236,
5/28/2019 at 2:25 PM, 5 OF 7,
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

EXHIBIT A
TO
SPECIAL WARRANTY DEED

LEGAL DESCRIPTION

A TRACT OR PARCEL OF LAND NO. 6A-R(1), BEING A PORTION OF PROPERTY DESCRIBED IN THE RECORDS OF THE ADAMS COUNTY CLERK & RECORDER IN BOOK 16, PAGE 514, LOCATED IN THE SW 1/4 SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST, OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, SAID TRACT OR PARCEL BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

COMMENCING AT A POINT WHENCE THE CENTER QUARTER CORNER OF SAID SECTION 9 BEARS N. 02°58'29" E., A DISTANCE OF 924.33 FEET, SAID POINT ALSO BEING THE TRUE POINT OF BEGINNING;
1. THENCE S. 00°55'39" E., A DISTANCE OF 297.64 FEET, TO A POINT ON THE NORTHERLY LINE OF LOT 1, BLOCK 2, PRESTRESSED-CON SUBDIVISION, SECOND FILING;
2. THENCE ALONG SAID PROPERTY LINE N. 74°58'42" W., A DISTANCE OF 646.21 FEET;
3. THENCE N. 02°26'59" E., A DISTANCE OF 86.25 FEET;
4. THENCE N. 85°55'00" E., A DISTANCE OF 617.19 FEET, TO THE TRUE POINT OF BEGINNING.

BASIS BEARINGS: BEARINGS ARE BASED ON THE EAST LINE OF THE SW 1/4 OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST, OF THE 6TH PRINCIPAL MERIDIAN, BEING NORTH 00°03'19" EAST. THE CENTER QUARTER CORNER OF SAID SECTION IS A 3 1/4" ALUMINUM CAP (STAMPED LS 16401) IN A RANGE BOX. THE SOUTH QUARTER CORNER OF SAID SECTION IS MONUMENTED BY A WITNESS CORNER, OFFSET 5.00 FEET TO THE WEST ALONG THE SOUTH LINE OF THE SW 1/4 OF SAID SECTION, BEING A 2 1/2" ALUMINUM CAP (STAMPED PLS 11372) IN A RANGE BOX.

Electronically Recorded RECEPTION#: 2019000040236,
5/28/2019 at 2:25 PM, 6 OF 7,
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

EXHIBIT B
TO
SPECIAL WARRANTY DEED

TITLE EXCEPTIONS

1. TAXES FOR THE YEAR 2019, A LIEN NOT YET DUE AND PAYABLE.

2. RIGHT OF THE PROPRIETOR OF A VEIN OR LODE TO EXTRACT AND REMOVE HIS ORE THEREFROM, SHOULD THE SAME BE FOUND TO PENETRATE OR INTERSECT THE PREMISES HEREBY GRANTED, AND A RIGHT OF WAY FOR DITCHES OR CANALS CONSTRUCTED BY THE AUTHORITY OF THE UNITEDSTATES, AS RESERVED IN UNITED STATES PATENT RECORDED AUGUST 21, 1897 IN BOOK A67 AT PAGE 272.

3. TERMS, CONDITIONS, PROVISIONS, BURDENS, OBLIGATIONS AND EASEMENTS AS TO THE RESERVATION OF OIL, GAS OR OTHER HYDROCARBONS, AS DEFINED AND DESCRIBED IN SPECIAL WARRANTY DEED RECORDED JUNE 30, 1955 IN BOOK 556 AT PAGE 284.

4. ANY TAX, LIEN, FEE, OR ASSESSMENT BY REASON OF INCLUSION OF SUBJECT PROPERTY IN THE NORTH PECOS WATER AND SANITATION DISTRICT, AS EVIDENCED BY INSTRUMENT RECORDED JANUARY 07, 1974, IN BOOK 1907 AT PAGE 665.

5. TERMS, CONDITIONS, PROVISIONS, BURDENS, OBLIGATIONS AND EASEMENTS AS SET FORTH AND GRANTED IN PRIVATE WAY LICENSE RECORDED SEPTEMBER 28, 1982 IN BOOK 2681 AT PAGE 765.

6. ANY TAX, LIEN, FEE, OR ASSESSMENT BY REASON OF INCLUSION OF SUBJECT PROPERTY IN THE HYLAND HILLS PARK AND RECREATION DISTRICT, AS EVIDENCED BY INSTRUMENT RECORDED SEPTEMBER 19, 1990, IN BOOK 3712 AT PAGE 402.

7. TERMS, CONDITIONS, PROVISIONS, BURDENS, OBLIGATIONS AND EASEMENTS AS SET FORTH IN UNDERGROUND FACILITIES INFORMATION RECORDED MARCH 15, 1993 IN BOOK 4038 AT PAGE 101.

8. TERMS, RESERVATIONS, COVENANTS, CONDITIONS, PROVISIONS, RAILROAD RIGHTS, BURDENS, OBLIGATIONS AND EASEMENTS AS DEFINED AND DESCRIBED IN QUITCLAIM DEED RECORDED AUGUST 11, 2009 UNDER RECEPTION NO. 2009000059722.

9. EASEMENT GRANTED TO COUNTY OF ADAMS, STATE OF COLORADO, FOR DRAINAGE AND MAINTENANCE OF COUNTY OWNED FACILITIES, AND

Electronically Recorded RECEPTION#: 2019000040236,
5/28/2019 at 2:25 PM, 7 OF 7,
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

INCIDENTAL PURPOSES, BY INSTRUMENT RECORDED APRIL 03, 2019, UNDER RECEPTION NO. 2019000024091.

12406766_2

Electronically Recorded RECEPTION#: 2019000040239,
5/28/2019 at 2:25 PM, 1 OF 7,
REC: $43.00 DocStamp: $50.00
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

When recorded return to:
Fox Rothschild LLP
1225 17th Street, Suite 2200
Denver, CO 80202
Attn: Michael Friedman, Esq.

Doc Fee $50.00

BARGAIN AND SALE DEED

ROCKY MOUNTAIN PRESTRESS, LLC, a Colorado limited liability company ("Grantor"), whose street address is 5801 Pecos Street, Denver, CO 80221, for the consideration of Ten Dollars ($10.00), in hand paid, and other good and valuable consideration, hereby sells and conveys to Pecos Logistics Park, LLLP, a Colorado limited liability limited partnership ("Grantee") , whose street address is 4221 Brighton Boulevard, Denver, CO 80216, the following real property in the County of Adams and State of Colorado, to wit:

the real property described in Exhibit A attached hereto and made a part hereof (the "Property"),

with all its appurtenances.

Grantor makes no warranties of title, express or implied, with respect to title to the Property.

The street address for the foregoing property is Vacant Land.

Grantee covenants and agrees as follows:

(a) Grantee's interest shall be subject to the rights and interests of BNSF Railway Company ("BNSF") its licensees, permittees and other third parties in and to all existing driveways, roads, utilities, fiber optic lines, tracks, wires and easements of any kind whatsoever on the Property whether owned, operated, used or maintained by the BNSF, its licensees, permittees or other third parties and whether or not of public record. BNSF shall have a perpetual easement on the Property for the use of such existing driveways, roads, utilities, fiber optic lines, tracks, wires and easements by BNSF and BNSF's licensees, permittees and customers.

(b) Grantee's interest shall further be subject to the reservation by BNSF of all coal, oil, gas, casing-head gas and all ores and minerals of every kind and nature including sand and gravel underlying the surface of the Property, together with the full right, privilege and license at any and all times to explore, or drill for and to protect, conserve, mine, take, remove and market any and all such products in any manner which will not damage structures on the surface of the Property, together with the right of access at all times to exercise said rights.

Land Title GUARANTEE COMPANY

(c) Any improvements constructed or altered on the Property after the date BNSF quitclaimed its interest to Grantor shall be constructed or altered in such a manner to provide adequate drainage of water away from any of BNSF's railroad tracks on nearby property.

(d) BNSF RESERVED UNTO ITSELF, ITS SUCCESSORS AND ASSIGNS, IN PERPETUITY, ANY AND ALL NON-RIPARIAN WATER AND WATER RIGHTS ASSOCIATED WITH THE PROPERTY, INCLUDING BUT NOT LIMITED TO, ANY AND ALL DITCHES AND DITCH RIGHTS, WATER WELLS, SPRINGS, DIVERSION WORKS, WATER LINES, PIPES, PUMPS, MOTORS, GENERATORS, ELECTRICAL GEAR AND WIRES, AND ANY RELATED EQUIPMENT AND IMPROVEMENTS WHATSOEVER, HISTORICALLY USED UPON OR ASSOCIATED WITH THE PROPERTY, INCLUDING ALL MUTUAL WATER COMPANY SHARES, DITCH SHARES, WATER SERVICE AGREEMENTS AND CONTRACTS, AND WATER CLAIMS, AND INCLUDING BUT NOT LIMITED TO, ALL UNAPPROPRIATED, UNDEVELOPED OR UNUSED WATER AND WATER RIGHTS ASSOCIATED WITH OR UNDERLYING THE PROPERTY, AND THE EXCLUSIVE RIGHT TO DEVELOP AND TAKE WATER FROM THE PROPERTY BY ANY MEANS, AND INCLUDING ALL APPROPRIATIONS, PRIORITIES, PERMITS AND CERTIFICATES WHICH ARE APPURTENANT TO, ASSOCIATED WITH, USED UPON, FLOWING OVER, UNDER, OR LYING ON, IN, OR UNDER THE PROPERTY, TOGETHER WITH THE PERPETUAL RIGHT TO CONSTRUCT, INSTALL, OPERATE, REPLACE, REWORK, RECONSTRUCT, REHABILITATE AND MAINTAIN ANY AND ALL WATER DIVERSION, PRODUCTION, AND TRANSPORTATION STRUCTURES, EQUIPMENT, IMPROVEMENTS AND PIPING, INCLUDING BUT NOT LIMITED TO, HEADGATES, DIVERSION STRUCTURES, WATER WELLS, WATER WELL HOUSES, WATER WELL CASING, WATER WELL SCREENS, SPRING COLLECTION GALLERIES, SUMPS, WATER PIPES, AND RELATED ELECTRICAL GEAR AND WIRES, AND TO CONSTRUCT, INSTALL, OPERATE AND MAINTAIN WATER PUMPS AND HYDROELECTRIC GENERATION EQUIPMENT AND ALL EQUIPMENT NECESSARY, CONVENIENT OR RELATED TO THE PRODUCTION, TRANSPORTATION OR DELIVERY OF WATER FROM, ON, UNDER OR ACROSS THE PROPERTY, OR ANY PORTION THEREOF.

(e) For 99 years after the date that Grantor acquired the Property, Grantee covenants and agrees that the Property shall be used solely for non-residential purposes and that the groundwater will not be used for drinking water or irrigation purposes.

(f) Grantee has been allowed to make an inspection of the Property. GRANTEE IS PURCHASING THE PROPERTY ON AN "AS-IS WITH ALL FAULTS" BASIS WITH ANY AND ALL PATENT AND LATENT DEFECTS, INCLUDING THOSE RELATING TO THE ENVIRONMENTAL CONDITION OF THE PROPERTY, AND IS NOT RELYING ON ANY REPRESENTATION OR WARRANTIES, EXPRESS OR IMPLIED, OF ANY KIND WHATSOEVER FROM BNSF AS TO ANY MATTERS CONCERNING THE PROPERTY, including, but not limited to the physical condition of the Property; zoning status; tax consequences of this transaction; utilities; operating history or projections or valuation; compliance by the Property with Environmental Laws (defined below) or other laws, statutes, ordinances, decrees, regulations and other requirements applicable to the Property; the presence of any Hazardous

Substances (defined below), wetlands, asbestos, lead, lead-based paint or other lead containing structures, urea formaldehyde, or other environmentally sensitive building materials in, on, under, or in proximity to the Property; the condition or existence of any of the above ground or underground structures or improvements, including tanks and transformers in, on or under the Property; the condition of title to the Property, and the leases, easements, permits, orders, licenses, or other agreements, affecting the Property (collectively, the "Condition of the Property"). Grantee represents and warrants to Grantor that Grantee has not relied and will not rely on, and BNSF is not liable for or bound by, any warranties, guaranties, statements, representations or information pertaining to the Property or relating thereto (including specifically, without limitation, Property information packages distributed with respect to the Property) made or furnished by BNSF, the manager of the Property, or any real estate broker or agent representing or purporting to represent BNSF, to whomever made or given, directly or indirectly, orally or in writing. Grantee assumes the risk that Hazardous Substances or other adverse matters may affect the Property that were not revealed by Grantee's inspection and indemnifies, holds harmless and hereby waives, releases and discharges forever BNSF and its officers, directors, shareholders, employees and agents (collectively, "Indemnitees") from any and all present or future claims or demands, and any and all damages, Losses, injuries, liabilities, causes of actions (including, without limitation, causes of action in tort or asserting a constitutional claim) costs and expenses (including, without limitation fines, penalties and judgments, and attorneys' fees) of any and every kind or character, known or unknown, arising from or in any way related to the Condition of the Property or alleged presence, use, storage, generation, manufacture, transport, release, leak, spill, disposal or other handling of any Hazardous Substances in, on or under the Property. Losses shall include without limitation (a) the cost of any investigation, removal, remedial, restoration or other response action that is required by any Environmental Law, that is required by judicial order or by order of or agreement with any governmental authority, or that is necessary or otherwise is reasonable under the circumstances, (b) capital expenditures necessary to cause the BNSF remaining property or the operations or business of BNSF on its remaining property to be in compliance with the requirements of any Environmental Law, (c) Losses for or related to injury or death of any person, (d) Losses for or related to injury or damage to animal or plant life, natural resources or the environment, and (e) Losses arising under any Environmental Law enacted after transfer. The rights of BNSF under this section shall be in addition to and not in lieu of any other rights or remedies to which it may be entitled under this document or otherwise. This indemnity specifically includes the obligation of Grantee to remove, close, remediate, reimburse or take other actions requested or required by any governmental agency concerning any Hazardous Substances on the Property. The term "Environmental Law" means any federal, state or local statute, regulation, code, rule, ordinance, order, judgment, decree, injunction or common law relating in any way to human health, occupational safety, natural resources, plant or animal life or the environment, including without limitation, principles of common law and equity, the Resource Conservation and Recovery Act, the Comprehensive Environmental Response, Compensation and Liability Act, the Toxic Substances Control Act, and any similar or comparable state or local law. The term "Hazardous Substance" means any hazardous, toxic, radioactive or infectious substance, material or waste as defined, listed or regulated under any Environmental Law, and includes without limitation petroleum oil and any of its fractions.

Electronically Recorded RECEPTION#: 2019000040239,
5/28/2019 at 2:25 PM, 4 OF 7,
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

The covenants and agreements set forth in paragraphs (a) through (f), above, shall be binding upon Grantee and its heirs, successors and assigns, and shall be covenants running with the land benefiting BNSF and its heirs, successors and assigns.

Rocky Mountain Prestress, LLC,
a Colorado limited liability company

By:_____
Name: V. David Holsteen
Title: General Manager

STATE OF COLORADO)
) ss.
CITY AND COUNTY OF DENVER)

The foregoing instrument was acknowledged before me this 16 day of May, 2019, by V. David Holsteen as General Manager of Rocky Mountain Prestress, LLC, a Colorado limited liability company.
Witness my hand and official seal.

My commission expires: 8-29-21

Notary Public _____

THOMAS J BLAKE
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19874017358
My Commission Expires August 29, 2021

Electronically Recorded RECEPTION#: 2019000040239,
5/28/2019 at 2:25 PM, 5 OF 7,
TD Pgs: 3 Josh Zygielbaum, Adams County, CO.

EXHIBIT A
TO
BARGAIN AND SALE DEED

(Legal Description)

A PARCEL OF LAND IN THE NORTHWEST 1/4 OF THE SOUTHWEST 1/4 OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH PRINCIPAL MERIDIAN, ADAMS COUNTY, STATE OF COLORADO, MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BASIS OF BEARINGS: THE BASIS OF BEARINGS IS THE WEST LINE OF THE SOUTHWEST ONE-QUARTER OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH PRINCIPAL MERIDIAN. THE SOUTH POINT OF SAID LINE IS A FOUND 3-1/4" ALUMINUM CAP STAMPED "FLATIRONS SURVEYING 1996 LS 16406" IN A RANGE BOX. THE NORTH POINT OF SAID LINE IS A FOUND 3-INCH ALUMINUM CAP STAMPED "TIMBERLINE BOUNDARY AND SURVEY LLC 2016 PLS 36072" 0.5 FEET BELOW GRADE. THE MEASURED BASIS OF BEARINGS BETWEEN SAID POINTS IS NORTH 00° 13' 46" WEST A DISTANCE OF 2,640.41 FEET. HOWEVER, THE BASIS OF BEARINGS HAS BEEN ROTATED COUNTERCLOCKWISE 00° 02' 51" TO BE PARALLEL WITH THE BASIS OF BEARINGS USED ON THE PLAT PRESTRESSED-CON SUBDIVISION, SECOND FILING, RECORDED AT SURVEY DEPOSIT FILE NO. 14, MAP NO. 765, PLAT RECEPTION NUMBER (R.N.) 336912 ON AUGUST 5, 1981 IN THE RECORDS OF SAID COUNTY. THE PLAT WAS ALSO RECORDED AT RN 1981020336912 IN THE RECORDS OF SAID COUNTY. THE ADJUSTED BASIS OF BEARINGS IS NORTH 00° 16' 37" WEST.

COMMENCING AT THE SOUTH POINT OF THE BASIS OF BEARINGS;
THENCE NORTH 00° 16' 37" WEST A DISTANCE OF 1,464.88 ALONG THE WEST LINE OF THE SW1/4 OF SAID SECTION 9 TO THE COMMON CORNER OF:
1. THE NORTHEAST CORNER OF THAT PARCEL DESCRIBED AT R.N. 2009000017689 AND RECORDED ON MARCH 12, 2009 IN THE RECORDS OF SAID COUNTY;
2. THE SOUTHEAST CORNER OF PARCEL NO. 2 AS DESCRIBED AT R.N. 2017000089773 AND RECORDED ON OCTOBER 13, 2017 IN THE RECORDS OF SAID COUNTY;
3. NORTHWEST CORNER OF LOT 30, BLOCK 4 OF THE SCAVALENTI SUBDIVISION RECORDED AT BOOK 5 PAGE 84, R.N. 446584 ON MAY 2, 1955 IN THE RECORDS OF SAID COUNTY, BEING THE POINT OF BEGINNING:

THENCE ALONG THE EAST LINE OF SAID PARCEL AT R.N. 2017000089773, ALSO BEING THE WEST LINE OF THE SW1/4 OF SECTION 9, NORTH 00° 16' 37" WEST A DISTANCE OF 104.36 FEET TO A POINT ON THE SOUTH LINE OF A PARCEL OF LAND DESCRIBED AS PARCEL NO. 3A AT R.N. 2013000078679 AND RECORDED ON SEPTEMBER 9, 2013 IN THE RECORDS OF SAID COUNTY, ALSO BEING A POINT ON

THE NORTHERLY LINE OF THE FORMER COLORADO AND SOUTHERN RAILWAY (C. & S.R.) AS RECORDED AUGUST 15, 1870 UNDER RECEPTION NUMBER 1870901834 (BOOK 28 AT PAGE 266) IN THE CITY AND COUNTY OF DENVER, OFFICE OF THE CLERK AND RECORDER, STATE OF COLORADO;

THENCE ALONG THE SOUTH LINE OF SAID PARCEL NO. 3A, ALSO BEING THE NORTHERLY LINE OF SAID C. & S.R. NORTH 73° 06' 39" EAST A DISTANCE OF 151.41 FEET;

THENCE CONTINUING ALONG SAID SOUTH LINE, ALSO BEING THE NORTHERLY LINE OF SAID C. & S.R., IN AN EASTERLY DIRECTION WITH A TANGENT CURVE TURNING TO THE RIGHT HAVING A RADIUS OF 1,482.69 FEET, A CENTRAL ANGLE OF 02° 59' 57" AND AN ARC LENGTH OF 77.61. THE CHORD OF SAID CURVE BEARS NORTH 74° 36' 37" EAST A DISTANCE OF 77.60 FEET TO THE SOUTHEAST CORNER OF SAID PARCEL NO. 3A;

THENCE CONTINUING ALONG THE NORTHERLY LINE OF SAID C. & S.R., ALSO BEING THE SOUTHERLY LINE OF A PARCEL OF UNION PACIFIC RAILROAD LAND DESCRIBED IN BOOK 16 AT PAGE 514 IN THE RECORDS OF SAID COUNTY, ON A COMPOUND TANGENT CURVE TURNING TO THE RIGHT HAVING A RADIUS OF 1,482.69 FEET, A CENTRAL ANGLE OF 01° 28' 14" AND AN ARC LENGTH OF 38.05 FEET. THE CHORD OF SAID CURVE BEARS NORTH 76° 50' 42" EAST A DISTANCE OF 38.05 FEET;

THENCE CONTINUING ALONG THE NORTHERLY LINE OF SAID C. & S.R., ALSO BEING THE SOUTHERLY LINE OF SAID UNION PACIFIC RAILROAD, ON A NON-TANGENT CURVE TO THE RIGHT HAVING A RADIUS OF 1,575.85 FEET, A CENTRAL ANGLE OF 26° 49' 26" AND AN ARC LENGTH OF 737.76 FEET. THE CHORD OF SAID CURVE BEARS SOUTH 88° 26' 42" EAST A DISTANCE OF 731.04 FEET;

THENCE CONTINUING ALONG THE NORTHERLY LINE OF SAID C. & S.R., ALSO BEING THE SOUTHERLY LINE OF SAID UNION PACIFIC RAILROAD, SOUTH 75° 02' 00" EAST A DISTANCE OF 332.08 FEET TO THE NORTHWEST CORNER OF PARCEL H RECORDED AT R.N. 2017000035300 ON APRIL 24, 2017 IN THE RECORDS OF SAID COUNTY;

THENCE ALONG THE WEST LINE OF SAID PARCEL H SOUTH 00° 00' 00" EAST A DISTANCE OF 103.51 FEET TO A POINT ON THE NORTH LINE OF PARCEL A AS DESCRIBED AT R.N. 2017000035300 ON APRIL 24, 2017 IN THE RECORDS OF SAID COUNTY, SAID POINT ALSO BEING ON THE SOUTHERLY LINE OF SAID C. & S.R.;

THENCE ALONG THE NORTHERLY LINE OF SAID PARCEL A, ALSO BEING THE SOUTHERLY LINE OF SAID C. & S.R. NORTH 75° 02' 00" WEST A DISTANCE OF 358.82 FEET;

THENCE CONTINUING ALONG THE NORTHERLY LINE OF SAID PARCEL A, ALSO BEING THE SOUTHERLY LINE OF SAID C. & S.R., IN A WESTERLY DIRECTION WITH A TANGENT CURVE TURNING TO THE LEFT HAVING A RADIUS OF 1,475.85, A CENTRAL ANGLE OF 11° 26' 33", AND AN ARC LENGTH OF 294.74 FEET. THE CHORD OF SAID CURVE BEARS NORTH 80° 45' 16" WEST A DISTANCE OF 294.25 FEET TO THE NORTHWEST CORNER OF SAID 'PARCEL A', ALSO BEING THE NORTHEAST CORNER OF BLOCK 4, LOT 5 OF THE CLEARVIEW SUBDIVISION RECORDED AT PLAT BOOK 4 PAGE 48, R.N. 333198 ON JULY 27, 1948 IN THE RECORDS OF SAID COUNTY;

THENCE CONTINUING ALONG THE NORTHERLY LINE OF SAID BLOCK 4 OF THE CLEARVIEW SUBDIVISION, ALSO BEING THE SOUTHERLY LINE OF SAID C. & S.R. IN A WESTERLY DIRECTION WITH A COMPOUND TANGENT CURVE TURNING TO THE LEFT HAVING A RADIUS OF 1,475.85, A CENTRAL ANGLE OF 12° 56' 30", AND AN ARC LENGTH OF 333.36 FEET, TO THE NORTHWEST CORNER OF LOT 1, BLOCK 4 OF SAID CLEARVIEW SUB., ALSO BEING THE NORTHEAST CORNER OF LOT 26, BLOCK 4 OF SAID SCAVALENTI SUBDIVISION. THE CHORD OF SAID CURVE BEARS SOUTH 87° 03' 12" WEST A DISTANCE OF 332.65 FEET;

THENCE ALONG THE NORTH LINE OF SAID BLOCK 4 OF THE SCAVALENTI SUBDIVISION, ALSO BEING THE SOUTHERLY LINE OF SAID C. & S.R. ON A COMPOUND TANGENT CURVE TURNING TO THE LEFT HAVING A RADIUS OF 1,475.85, A CENTRAL ANGLE OF 2° 26' 23", AND AN ARC LENGTH OF 62.84 FEET. THE CHORD OF SAID CURVE BEARS SOUTH 79° 21' 46" WEST A DISTANCE OF 62.84 FEET;

THENCE CONTINUING ALONG THE NORTH LINE OF SAID BLOCK 4 OF THE SCAVALENTI SUBDIVISION, ALSO BEING THE SOUTHERLY LINE OF SAID C. & S.R. ON A NON-TANGENT CURVE TURNING TO THE LEFT HAVING A RADIUS OF 1,382.69, A CENTRAL ANGLE OF 4° 25' 43", AND AN ARC LENGTH OF 106.88 FEET. THE CHORD OF SAID CURVE BEARS SOUTH 75° 19' 31" WEST A DISTANCE OF 106.85 FEET;

THENCE CONTINUING ALONG THE NORTH LINE OF SAID BLOCK 4 OF THE SCAVALENTI SUBDIVISION, ALSO BEING THE SOUTHERLY LINE OF SAID C. &S.R. SOUTH 73° 06' 32" WEST A DISTANCE OF 181.25 FEET TO THE POINT OF BEGINNING.

Exhibit I
Description of Entities Involved in Formation

Pursuant to Section 10-05-03-03-02-07 of the Adams County Special District Guidelines and Regulations, the following is a list of all persons, corporations, and other private or public entities involved in the formation of this District and an explanation of the role played by each of those involved, and a discussion of the entities' previous work in Adams County or the region related to District and land development.

1. Proponent and Project Developer: Westfield Development Company, Inc.

The Project is being developed by Westfield Development Company, Inc. (the "Developer"), on behalf of Pecos Logistics Park, LLLP, the sole owner of all property within the District. Westfield Development Company, Inc., is a Denver-based real estate investment, development and management company with experience investing in and developing commercial projects similar to the Project along the entire Front Range from Colorado Springs to Fort Collins and from Golden to Aurora.

2. Legal Counsel: Spencer Fane LLP

Spencer Fane LLP prepared the majority of the Service Plan and will facilitate the organization process for the District. Spencer Fane has served as general counsel to scores of Colorado's special districts and municipalities, including cities, fire protection districts, water and sanitation districts, metropolitan districts, business improvement districts, intergovernmental authorities, and others for over 45 years. They provide services regarding the formation and ongoing representation of these entities in the areas of municipal law, election law, TABOR issues, finance, water law, environmental law, litigation, and other related areas.

3. Financial Advisor: Stifel, Nicolaus & Company, Inc.

Stifel advised the Proponent in various financial components of the Service Plan and prepared the Financial Plan attached as Exhibit E. Stifel is a national premier full service investment banking firm. Stifel is the number one underwriter of non-rated development transactions in the country, having underwritten and sold over $1.4 billion of development bonds in 2018 (Source: Thomson Reuters). In recent years Stifel has underwritten over $1.5 billion of bonds for numerous clients located in Adams County, Colorado.

4. Engineer: HR Green

HR Green advised the Proponent in the preparation of various engineering components of the Service Plan, including the Estimated Cost of Public Improvements and the Preliminary Engineering Survey, attached to the Service Plan as Exhibits C and D, respectively. HR Green is a professional engineering and technical consulting firm providing development services throughout Colorado. HR Green is honored to be one of the nation's longest operating engineering firms. For more than 100 years, the HR Green family of companies has been

dedicated to its clients' success. The HR Green family of companies includes HR Green, Inc., HR Green Pacific, HR Green California, and HR Green Development.

5. Architect: Grey Wolf Architecture

Grey Wolf Architecture advised the Proponent in the preparation of various engineering components of the Service Plan, including the Estimated Cost of Public Improvements and the Preliminary Engineering Survey, attached to the Service Plan as Exhibits C and D, respectively. Grey Wolf Architecture is a Denver-based full service commercial architectural design firm specializing in master planning, industrial planning and design, interior architecture, retail and multi-family projects.

Exhibit J
Proposed Developer Advance and Reimbursement Agreement

ADVANCE AND REIMBURSEMENT AGREEMENT

This Advance and Reimbursement Agreement (the "**Agreement**") is made and entered into effective as of the ____ day of _____, 2019, by and between PECOS LOGISTICS PARK METROPOLITAN DISTRICT, a quasi-municipal corporation and political subdivision of the State of Colorado, (the "District") and WESTFIELD DEVELOPMENT COMPANY, INC., a Colorado corporation (the "**Company**") (the District and the Company collectively, "**Parties**," or any of the Parties, a "**Party**," and all other capitalized terms used herein shall have the meanings hereinafter set forth).

RECITALS

A. The Service Plan for the District (the "**Service Plan**") has been duly approved by the Board of County Commissioners of Adams County, Colorado (the "**County**"), and the District has been duly organized pursuant to the provisions of Article 1 of Title 32, C.R.S.

B. Pursuant to the Service Plan the District is empowered to provide street, traffic and safety, water, sanitation, storm drainage, transportation, covenant control, security and other improvements and services within and without the boundaries of the District for the benefit of the general public as well as the properties and development pursued by the Company (the "Project").

C. Pursuant to Section 32-1-1001(1)(f) and (h), C.R.S., the District has the power to acquire real and personal property, including rights and interests in property and easements necessary for District functions or operations, and to acquire, construct and install the public improvements authorized in the Service Plan.

D. At a public election held by the District on November 5, 2019, a majority of the eligible electors voting at such election voted in favor of, among other matters, the District incurring indebtedness and other multiple-fiscal year financial obligations to finance the acquisition, construction, installation and completion of the public improvements authorized in the Service Plan.

E. Because the District does not have the ability at present to finance the planning, design, engineering, construction, installation and completion of certain public improvements as more specifically described in the Service Plan (the "**Public Improvements**"), the Company has agreed to construct and complete the Public Improvements, and to transfer the Public Improvements to the District or the County or other appropriate entity for public use or, in the alternative, has agreed to advance to the District the funds necessary to construct and complete the Public Improvements for the benefit of the District and the public, generally.

F. It is in the public interest for the District to acquire and/or facilitate the construction of the Public Improvements and, when financially feasible, to reimburse the Company or its assignee for the costs of the Public Improvements and for Advances (as defined herein) (together, the "**Reimbursable Costs**") through and by means of the issuance by the District of the District's bonds and other legally available funds in accordance with all limitations set forth in the Service Plan and this Agreement.

AGREEMENT

In consideration of the agreements, covenants and undertakings set forth herein and for other good and sufficient consideration, the receipt of which is hereby acknowledged, the Parties agree as follows:

1. Representations, Warranties and Covenants Relating to Completed Public Improvements. With respect to any Public Improvement listed in Exhibit A, the Company represents, warrants and covenants to the best of its current knowledge as follows:

a. All Public Improvements have been constructed, installed and completed in conformance with all duly approved designs, plans and specifications and the requirements, standards and specifications of the District or other appropriate entity, as applicable, and have been or will be conveyed, transferred or dedicated to the District or other appropriate entity for public use, free of all liens, encumbrances and obligations of every nature other than those of record or that a survey or inspection thereof would disclose.

b. The foregoing representations, warranties and covenants are made as of the date of this Agreement and shall be deemed to be continuing for all purposes for any applicable warranty period unless otherwise approved in writing by the District.

2. Completion and Transfer of Public Improvements. After the date of the execution of this Agreement, upon completion, the Company shall transfer the Public Improvements to the District or, if so directed by the District, to another appropriate entity upon completion and acceptance of the Public Improvements by the District or other appropriate entity (collectively, the "Accepting Jurisdictions"), as applicable, as follows:

a. The Public Improvements shall conform to the requirements, standards and specifications of all public and/or private agencies to which the Public Improvements may be or are required to be dedicated or conveyed by the District in addition to any standards or requirements adopted by the District. At its discretion and request, the District may require the Company to arrange for the work to be certified by the District's engineers, at the District's sole cost and expense, so that the engineers will be able to advise and certify to the District that all work was performed in compliance with the applicable drawings, standards and specifications, and that the costs incurred to complete the Public Improvements are consistent with industry standards applicable in the Denver Metropolitan Area.

b. As a precondition to the conveyance, dedication or other transfer of any Public Improvements to the District or the Accepting Jurisdictions for ownership, maintenance and repair, the Company shall provide the District or the Accepting Jurisdictions, as applicable, with a guarantee, to secure performance of warranty obligations against defects in materials, workmanship, construction and installation of the facilities or improvements, all for a two-year period from acceptance of the Public Improvements. This requirement shall not apply to any improvements for which Company satisfies all the requirements of the entity to which the improvement will ultimately be conveyed or dedicated if that entity agrees to take title and to release the District from any ongoing responsibility.

c. The Company shall provide to the District or, if so directed by the District, to the Accepting Jurisdictions: (i) if required, a special warranty or quitclaim deed transferring and conveying the Company's interests in the Public Improvements, free and clear of all liens, encumbrances or security interests of any nature, except those of record and those a survey or inspection thereof would disclose, and (ii) if applicable, a partial release of its interests in the Public Improvements from any lender that has loaned funds to complete the Public Improvements, together with any easements and rights-of-way necessary for the convenient construction, operation, repair, replacement or maintenance of any Public Improvements located on any property that has not been conveyed, transferred or dedicated to the District or the Accepting Jurisdictions, in a commercially reasonable form.

d. The Reimbursable Costs of any Public Improvements either completed prior to the execution of this Agreement (Exhibit A) or subsequently acquired by the District or transferred to the Accepting Jurisdictions shall be determined based upon actual costs verified by the Company and confirmed by the District's engineers.

(i) The Reimbursable Costs of the Public Improvements shall include all construction costs, planning, design, engineering, surveying, construction management, legal and other consulting services, and any other allowable capital expense relating to the Public Improvements.

(ii) Before any payment of Reimbursable Costs for Public Improvements is made hereunder, the Company shall provide, and if requested shall reasonably supplement, at the sole cost and expense of the Company, a schedule of the Reimbursable Costs for the Public Improvements prepared and audited by an independent public accountant, professional engineer, appraiser or valuation consultant reasonably acceptable to the District, substantiating the amount of the Reimbursable Costs.

(iii) The Company shall also provide to the District or the Accepting Jurisdictions, as applicable, "as-built" drawings of all Public Improvements or a certification signed by a licensed professional engineer confirming the location and extent of the Public Improvements, together with supporting maps and other documentation as may be reasonably required by the District, or the Accepting Jurisdictions, at the Company's sole cost and expense, including without limitation any appraisals, surveys, environmental reports, permits, assignments of construction warranties, lien waivers, releases and other documentation relating to the Public Improvements or the transfer thereof.

e. The Company shall, with the prior concurrence of the District, transfer such Public Improvement in compliance with all requirements set forth in this Section 2 and all other applicable provisions of this Agreement. The District shall not accept conveyance of any Public Improvements or be obligated to reimburse or pay interest for a Public Improvement until such Public Improvement is completed. Upon completion of each of the Public Improvements in conformance with all applicable requirements, standards and specifications of the Service Plan and all public and/or private agencies to which the Public Improvements may be or are required to be dedicated to, or conveyed by the District, in addition to any standards or requirements adopted by the District, such Public Improvements, to the extent the same will be accepted by the District, shall be accepted for ownership by the District.

3. Advances.

a. The Company, in its sole discretion, may, but shall not be obligated to in any manner, advance sums (the "**Advances**") as requested from time to time by the District to pay the costs of the Public Improvements and any management, operating and administrative expenses in accordance with the terms of this Agreement.

b. If the District determines that it will not have sufficient funds available to pay the anticipated costs of the Public Improvements as well as operating and administrative expenses of the District, it shall calculate the anticipated amount of such funding shortfall (the "**Funding Shortfall**"), which shall be classified by nature of use between capital and operating expenses. The District shall submit a written request to the Company to deposit the Funding Shortfall with the District's bank. The Company, after reasonable verification of such Funding Shortfall, may, in its sole discretion, but shall have no obligation to in any manner, make an Advance and fund the Funding Shortfall after such notice from the District.

4. Reimbursement of Reimbursable Costs. The Parties acknowledge and agree that the District shall pay to the Company for the completed Public Improvements an amount equal to the Reimbursable Costs incurred by Company, and any Advances made hereunder plus 7% simple annual interest from the date of such advances, said interest to be calculated on the basis of 360-day years comprised of 12 months of 30 days each, but in no event shall the total amount paid to Company exceed $20,000,000. Subject to the availability of funds budgeted and appropriated for payment under this Agreement, as described below, the District shall pay to the Company installments of that amount as follows, subject to the District being satisfied in the exercise of its sole discretion that the Company has, in the case of each installment date, expended actual capital costs of at least a like amount:

a. 100% by December 31, 2020;

b. The Parties acknowledge that in order to pay the Reimbursable Costs, in conformance with its electoral authorization, the District intends to complete the issuance of its general obligation bonds (the "Bonds") in the total amount necessary to yield proceeds to be used for the purpose of funding the Public Improvements as set forth in this Agreement. The Parties further acknowledge and agree that the District's obligation to pay the Reimbursable Costs is expressly conditioned upon the District successfully issuing all of the Bonds in a form and at rates acceptable to the District's Board of Directors in the exercise of their sole discretion; provided that the District reserves the right, but shall have no obligation to substitute other funds for the acquisition of the Public Improvements if it so desires.

c. It is expressly agreed that the District's obligations hereunder may be further documented through other instruments including without limitation bonds or other evidences of indebtedness issued directly to the Company as authorized by Colorado law and the District's Service Plan.

5. Waiver of Covenants. The District, in its discretion, may waive any of the covenants of the Parties set forth herein by written notice to the Company; provided, however,

that such waiver shall not constitute a general waiver of all covenants, nor shall any such waiver prevent the District from enforcing other terms of this Agreement.

6. Integrated Agreement and Amendments. This Agreement constitutes the entire agreement of the Parties with respect to the District's reimbursement obligation and the other matters set forth herein and replaces in their entirety any prior agreements, understandings, warranties or representations made by or between the Parties with respect to the subject matter hereof. This Agreement may be amended only by the agreement of each Party in writing.

7. Notice. Any notice, demand or other communication required or permitted to be given hereunder shall be in writing and delivered personally or sent by overnight national courier service or by overnight or registered mail, postage prepaid, return receipt requested, addressed to the Party at the address that follows or as either Party may subsequently designate from time to time in writing. Notice shall be considered given when delivered or, if mailed by registered mail, on the third day after such notice is mailed.

To the District:
Pecos Logistics Park Metropolitan District
c/o Spencer Fane LLP
Attention: Matthew Dalton
1700 Lincoln Street, Suite 2000
Denver, Colorado 80203

To the Company:
Westfield Development Company, Inc.
4221 Brighton Blvd.
Denver, CO 80216

8. Assignment. This Agreement shall not be assigned, except by the prior written agreement of each Party or as expressly provided herein. This Agreement shall inure to the mutual benefit of the Parties and their respective successors and authorized assigns.

9. Severability. If any clause or provision of this Agreement shall be adjudged to be invalid and unenforceable by a court of competent jurisdiction or by operation of law, such clause or provision shall not affect the validity of this Agreement as a whole or of its other clauses and provisions.

10. Default / Remedies. In the event of any breach or default of this Agreement, each Party shall be entitled to exercise any remedy available in equity or at law. In this regard, this Agreement may be enforced by specific performance or injunction, or pursuant to such other legal and/or equitable relief as may be available under the laws of the State of Colorado. The prevailing Party shall be entitled to reasonable attorney fees and costs. Absent bad faith or fraud by the District, no penalty shall be imposed upon the District because of its inability to pay any portion of the Reimbursable Costs of the Public Improvements to the Company. There shall be no acceleration in the repayment of outstanding Advances in the event of any default. Nothing contained herein shall allow recovery for consequential or punitive damages. Venue for any judicial action shall be in the District Court for the County of Adams.

11. Counterpart Execution. This Agreement may be executed in multiple counterparts, and the signature of a Party affixed to a counterpart signature of the other Party shall be deemed to constitute execution of the Agreement.

12. Term. The term of this Agreement shall end on the date that the Reimbursable Costs of the Public Improvements and any interest thereon have been paid in full to the Company or its assignee in accordance with the terms hereof or December 31, 2059, whichever date occurs first in time.

13. Agreement Not an Indebtedness or Multiple Fiscal Year Financial Obligation. The payment obligations under this Agreement shall be subject to annual appropriation by the Board of Directors of the District in the exercise of their sole and unfettered discretion. The terms and conditions of this Agreement shall not be construed as a multiple-fiscal year direct or indirect district debt or other financial obligation within the meaning of Article X, Section 20 of the Colorado Constitution.

14. Governmental Immunity. Nothing herein shall be construed as a waiver of the rights and privileges of the District pursuant to the Colorado Governmental Immunity Act.

15. Governing Law. This Agreement shall be governed by and construed in accordance with the internal laws of the State of Colorado.

16. Authority. By its execution hereof, each party hereto represents and warrants that its representative signing hereunder has full power and lawful authority to execute this document and bind the respective party to the terms hereof.

17. Supplemental Public Securities Act. The District hereby elects to apply all of the provisions of the Supplemental Public Securities Act, found at Title 11, Article 57, Part 2, C.R.S. to this Agreement. This recital shall be conclusive evidence of the validity and the regularity of the District's execution of this Agreement after its delivery for value.

EXECUTED as of the date and year first above written.

PECOS LOGISTICS PARK METROPOLITAN DISTRICT, a quasi-municipal corporation and political subdivision of the State of Colorado

By: _____
President

WESTFIELD DEVELOPMENT COMPANY, INC., a Colorado corporation

By: _____
Authorized Signatory

EXHIBIT A

Description of Completed Public Improvements

Exhibit K
Overlap Consent Resolution

RESOLUTION OF
THE BOARD OF DIRECTORS OF THE
BERKELEY WATER AND SANITATION DISTRICT
ADAMS COUNTY AND JEFFERSON COUNTY, COLORADO

A RESOLUTION CONSENTING TO THE PROVISION OF WATER AND SANITATION SERVICES BY PECOS LOGISTICS PARK METROPOLITAN DISTRICT, WHOSE BOUNDARIES AND SERVICES WILL OVERLAP WITH THE BOUNDARIES AND SERVICES OF BERKELEY WATER AND SANITATION DISTRICT

WHEREAS, Berkeley Water and Sanitation District ("Berkeley") is a quasi-municipal corporation and political subdivision of the State of Colorado operating under Article 1 of Title 32, C.R.S.

WHEREAS, within its boundaries, Berkeley is the primary provider of municipal collection and transmission of wastewater and treatment or delivery of same to Metro Wastewater Reclamation District for treatment; and

WHEREAS, Section 32-1-107(2), C.R.S., provides generally that no special district may be organized wholly or partly within an existing special district providing the same service; and

WHEREAS, Section 32-1-107(3)(b)(IV), C.R.S., provides that an overlapping special district may be authorized to provide the same service as the existing special district if, among other requirements, the board of directors for the existing special district consents to the overlapping special district providing the same service; and

WHEREAS, upon organization of the proposed Pecos Logistics Park Metropolitan District (the "Metro District"), the boundaries of the Metro District and Berkeley will overlap; and

WHEREAS, Berkeley has received a request from the proponents of the Metro District to consent to the Metro District providing water and sanitation services to property that is within the boundaries of the Metro District, which overlaps with the boundaries of Berkeley, as set forth on the map attached hereto as Exhibit A, pursuant to Section 32-1-107(3)(b)(IV), C.R.S.; and

WHEREAS, it is anticipated that the Metro District shall have the authority pursuant to the Special District Act, C.R.S. § 32-1-101, et seq., as amended, and the Metro District's service plan to provide various public improvements and services, including but not limited to financing, construction, operation and maintenance of water, nonpotable irrigation water, storm sewer and sanitation and wastewater pre-treatment improvements (collectively, the "District's Improvements and Services") to support the development to be known as the Pecos Logistics Industrial Business Park (the "Project"); and

WHEREAS, Berkeley also has the authority to provide public improvements and services pursuant to the Special District Act, C.R.S. § 32-1-101, et seq., and its statement of purposes;

however, Berkeley is not currently providing, nor does it intend to provide, financing of the public improvements that will duplicate or interfere with the Metro District's Improvements and Services to support the Project; and

WHEREAS, the Metro District does not intend to provide any public improvements or services that will duplicate or interfere with improvements or services currently provided by Berkeley or that may be provided by Berkeley in the future; and

WHEREAS, Berkeley consents to the organization of the Metro District and to the Metro District providing water and sanitation services within overlapping areas, upon the terms and conditions hereinafter set forth.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of Berkeley Water and Sanitation District, County of Adams and Jefferson, State of Colorado, that:

1. Berkeley hereby consents to the organization of the proposed District with overlapping boundaries and to the Metro District possessing the authority to provide the Metro District's Improvements and Services subject to the following conditions:

A. The proponents of the Metro District will furnish the draft service plan, and any amendments thereto, to Berkeley for review. The service plan will provide that Berkeley is the primary provider of municipal wastewater collection and delivery services within Berkeley's boundaries and that the Metro District may not duplicate services provided by Berkeley. Berkeley shall have 30 days to review, comment on and approve any changes to sections 6a or IX the plan, related to Berkeley, such approval not to be unreasonably withheld. The service plan shall be deemed approved if no written comments are provided to the proponents within the 30-day period.

B. The District's Improvements and Services may not duplicate or interfere with any public improvements or services currently provided by Berkeley or that may be provided by Berkeley in the future without the express written consent of Berkeley.

C. Following the organization of the District, the District shall enter into an intergovernmental agreement with Berkeley concerning the District's provision of the District's Improvements and Services in substantially the form attached hereto as **Exhibit B**, regarding construction of certain sewer improvements needed to connect the property within the District into Berkeley's facilities and application of Berkeley rules and regulations. The District shall deliver an executed copy of the IGA to the Berkeley within 30 days of recordation of the court order organizing the District. If the IGA is not delivered within 30 days, Berkeley's approval of the provision of water and sanitation improvements and facilities as provided in this Resolution shall be suspended until such time as the IGA is delivered.

2. Berkeley's consent is expressly conditioned on the Metro District's compliance with the conditions stated herein. Failure by the Metro District to comply with the express

conditions stated herein shall nullify the consent of Berkeley to the formation and overlap of the District pursuant to Section 32-1-107, C.R.S.

3. Berkeley's consent to the Metro District's overlapping boundaries and powers does not constitute its approval of the service plan or its financing, construction, acquisition, installation and maintenance of water and sanitary sewer improvements and facilities. Berkeley takes no position on the organization of the Metro District and takes no responsibility for any current or future debt of the Metro District.

4. Neither Berkeley nor the District shall be deemed a partner, joint venture, or agent of the other.

5. Berkeley's consent via this Resolution will expire unless the County of Adams approves the service plan within one year of the date of this Resolution.

Dated this 15TH day of APRIL, 2019.

BERKELEY WATER AND SANITATION DISTRICT

By: _____
President

ATTEST:

_____
Secretary

EXHIBIT A

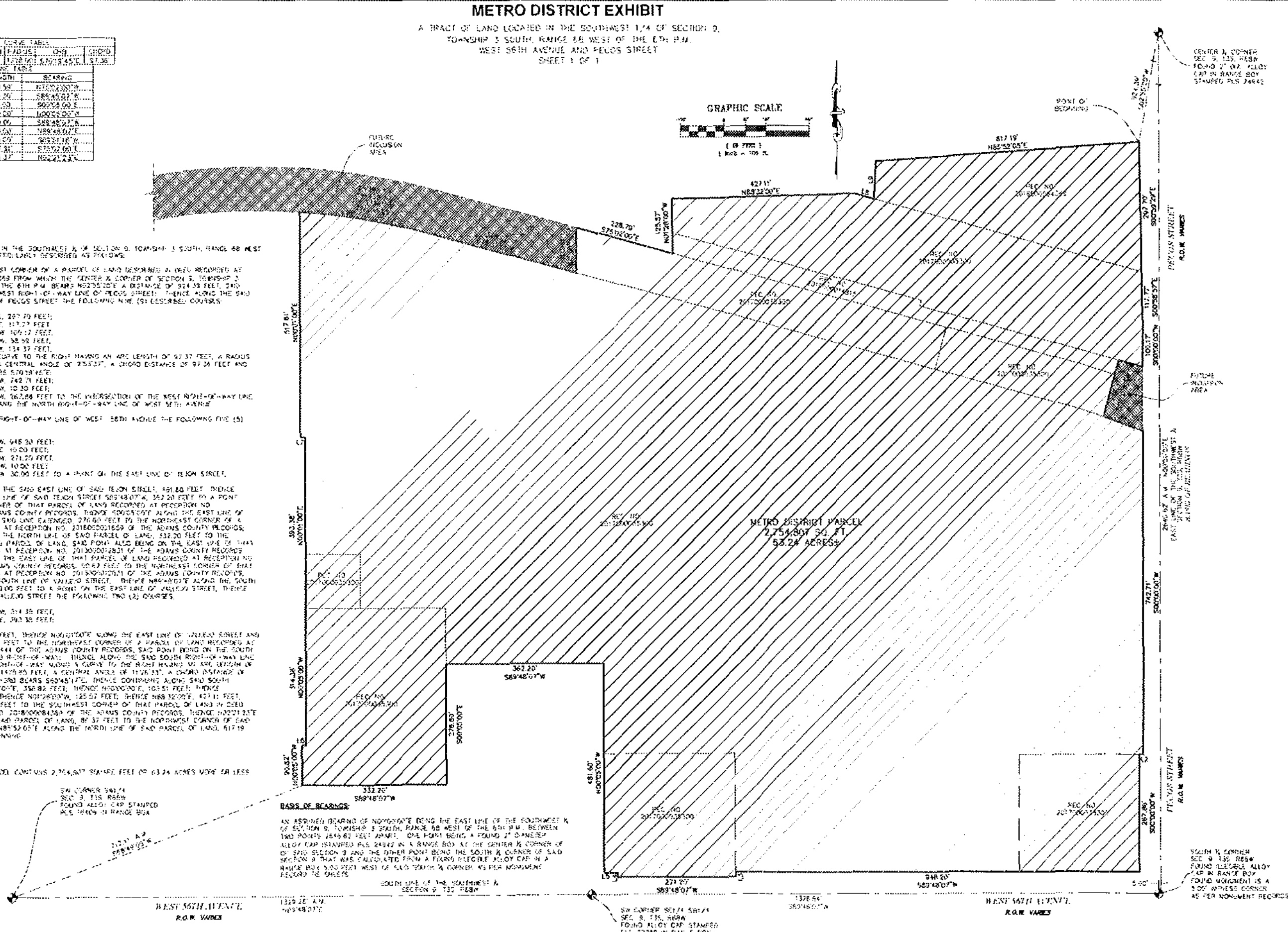
(Proposed boundaries of Metro District)

METRO DISTRICT EXHIBIT

A TRACT OF LAND LOCATED IN THE SOUTHWEST 1/4 OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH P.M.
WEST 56TH AVENUE AND PECOS STREET
SHEET 1 OF 1

CURVE TABLE				
CURVE	LENGTH	RADIUS	CHB	CHORD
C1	97.37'	1925.00'	S70°19'45"E	97.36'

LINE TABLE		
LINE	LENGTH	BEARING
L1	58.59'	N75°02'00"W
L2	10.30'	S89°45'07"W
L3	10.00'	S00°05'00"E
L4	10.00'	N00°05'00"W
L5	30.00'	S89°48'07"W
L6	10.00'	N89°48'07"E
L7	10.00'	S89°51'16"W
L8	47.91'	S75°02'00"E
L9	86.37'	N02°21'23"E



LEGAL DESCRIPTION:

A TRACT OF LAND LOCATED IN THE SOUTHWEST ¼ OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH P.M., MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE NORTHEAST CORNER OF A PARCEL OF LAND DESCRIBED IN DEED RECORDED AT RECEPTION NO. 2018000084369 FROM WHICH THE CENTER ¼ CORNER OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH P.M. BEARS N02°35'20"E A DISTANCE OF 924.39 FEET, SAID POINT ALSO BEING ON THE WEST RIGHT-OF-WAY LINE OF PECOS STREET; THENCE ALONG THE SAID WEST RIGHT-OF-WAY LINE OF PECOS STREET THE FOLLOWING NINE (9) DESCRIBED COURSES:

1. THENCE S00°59'29"E, 297.70 FEET;
2. THENCE S00°55'57"E, 117.77 FEET;
3. THENCE S00°00'00"W, 109.17 FEET;
4. THENCE N75°02'00"W, 58.59 FEET;
5. THENCE S15°01'02"W, 134.37 FEET;
6. THENCE ALONG A CURVE TO THE RIGHT HAVING AN ARC LENGTH OF 97.37 FEET, A RADIUS OF 1925.00 FEET, A CENTRAL ANGLE OF 2°53'52", A CHORD DISTANCE OF 97.36 FEET AND WHOSE CHORD BEARS S70°19'45"E;
7. THENCE S00°00'00"W, 742.71 FEET;
8. THENCE S89°45'07"W, 10.30 FEET;
9. THENCE S00°00'00"W, 267.86 FEET TO THE INTERSECTION OF THE WEST RIGHT-OF-WAY LINE OF PECOS STREET AND THE NORTH RIGHT-OF-WAY LINE OF WEST 56TH AVENUE.

THENCE ALONG THE NORTH RIGHT-OF-WAY LINE OF WEST 56TH AVENUE THE FOLLOWING FIVE (5) COURSES:

1. THENCE S89°48'07"W, 948.20 FEET;
2. THENCE S00°05'00"E, 10.00 FEET;
3. THENCE S89°48'07"W, 271.20 FEET;
4. THENCE N00°05'00"W, 10.00 FEET;
5. THENCE S89°48'07"W, 30.00 FEET TO A POINT ON THE EAST LINE OF TEJON STREET.

THENCE N00°05'00"W ALONG THE SAID EAST LINE OF SAID TEJON STREET, 481.60 FEET; THENCE DEPARTING FROM SAID EAST LINE OF SAID TEJON STREET S89°48'07"W, 362.20 FEET TO A POINT BEING THE NORTHWEST CORNER OF THAT PARCEL OF LAND RECORDED AT RECEPTION NO. 2012000088342 OF THE ADAMS COUNTY RECORDS; THENCE S00°05'00"E ALONG THE EAST LINE OF SAID PARCEL OF LAND AND SAID LINE EXTENDED, 278.60 FEET TO THE NORTHEAST CORNER OF A PARCEL OF LAND RECORDED AT RECEPTION NO. 2018000021659 OF THE ADAMS COUNTY RECORDS; THENCE S89°48'07"W ALONG THE NORTH LINE OF SAID PARCEL OF LAND, 332.20 FEET TO THE NORTHWEST CORNER OF SAID PARCEL OF LAND, SAID POINT ALSO BEING ON THE EAST LINE OF THAT PARCEL OF LAND RECORDED AT RECEPTION NO. 2013000012831 OF THE ADAMS COUNTY RECORDS; THENCE N00°05'00"W ALONG THE EAST LINE OF THAT PARCEL OF LAND RECORDED AT RECEPTION NO. [illegible] OF THE ADAMS COUNTY RECORDS, 90.52 FEET TO THE NORTHEAST CORNER OF THAT PARCEL OF LAND RECORDED AT RECEPTION NO. 2013000012831 OF THE ADAMS COUNTY RECORDS, SAID POINT BEING ON THE SOUTH LINE OF VALLEJO STREET; THENCE N89°48'07"E ALONG THE SOUTH LINE OF VALLEJO STREET, 10.00 FEET TO A POINT ON THE EAST LINE OF VALLEJO STREET; THENCE ALONG THE EAST LINE OF VALLEJO STREET THE FOLLOWING TWO (2) COURSES:

1. THENCE N00°05'00"W, 314.38 FEET;
2. THENCE N00°01'00"E, 393.38 FEET;

THENCE S89°51'16"W, 10.00 FEET; THENCE N00°01'00"E ALONG THE EAST LINE OF VALLEJO STREET AND SAID LINE EXTENDED, 517.61 FEET TO THE NORTHEAST CORNER OF A PARCEL OF LAND RECORDED AT RECEPTION NO. 2007000058444 OF THE ADAMS COUNTY RECORDS, SAID POINT BEING ON THE SOUTH LINE OF THE BNSF RAILROAD RIGHT-OF-WAY; THENCE ALONG THE SAID SOUTH RIGHT-OF-WAY LINE OF SAID BNSF RAILROAD RIGHT-OF-WAY ALONG A CURVE TO THE RIGHT HAVING AN ARC LENGTH OF 294.73 FEET, A RADIUS OF 1475.85 FEET, A CENTRAL ANGLE OF 11°26'33", A CHORD DISTANCE OF 294.25 FEET AND WHOSE CHORD BEARS S80°45'17"E; THENCE CONTINUING ALONG SAID SOUTH RIGHT-OF-WAY LINE S75°02'00"E, 358.82 FEET; THENCE N00°00'00"E, 103.51 FEET; THENCE S75°02'00"E, 228.79 FEET; THENCE N01°28'00"W, 125.57 FEET; THENCE N89°32'00"E, 427.11 FEET; THENCE S75°02'00"E, 47.91 FEET TO THE SOUTHWEST CORNER OF THAT PARCEL OF LAND IN DEED RECORDED AT RECEPTION NO. 2018000084369 OF THE ADAMS COUNTY RECORDS; THENCE N02°21'23"E ALONG THE WEST LINE OF SAID PARCEL OF LAND, 86.37 FEET TO THE NORTHWEST CORNER OF SAID PARCEL OF LAND; THENCE N85°52'05"E ALONG THE NORTH LINE OF SAID PARCEL OF LAND, 817.19 FEET TO THE POINT OF BEGINNING.

COUNTY OF ADAMS,
STATE OF COLORADO

THE ABOVE DESCRIBED PARCEL CONTAINS 2,754,807 SQUARE FEET OR 63.24 ACRES MORE OR LESS.

BASIS OF BEARINGS:

AN ASSUMED BEARING OF N00°00'00"E BEING THE EAST LINE OF THE SOUTHWEST ¼ OF SECTION 9, TOWNSHIP 3 SOUTH, RANGE 68 WEST OF THE 6TH P.M., BETWEEN TWO POINTS 2646.62 FEET APART. ONE POINT BEING A FOUND 2" DIAMETER ALLOY CAP STAMPED PLS 24942 IN A RANGE BOX AT THE CENTER ¼ CORNER OF OF SAID SECTION 9 AND THE OTHER POINT BEING THE SOUTH ¼ CORNER OF SAID SECTION 9 THAT WAS CALCULATED FROM A FOUND ILLEGIBLE ALLOY CAP IN A RANGE BOX 5.00 FEET WEST OF SAID SOUTH ¼ CORNER AS PER MONUMENT RECORD TIE SHEETS.

NOTE: THIS EXHIBIT IS NOT A MONUMENTED LAND SURVEY PLAT OR IMPROVEMENT SURVEY PLAT AND IS NOT TO BE RELIED UPON AS SUCH. THIS EXHIBIT IS FOR INFORMATIONAL PURPOSES ONLY.

Exhibit A Legal Description and Map

811. Know what's below. Call before you dig.

PREPARED BY: 39 NORTH ENGINEERING AND SURVEYING LLC
4495 HALE PARKWAY
SUITE 300
DENVER, COLORADO 80220
PH: 303-325-5071
EMAIL: [illegible]@39north.net

EXHIBIT B
(Form of Intergovernmental Agreement)

INTERGOVERNMENTAL AGREEMENT

THIS INTERGOVERNMENTAL AGREEMENT ("Agreement") is made and entered into this 15th day of April, 2019, by and between the PECOS LOGISTICS PARK METROPOLITAN DISTRICT (the "Metro District"), and the BERKELEY WATER AND SANITATION DISTRICT ("Berkeley"), all quasi-municipal corporations and political subdivisions of the State of Colorado (the Metro District and Berkeley may each be referred to herein individually as a "Party" and collectively as the "Parties").

WHEREAS, the Metro District is authorized pursuant to the Special District Act, C.R.S. § 32-1-101, et seq., as amended, and the Metro District's service plan to provide various public improvements and services including but not limited to water, nonpotable irrigation water, storm sewer, sanitation and wastewater facilities, street, traffic safety protection, television relay and translation, mosquito control, covenant enforcement and design review and security, (collectively, the "Metro District's Improvements and Services") to support the development to be known as the Pecos Logistics Industrial Business Park (the "Project"); and

WHEREAS, the Metro District's boundaries and the Project are located within Berkeley, which also has the authority to provide public improvements and services pursuant to the Special District Act, C.R.S. § 32-1-101, et seq., as amended, and its statement of purposes; however, Berkeley is not currently providing, nor does it intend to provide, public improvements or services that will duplicate or interfere with the Metro District's Improvements and Service to support the Project; and

WHEREAS, the Metro District does not intend to provide any public improvements or services that will duplicate or interfere with public improvements or services currently provided by Berkeley or that may be provided by Berkeley in the future; and

WHEREAS, the Parties are authorized to enter into this Agreement by Colo. Const. Art. XIV, Sec. 18(2)(a) and Section 29-1-203(1) and (2), C.R.S.

WHEREAS, the Parties have determined it to be in the best interest of their respective taxpayers, residents and property owners to enter into this Agreement.

NOW, THEREFORE, for and in consideration of the covenants and mutual agreements herein contained, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

1. Application of Berkeley Rules and Regulations. The Metro District hereby acknowledges that the property within its boundaries shall be subject to all of the rules, regulations, procedures, and requirements of Berkeley, and any rates, fees, tolls, charges or taxes that are imposed by Berkeley within the area of Berkeley overlapped by the Metro District. The Metro District shall not in any way interfere with or otherwise preclude or prevent Berkeley from enforcing and collecting any rate, fee, toll, charge or property tax properly imposed by Berkeley.

2. Construction of Sewer Improvements. The primary purpose of the Metro District is to finance the construction of public improvements necessary and appropriate for the development of the property within its service area. All sewer improvements installed by the Metro District shall comply with the Rules and Regulations and Engineering Standards of Berkeley. The Metro District will not undertake construction or installation of any sewer improvements until the Parties have entered into a Plan / Project Review Fee Agreement and Sewer Main Extension Agreement, in form acceptable to Berkeley.

3. Limited Authority. The Metro District shall not provide any public improvements or services, including but not limited to the Metro District's Improvements and Services, that will duplicate or interfere with public improvements or services currently provided by Berkeley or that may be provided by Berkeley in the future, without Berkeley's express written consent. Berkeley shall remain the primarily municipal provider of wastewater collection, transmission and/or treatment services.

4. Entire Agreement; Amendment. This Agreement constitutes the entire agreement between the Parties covering the subject matter hereof. This Agreement may be amended, modified, changed or terminated in whole or in part by a written agreement duly authorized and executed by the Parties.

5. Enforcement. The Parties agree that this Agreement may be enforced in law or in equity for specific performance, injunction, or other appropriate relief including damages, as may be available according to the laws and statutes of the State of Colorado.

6. Third Party Beneficiaries. This Agreement is intended to describe the responsibilities and rights of and between the named Parties and is not intended to and shall not be deemed to confer any rights upon any person or entity not named as a Party.

7. Assignability. No Party may assign its rights or delegate its duties hereunder without the prior written consent of the other Party.

8. Successors and Assigns. This Agreement and the rights and obligations created hereby shall be binding upon and inure to the benefit of the Parties and their respective successors and permitted assigns.

9. Waiver. The waiver of any breach, or alleged breach, of this Agreement by a Party hereto shall not constitute a continuing waiver of any subsequent breach by said Party of the same or any other provision of this Agreement.

10. Counterparts. This Agreement may be executed in one or more counterparts, which when taken together shall constitute one and the same original. Facsimile or electronic mail transmittals of this Agreement with the Parties' signature(s) shall be binding instruments, the same as originals.

11. No Waiver of Governmental Immunity. The Parties are quasi-municipal corporations and political subdivisions of the State of Colorado, and are relying on and do not waive or intend to waive by this Agreement or any provision hereof, the monetary limitations or

any other rights, immunities, and protections provided by the Colorado Governmental Immunity Act, C.R.S. Section 24-10-101, et seq., as from time to time amended, or otherwise available to the Parties.

12. No Personal Liability. No elected official, director, officer, agent, or employee of the Parties shall be charged personally or held contractually liable under any term or provision of this Agreement or because of any breach thereof.

[remainder of page intentionally left blank]

PECOS LOGISTICS PARK METROPOLITAN DISTRICT

By:_____

Name:_____

Its:_____

BERKELEY WATER AND SANITATION DISTRICT

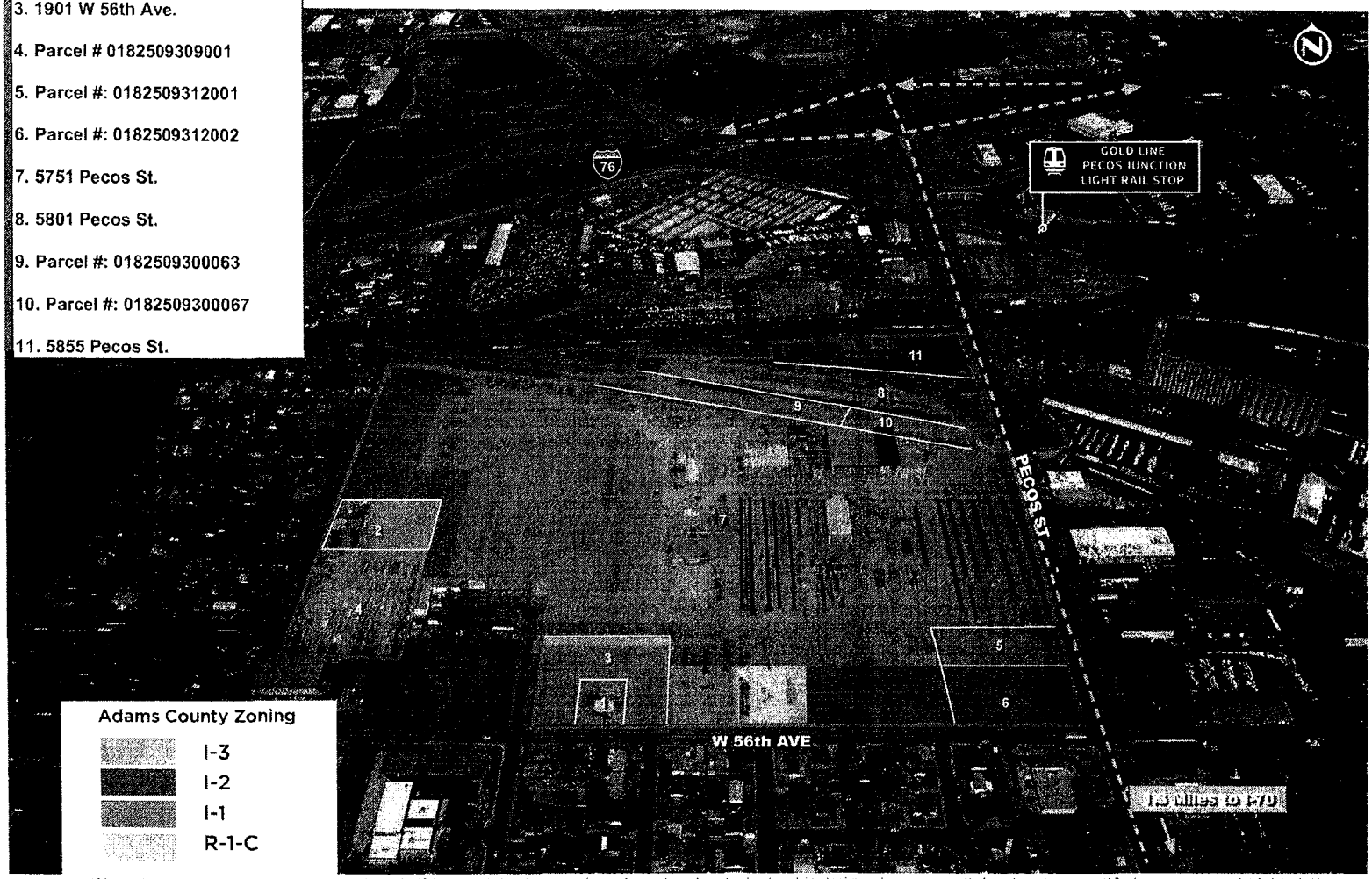
By: Maynard King

Name: Maynard King

Its: PRESIDENT

1. 1921 W 56th Ave.
2. 5700 Vallejo St.
3. 1901 W 56th Ave.
4. Parcel # 0182509309001
5. Parcel #: 0182509312001
6. Parcel #: 0182509312002
7. 5751 Pecos St.
8. 5801 Pecos St.
9. Parcel #: 0182509300063
10. Parcel #: 0182509300067
11. 5855 Pecos St.

PECOS SITE | 62.53 ACRES



PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: 8/6/19
SUBJECT: Adams 12 Five Star Schools Contract
FROM: Herb Covey, Interim Director
AGENCY/DEPARTMENT: Human Services Department
HEARD AT STUDY SESSION ON: n/a
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: Approval from the Board of County Commissioners for the renewal of Adams 12 Five Star Schools contract to continue to enable timely processing of Health First Colorado applications.

BACKGROUND:

Adams County Human Services Department contracts with various medical providers to process medical assistance applications on behalf of their clients. Adams County hires community support specialists (CSS) that can quickly process medical assistance applications submitted by clients at these organizations.

Funding to pay for the salaries and benefits of the Adams County CSS who work on each of these contracts is as follows:

> Adams 12 Five Star Schools will fund 10 percent (10%) of the salary and benefits for the Adams County CSS. The remaining ninety percent (90%) will be reimbursed with federal Medicaid and State funds. The supervisory costs are included in the cost of the agreement.

Adams County Human Services Department's recommendation is to approve this contract amendment to enable timely processing of Medicaid applications. This contract will enhance the delivery of medical services to needy families in Adams County.

The spending authority for this FTE position is already budgeted. No budget action is required. This agenda item is a renewal of the contract that is currently in place with Adams 12 Five Star Schools.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Adams County Human Services Department
Adams County Finance Department
Adams 12 Five Star Schools

ATTACHED DOCUMENTS:

Resolution
Contract between Adams County and Adams 12 Five Star Schools

FISCAL IMPACT:

Please check if there is no fiscal impact ☐ . If there is fiscal impact, please fully complete the section below.

Fund: 15

Cost Center: 99915, 3060M1004010

	Object Account	Subledger	Amount
Current Budgeted Revenue:	99915.5755		50,873,648
Additional Revenue not included in Current Budget:			
Total Revenues:			50,873,648

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:	Various		75,494.01
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			75,494.01

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

RESOLUTION APPROVING THE AGREEMENT BETWEEN THE COUNTY OF ADAMS, COLORADO AND ADAMS 12 FIVE STAR SCHOOLS TO PROVIDE MEDICAID APPLICATION PROCESSING AT ADAMS 12 FIVE STAR SCHOOLS FACILITY

WHEREAS, Adams 12 Five Star Schools requested to reimburse Adams County Human Services to employ an intake specialist to process Health First Colorado applications; and,

WHEREAS, current satellite intake specialist deployments have resulted in reducing the typical Health First Colorado application processing time frame from 45-60 days to 2-14 days, significantly improving client services, and facilitating cost savings; and,

WHEREAS, without an on-site specialist, Adams 12 Five Star Schools financial counselors would have to transport application forms to Adams County Human Services, which would delay Health First Colorado eligibility determination, provision of medical services to needy families, and timely payment for those services; and,

WHEREAS, ten percent (10%) will be funded by Adams 12 Five Star Schools and 90 percent (90%) will be funded by Colorado Department of Health Care Policy and Financing and the State of Colorado to pay for the intake specialist's salary and health insurance coverage and miscellaneous expenses for one and one half year; and,

WHEREAS, the County Attorney's Office authorized execution of the agreement.

NOW THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the Agreement between Adams County and Adams 12 Five Star Schools to provide Medicaid application processing at Adams 12 Five Star Schools' facility is hereby approved.

BE IT FURTHER RESOLVED, that the Chair is authorized to execute said agreement on behalf of Adams county.

AGREEMENT BETWEEN THE COUNTY OF ADAMS, COLORADO AND ADAMS 12 FIVE STAR SCHOOLS TO PROVIDE MEDICAID APPLICATION PROCESSING AT ADAMS 12 FIVE STAR SCHOOLS FACILITY

THIS AGREEMENT is made and entered into between the Adams County Human Services Department, hereinafter referred to as "ACHSD", and **ADAMS 12 FIVE STAR SCHOOLS**, hereinafter referred to as **ADAMS 12 FIVE STAR SCHOOLS**.

WITNESSETH:

WHEREAS, Adams 12 Five Star Schools accepts Medicaid applications each month from Adams County residents; and

WHEREAS, currently **Adams 12 Five Star Schools** must transmit said applications to the respective county social/human services locations for processing; and

WHEREAS, the need to convey application forms to county social/human services offices delays Medicaid eligibility determination, provision of medical services to needy individuals and families, and timely payment for those services to **Adams 12 Five Star Schools;** and

WHEREAS, Adams 12 Five Star Schools sometimes provides medical services to indigent patients prior to Medicaid eligibility determination, thus risking non-payment for those services if treated patients are later deemed ineligible; and

WHEREAS, Adams 12 Five Star Schools is willing to pay 10 percent (10%) of the salary and benefits and provide a working space and appropriate office equipment for a Community Support Specialist, including coverage; and

WHEREAS, Adams County has agreed to allow one Community Support Specialist, employed by Adams County, to process **Adams 12 Five Star Schools** Medicaid applications for Adams County.

NOW THEREFORE, FOR AND IN CONSIDERATION of the covenants and agreements below appearing, the parties agree as follows:

A. Scope of Services. One full time Community Support Specialist employed by Adams County shall be assigned to work at the **Adams 12 Five Star Schools**. The Community Support Specialist shall be responsible for determining eligibility for Medicaid applicants, and for entering eligibility data into the Colorado Benefits Management System to complete the eligibility determination process. The Community Support Specialist will

process up to 100 actions (applications, adding "Needy Newborns" and "pregnant women", including billing back dates) per month, and assist **Adams 12 Five Star Schools** staff with Medicaid eligibility issues as related to this agreement. The Community Support Specialist will transfer completed processed cases to the respective county departments.

B. ACHSD Responsibilities and Accountability. ACHSD shall be responsible for training and supervising the Community Support Specialist. ACHSD will oversee the specialist's work to ensure compliance with pertinent federal and state laws and regulations. ACHSD will conduct periodic case reviews to assess the timeliness and accuracy of Medicaid applications processed by the **Adams 12 Five Star Schools** Community Support Specialist. Further, ACHSD staff will facilitate any audits conducted of the specialist's work.

C. Employment. The Community Support Specialist shall be an employee of ACHSD. The specialist shall be employed full-time (40 hours per week) by ACHSD. As such, the specialist will be subject to the policies, procedures, rules, regulations, directives, and orders of ACHSD. The Community Support Specialist shall comply with the policies of **Adams 12 Five Star Schools,** to the extent that such policies and regulations are not in conflict with those of the ACHSD and/or are not in conflict with agreements herein contained. If such conflict arises and the policy is material to the role of the Community Support Specialist, the parties shall meet to discuss and determine which policy shall govern. The Community Support Specialist shall be subject to the supervision of ACHSD, accountable to ACHSD, shall work between the hours of 7:00 a.m. to 5:30 p.m. Monday through Friday, and shall observe the same holidays as Adams County employees.

D. **Adams 12 Five Star Schools** Financial Responsibility. 10 percent[1] of the average salary costs, employer taxes, retirement contribution, health insurance, and other applicable benefits for the Community Support Specialist including coverage in accordance with rates specified by ACHSD, shall be paid to ACHSD effective upon the start date of the Community Support Specialist. In addition, a proportionate share of the salary costs, health insurance and other applicable benefits for the supervisory functions of the Community Support Specialist totaling $325 per month effective the Community Support Specialist's start date and adjusted annually thereafter shall be paid by **Adams 12 Five Star Schools** to ACHSD. A memo stating the new average cost of a Community Support Specialist and new average cost of the supervisory functions salary and benefits will be sent to **Adams 12 Five Star Schools** within the 1st quarter of each year.

Notwithstanding the Term (Section J) of this Agreement, financial responsibility for payments owed by **Adams 12 Five Star Schools** for salary

[1] CMS has approved a waiver allowing ACHSD to charge 90 percent of these costs to Medicaid and the State of Colorado , with the remaining ten percent chargeable to the contracting entity.

and related expenses shall not commence until the Community Support Specialist has been hired and has started work as an ACHSD employee. In the unlikely event that the Colorado Medicaid program ceases financial support for the Medicaid eligibility function, and if mutually agreed to, the full cost of the Community Support Specialist will be borne by **Adams 12 Five Star Schools**, plus a proportionate share of the supervisor's salary and benefits.

ACHSD shall be responsible for the worker's compensation coverage for the Community Support Specialist and the Supervisor.

Payments will be made in monthly installments, for the total amount invoiced by ACDHS for all salary, benefits, supervisory and additional costs, payable within forty-five (45) days of receipt of the invoice, hereunder beginning the first month the Community Support Specialist has started work at **Adams 12 Five Star Schools** facility. To ensure timely payment by **Adams 12 Five Star Schools** ACHSD shall strive to submit all invoices to **Adams 12 Five Star Schools** within the first five (5) business days of the month.

Adams 12 Five Star Schools will be responsible for all costs associated with the Community Support Specialist's and Supervisor's parking at the **Adams 12 Five Star Schools** site.

Fund Availability. Financial obligations of the District payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, and otherwise made available.

E. Coverage for Long-Term Absences. ACHSD shall attempt to provide an on-site replacement staff for the **Adams 12 Five Star Schools** Community Support Specialist whenever the incumbent is absent for more than ten consecutive work days. In the event the Community Support Specialist will be absent for more than ten consecutive work days, **Adams 12 Five Star Schools** shall be notified as soon as possible in writing of the extended absence as well as receive a written plan for coverage, including identification of a contact person, to ensure timely application processing until the Community Support Specialist returns.

For periods of absence less than ten consecutive work days, ACHSD shall assume responsibility for timely processing until the incumbent returns. Additionally, ACHSD shall provide a single point of contact in these instances.

F. Workplace and Personal Computer Access **Adams 12 Five Star Schools** shall provide working space such as an office or cubicle, office equipment and supplies, a desktop computer (if applicable), and a locking file cabinet

for the Community Support Specialist. ACHSD, with the cooperation of the information technology staff of **Adams 12 Five Star Schools**, will establish and maintain connectivity to the Colorado Benefits Management System and other automated systems required by the Community Support Specialist.

G. Community Support Specialist Qualifications and Selection. The **Adams 12 Five Star Schools** Community Support Specialist shall be selected by ACHSD in accordance with ACHSD Human Resources specified qualifications for this position.

H. Liability Coverage. Pursuant to the Colorado Governmental Immunity Act, ACHSD agrees to be responsible for injuries or damages caused by or incurred by its respective public employees or agents arising from the performance of their duties and obligations under this Agreement, unless the act is willful and wanton or where sovereign immunity bars the action against the Parties. Nothing in this Agreement is intended to waive the provisions of the Colorado Immunity Act as it applies to ACHSD and its public employees. **Adams 12 Five Star Schools** agrees to be responsible for injuries with the respective public employees or agents, or damages sustained from any act or omission of its employees or agents arising from the performance of their duties and obligations under this Agreement, unless the act is reckless, willful or wanton.

I. Insurance. ACHSD and **Adams 12 Five Star Schools** shall exchange evidence of insurance showing general liability coverage for **Adams 12 Five Star Schools**, and general liability coverage of ACHSD in the minimum amount of the Colorado Governmental Immunity Act for protection from claims for bodily injury, death, property damage, or personal injury which may arise through the execution of this contract. Recipients of such evidence shall be the Adams County Risk Manager and **Adams 12 Five Star Schools** Vice President of Finance. Such evidence shall be approved by each recipient prior to commencement of this contract.

J. Term. This agreement shall commence on July 1, 2019 for a term of (18) months ending on December 31, 2020. The agreement shall be automatically renewed for successive one-year terms, unless either party gives sixty (60) days prior written notice of termination. Additionally, this agreement may be terminated without cause by either ACHSD or **Adams 12 Five Star Schools** upon thirty (30) days written notice, and in the event of such termination, **Adams 12 Five Star Schools** monthly financial obligation shall cease for all subsequent months.

K. Confidentiality. The Community Support Specialist shall comply with **Adams 12 Five Star Schools** confidentiality policies as well as all federal, state, and county administrative rules, laws and regulations governing client confidentiality, subject only to statutory exceptions applicable to criminal

investigations and proceedings. Nothing in this agreement shall constitute ACHSD becoming a HIPAA business associate with **Adams 12 Five Star Schools**.

L. Evaluation Plan. ACHSD and **Adams 12 Five Star Schools** will evaluate the project on an annual basis. This will include goals and objectives, workload, performance measures, timelines, milestones, data collection procedures, and other elements agreed to by ACHSD and **Adams 12 Five Star Schools** for this ongoing evaluation. ACHSD will continue to compile monthly reports and statistics which are presented at Liaison and Stakeholder meetings or whenever requested by **Adams 12 Five Star Schools**.

M. Contract Amendment. Amendment of this contract may be made only by written agreement and signed by all parties hereto.

N. Electronic Disposition of Document (Scanning and Photocopies). The Parties hereto agree and stipulate that the original of this document, including the signature page, may be scanned and stored in a computer database or similar device, and that any printout or other output readable by sight, the reproduction of which is shown to accurately reproduce the original of this document, may be used for any purpose just as if it were the original, including proof of the content of the original writing.

O. Immediate Termination for Cause. Should **Adams 12 Five Star Schools** become aware of any serious misconduct by the ACHSD employee such as policy violations or any act or omission that has an adverse impact on or causes damage to patients, staff, **Adams 12 Five Star Schools** reputation, property, **Adams 12 Five Star Schools** operations, **Adams 12 Five Star Schools** must immediately report such information to an ACHSD Supervisor and/or Management. ACHSD will investigate such allegations and take appropriate disciplinary action according to its policies and procedures, including terminating the employee if appropriate.

P. Access to Records. ACHSD, for itself and for its agents and employees, agrees to provide to the Controller General of the United States or the Department of Health and Human Services ("HHS"), and their duly authorized representatives, upon written request, reasonable access to this Agreement, books, documents and records until the expiration of four (4) years after the Services are furnished under the Agreement for the purpose of evaluating the nature and extent or the costs and Services provided. ACHSD also agrees that if ACHSD subcontracts for any of the duties under this Agreement at a value or cost of Ten Thousand Dollars ($10,000) or more over a twelve (12) month period, with a related organization, the subcontract shall contain a clause to the effect that the related organization must make available, upon written request, to HHS, the Controller General, or their duly authorized representatives, the subcontract, and the books, documents, and

records of the related organization that are necessary to verify the nature and extent of the costs until the expiration of four (4) years after the Services are furnished under the subcontract.

IN WITNESS WHEREOF, the parties hereto have caused their names to be affixed hereto.

BOARD OF COUNTY COMMISSIONERS
ADAMS COUNTY, COLORADO

_____ _____
Chair Date

ATTEST:
JOSH ZYGIELBAUM
CLERK AND RECORDER

APPROVED AS TO FORM:

_____
Adams County Attorney's Office

_____
Deputy Clerk

CONTRACTOR:

Laura Justice
Name: Laura Justice
Title: Purchasing Manager
Adams 12 Five Star Schools

Subscribed and sworn to before me this 19 day of June 2019, by Laura Justice.

Sonia Velasquez
Notary Public

My commission expires: Jan 22, 2022

SONIA VELASQUEZ
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20144002791
MY COMMISSION EXPIRES JANUARY 22, 2022

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Resolution Regarding Defense and Indemnification of Andrew Titus, Max Hefner, Adam Mohr, and Ross Yniguez as Defendants Pursuant to C.R.S. § 24-10-101, et seq., 19-cv-00555-CMA-KLM
FROM: Heidi Miller, County Attorney and Kerri A. Booth, Assistant County Attorney
AGENCY/DEPARTMENT: County Attorney's Office
HEARD AT STUDY SESSION ON N/A
AUTHORIZATION TO MOVE FORWARD: ☐ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners Adopt the Resolution Regarding Defense and Indemnification of Andrew Titus, Max Hefner, Adam Mohr, and Ross Yniguez as Defendants Pursuant to C.R.S.§ 24-10-101, e*t seq.*

BACKGROUND:

The Board of County Commissioners formally indemnifies employees and elected officials who are named in civil lawsuits. This lawsuit is brought by Alexander Noel Garcia who is an inmate held at the Adams County Detention Facility. Mr. Garcia claims that Deputies Andrew Titus, Max Hefner, Adams Mohr, and Ross Yniguez were deliberately indifferent to his serious medical need with regard to a CPAP machine when they each allegedly failed to ensure he was provided power for the machine.

The County Attorney's Office has reviewed the facts of this lawsuit and it has been determined that Deputy Andrew Titus, Deputy Max Hefner, Deputy Adam Mohr, and Deputy Ross Yniguez were each acting within the course and scope of their employment at all relevant times related to this lawsuit. Therefore, the County Attorney's Office is recommending that Deputy Andrew Titus, Deputy Max Hefner, Deputy Adam Mohr, and Deputy Ross Yniguez be indemnified for any potential damages that might arise out of this litigation.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Adams County Sheriff's Office

ATTACHED DOCUMENTS:

Resolution

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

Potential fiscal impact is unknown. If litigation results in settlement or judgment against the County or its employees/elected officials, there would be a fiscal impact. The potential amount of that impact is impossible to estimate at this time.

RESOLUTION REGARDING THE DEFENSE AND INDEMNIFICATION OF ANDREW TITUS, MAX HEFNER, ADAM MOHR, AND ROSS YNIGUEZ AS DEFENDANTS IN A CIVIL LAWSUIT PURSUANT TO C.R.S. § 24-10-101, ET SEQ.

WHEREAS, Adams County is a public entity pursuant to the Colorado Governmental Immunity Act; and,

WHEREAS, Adams County is obligated to bear the cost of the defense of its elected officials and employees and pay all judgments entered against its elected officials and employees pursuant to the Colorado Governmental Immunity Act so long as they acted within the course and scope of their employment and their acts were not willful and wanton; and,

WHEREAS, Andrew Titus, Max Hefner, Adam Mohr, and Ross Yniguez have been sued in the matter of Alexander Noel Garcia v. Hefner, et al. in the U.S. District Court, Case Number 19-cv-00555-CMA-KLM; said Defendants, being employees of Adams County at the time of the incident described in the Complaint; and,

WHEREAS, initial investigation has revealed to the satisfaction of the Board of County Commissioners and the determination has been made that the Defendants appear to have acted within the course and scope of their employment and their actions do not appear to be willful and wanton; and,

WHEREAS, pursuant to C.R.S. §§ 24-10-110, 24-10-113 and 24-10-118(5) Adams County hereby determines that it is in the public interest to bear the cost of defense for the Defendants against all asserted claims for compensatory and punitive damages which may be pled and to pay or settle any such compensatory and punitive damage claims against said Defendants; and,

WHEREAS, in exchange for such defense, the Defendants are required to cooperate fully in the defense of this matter, including but not limited to, assisting in the discovery process, participating in mediation, facilitation, or other measures deemed appropriate by the Board of County Commissioners, and Defendants acknowledge that Adams County may settle on behalf of the Defendants any or all asserted claims, including those for personal liability and punitive damages.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners of the County of Adams, State of Colorado, that Adams County shall bear the cost of defense for Andrew Titus, Max Hefner, Adam Mohr, and Ross Yniguez against all asserted

claims for compensatory and punitive damages which may be pled and to pay or settle any such compensatory and punitive damage claims against said Defendants in the matter of Alexander Noel Garcia v. Hefner, et al.

IT IS FURTHER RESOLVED that the Adams County Attorney is directed to enter her appearance as counsel for Defendants and to defend this matter.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Resolution approving a perpetual access easement from Adams County to City of Thornton for sewerline access purposes
FROM: Jill Jennings Golich, Director, Community & Economic Development Department
AGENCY/DEPARTMENT: Community & Economic Development
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners approves a resolution granting a perpetual access easement from Adams County to the City of Thornton

BACKGROUND:

The City of Thornton is requesting to enter into a perpetual access easement agreement with the County. Currently, there is an existing easement for construction and maintenance of a sewer line (Rec# 2016000065444), that traverses through Adams County owned property. The purpose of this access easement is for providing vehicular access to a sewerline easement held by the Grantee or its successors and assigns, to gain access to said sewerline easement to construct, lay, install, inspect, monitor, maintain, repair, renew, etc the underground sanitary sewer pipelines within said sewerline easement.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Community & Economic Development, Public Works, Office of the County Attorney

ATTACHED DOCUMENTS:

Perpetual Access Easement
BOCC Draft Resolution

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING A PERPETUAL ACCESS EASEMENT FROM ADAMS COUNTY TO THE CITY OF THORNTON FOR SEWER LINE ACCESS PURPOSES

WHEREAS, Adams County owns a fee parcel of land designated for floodplain known as Outlot A, Foxridge Estates Subdivision located in the Southwest Quarter of Section 11, Township 1 South, Range 67 West of the 6th Principal Meridian, County of Adams, State of Colorado (the "Property"); and,

WHEREAS, City of Thornton has constructed a sanitary sewer pipeline ("Todd Creek Interceptor Project") that goes through the Property; and,

WHEREAS, City of Thornton requires the conveyance of the Perpetual Access Easement over the County's property to gain access to the Todd Creek Interceptor Project; and,

WHEREAS, granting of the easement on the County property will not impact the County's use of the property.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the Perpetual Access Easement from Adams County to the City of Thornton, copy of which is attached hereto, be approved.

BE IT FURTHER RESOLVED, that the Chair of the Board of County Commissioners is hereby authorized to execute the Perpetual Access Easement.

PERPETUAL ACCESS EASEMENT

This Perpetual Access Easement ("Access Easement") entered into this ___ day of ____ 2019, is by and between the County of Adams, a body politic and corporate organized under and existing by virtue of the laws of the State of Colorado ("Grantor"), whose address is 4430 South Adams County Parkway, Brighton, CO 80601-8218 and the City of Thornton, 9500 Civic Center Drive, Thornton, CO 80229 ("Grantee") or collectively (the "Parties").

WITNESSETH

In consideration of Ten Dollars ($10) and other valuable consideration, the receipt and sufficiency of which is acknowledged by the Parties hereto, the Grantor does hereby grant, sell and convey to Grantee, its successors and assigns, a permanent non-exclusive access easement, for purposes of ingress and egress through, on, over, across and along the property described more fully on Exhibit A attached hereto and incorporated herein by this reference (the "Property") necessary for the Todd Creek Interceptor Sewer Line Project (the "Project") subject to the following terms and conditions:

1. No building, structure, or other above or below ground obstruction that may interfere with the purposes for which this Access Easement is granted may be placed, erected, installed or permitted upon the Property. In the event the terms of this paragraph are violated, such violation shall immediately be eliminated by the Grantor upon receipt of written notice from the Grantee or in the event the corrections have not been made within ten (10) days of receipt of such violation notice, the Grantee shall have the immediate right to correct or eliminate such violation. The Grantor shall not, in any manner, interfere in any manner with the purposes for which this Access Easement is granted, however; the Grantor reserves the right to grant access easement to others without the permission of the Grantee and the Parties shall cooperate with all other access easement holders on the Property.

2. The Grantor hereby acknowledges that the access granted herein is for the purpose of providing vehicular access to a sewerline easement held by Grantee or its successors and assigns and that the access granted herein may be utilized by Grantee or its successors and assigns to gain access to said sewerline easement to construct, lay, install, inspect, monitor, maintain, repair, renew, substitute, change the size of, replace, remove, operate and use one or more underground sanitary sewer pipelines, force mains, manholes, and all underground and surface appurtenances thereto within said sewerline easement.

3. Access rights will be exercised by the Grantee or its assigns, in, through, over and across the Property at any and all times deemed necessary by the Grantee for all purposes necessary and at all times convenient to exercise the rights granted to it by this Easement. With the written consent of Grantor, Grantee may improve the Property to accommodate the right of access granted herein.

4. The benefits and burdens of this Easement shall be binding upon and shall inure to the benefit of the Grantee and the Grantor and their successors and assigns.

5. The provisions of this Easement, including all benefits and burdens, shall run with the land.

6. To the extent allowed by law, Grantee shall indemnify and hold harmless Grantor, its employees, and officers for any clams for injury or property damage caused by the negligent actions or omissions of Grantee, its employees, contractors, or agents as a result of Grantee's activities connected with Grantee's use of this Easement. Nothing in this Easement shall be construed as waiving the parties' protections pursuant to the Colorado Governmental Immunity Act, CRS §24-10-101 *et. seq.*, or the common law. Grantee will maintain insurance

consistent with the requirements of the Colorado Governmental Immunity Act during the term of this easement.

In Witness Whereof the Parties hereto have executed this Access Easement to be effective as of the date first above written.

ATTEST:

GRANTOR:
Adams County Commissioners

_____
_____, Deputy Clerk

By:_____
Chair

STATE OF COLORADO)
) ss.
COUNTY OF ADAMS)

The foregoing instrument was acknowledged before me this ____ day of April 2019, by _____.

WITNESS my hand and official seal.

My commission expires: _____.

_____
NOTARY PUBLIC

GRANTEE
CITY OF THORNTON, COLORADO

_____
Jason Pierce
Infrastructure Engineering Director

ATTEST:

_____
Kristen N. Rosenbaum, City Clerk

APPROVED AS TO FORM:
Luis A. Corchado, City Attorney

_____
Senior Assistant City Attorney

EXHIBIT A

TODD CREEK INTERCEPTOR PROJECT - CIP 12-410
OWNER: ADAMS COUNTY
ADAMS COUNTY PARCEL NUMBER 0157111301035

LEGAL DESCRIPTION

A PORTION OF OUTLOT A, FOXRIDGE ESTATES SUBDIVISION, AS RECORDED APRIL 20TH, 1999 IN FILE 18, MAP 48, IN THE ADAMS COUNTY CLERK AND RECORDER'S OFFICE, SITUATED IN THE SOUTHWEST QUARTER OF SECTION 11, TOWNSHIP 1 SOUTH, RANGE 67 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, MORE PARTICULARLY DESCRIBED AS FOLLOWS:

PARCEL 1

BEGINNING AT THE NORTHWEST CORNER OF LOT 30 OF SAID FOXRIDGE ESTATES AND ON THE SOUTHERLY LINE OF SAID OUTLOT A;

THENCE DEPARTING SAID LOT AND SAID SOUTHERLY LINE, COINCIDENT WITH THE WESTERLY LINE OF SAID LOT 30, EXTENDED, NORTH 10°24'17" WEST A DISTANCE OF 16.27 FEET, TO A POINT ON THE SOUTHERLY LINE OF A PERMANENT EASEMENT AS RECORDED AT RECEPTION NUMBER 2016000065444 IN SAID CLERK AND RECORDER'S OFFICE;

THENCE DEPARTING SAID WESTERLY LINE, EXTENDED, AND COINCIDENT WITH THE SOUTHERLY LINE OF SAID EASEMENT, SOUTH 74°45'45" EAST A DISTANCE OF 227.32 FEET, TO A POINT AT THE INTERSECTION OF SAID SOUTHERLY LINE AND THE NORTHERLY LINE OF SAID LOT;

THENCE DEPARTING SAID SOUTHERLY LINE AND COINCIDENT WITH THE NORTHERLY LINE OF SAID LOT, NORTH 78°34'16" WEST A DISTANCE OF 220.77 FEET, TO THE POINT OF BEGINNING.

SAID PARCEL 1 CONTAINS 1,667 SQUARE FEET (0.038 ACRES), MORE OR LESS.

TOGETHER WITH

CONTINUED ON PAGE 2.

PREPARED BY TOM STARKWEATHER UNDER THE DIRECT SUPERVISION OF STEVEN A. DYNES, PLS 24949
FOR AND ON BEHALF OF THE CITY OF THORNTON

THIS EXHIBIT DOES NOT REPRESENT A MONUMENTED SURVEY BY THE CITY OF THORNTON SURVEY SECTION. IT IS INTENDED ONLY TO DEPICT THIS DESCRIPTION.	CITY OF THORNTON 12450 Washington Street Thornton, CO 80241 SURVEY SECTION 720-977-6210	JOB #:	DATE: 2019-03-14
		FILE NAME: TCI Access Easement-Outlot A	PAGE 1 OF 3

EXHIBIT A

TODD CREEK INTERCEPTOR PROJECT - CIP 12-410
OWNER: ADAMS COUNTY
ADAMS COUNTY PARCEL NUMBER 0157111301035

CONTINUED FROM PAGE 1

PARCEL 2

COMMENCING AT THE NORTHWEST CORNER OF SAID LOT 30;

THENCE COINCIDENT WITH THE NORTH LINE OF SAID LOT, SOUTH 78° 34' 16" EAST A DISTANCE OF 280.73 FEET, TO THE NORTHWEST CORNER OF LOT 29 OF SAID FOXRIDGE ESTATES;

THENCE DEPARTING THE NORTH LINE OF SAID LOT 30 AND COINCIDENT WITH THE NORTH LINE OF SAID LOT 29, SOUTH 78° 34' 16" EAST A DISTANCE OF 98.52 FEET, TO AN ANGLE POINT IN SAID NORTH LINE;

THENCE CONTINUING COINCIDENT WITH SAID NORTH LINE, SOUTH 86° 39' 02" EAST A DISTANCE OF 94.53 FEET, TO THE NORTHERLY LINE OF SAID PERMANENT EASEMENT AND THE POINT OF BEGINNING FOR THIS DESCRIPTION;

THENCE DEPARTING SAID NORTH LINE AND COINCIDENT WITH SAID NORTHERLY LINE, NORTH 74° 45' 45" WEST A DISTANCE OF 525.28 FEET, TO THE EASTERLY LINE OF A PERMANENT ACCESS EASEMENT AS RECORDED AT RECEPTION NUMBER 2016000065446 IN SAID CLERK AND RECORDER'S OFFICE;

THENCE DEPARTING WITH SAID NORTHERLY LINE AND COINCIDENT WITH SAID EASTERLY LINE, NORTH 25° 08' 15" WEST A DISTANCE OF 25.34 FEET;

THENCE DEPARTING SAID EASTERLY LINE, SOUTH 74° 56' 21" EAST A DISTANCE OF 642.81 FEET TO AN ANGLE POINT ON THE NORTH LINE OF SAID LOT 29;

THENCE COINCIDENT WITH THE NORTH LINE OF SAID LOT 29, NORTH 86° 39' 02" WEST A DISTANCE OF 103.33 FEET, TO THE POINT OF BEGINNING.

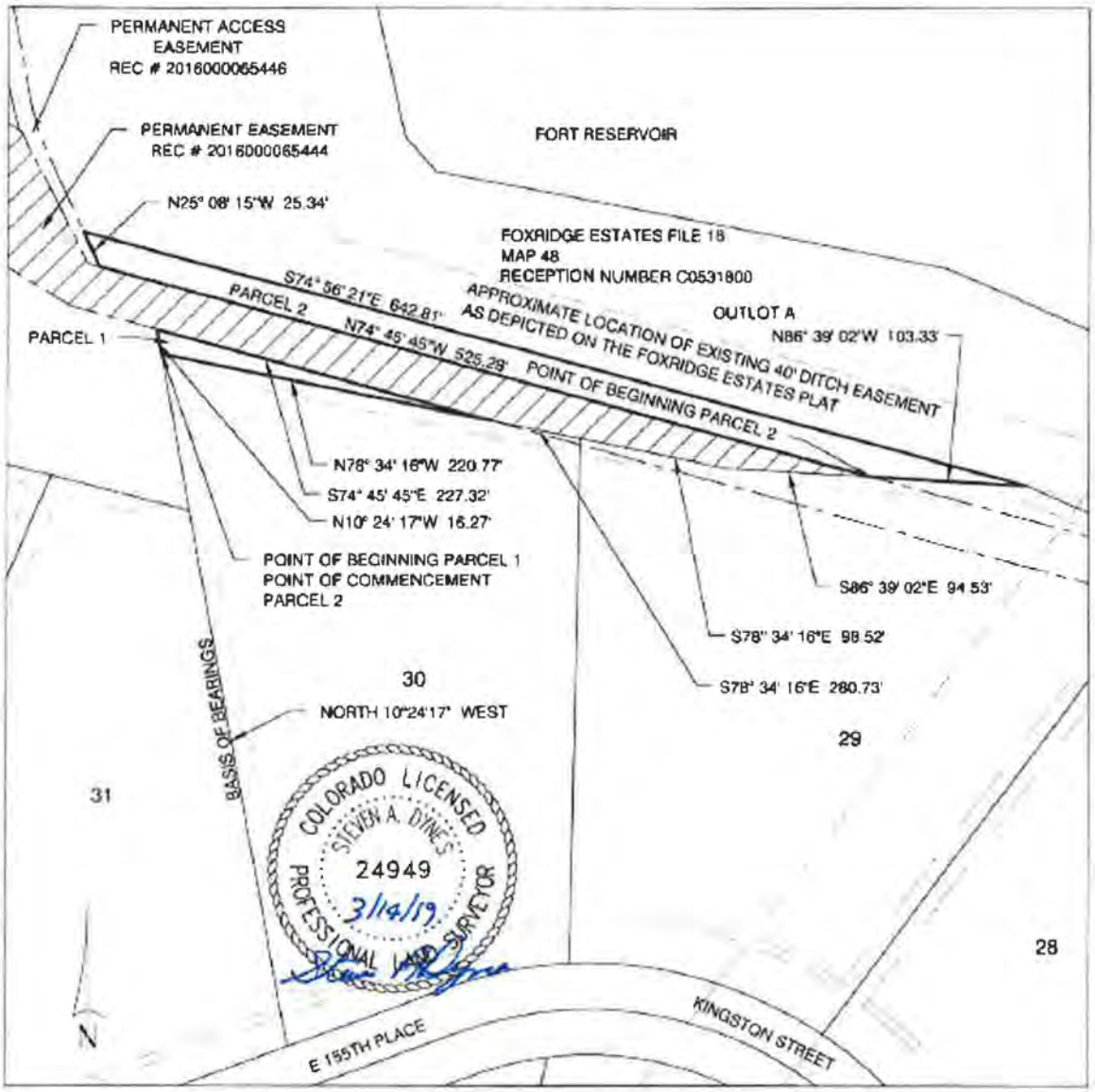
SAID PARCEL CONTAINS 11,811 SQUARE FEET (0.271 ACRES), MORE OR LESS.

THE BASIS OF BEARINGS FOR THESE DESCRIPTIONS IS THE WESTERLY LINE OF LOT 30, FOXRIDGE ESTATES, AND IS ASSUMED TO BEAR NORTH 10°24'17" WEST

PREPARED BY TOM STARKWEATHER UNDER THE DIRECT SUPERVISION OF STEVEN A. DYNES, PLS 24949.
FOR AND ON BEHALF OF THE CITY OF THORNTON

THIS EXHIBIT DOES NOT REPRESENT A MONUMENTED SURVEY BY THE CITY OF THORNTON SURVEY SECTION IT IS INTENDED ONLY TO DEPICT THIS DESCRIPTION.	CITY OF THORNTON 12450 Washington Street Thornton, CO 80241 SURVEY SECTION 720-977-6210	JOB #:	DATE: 2019-03-14
		FILE NAME: TCI Access Easement-Outlot A	PAGE 2 OF 3

EXHIBIT A



TODD CREEK INTERCEPTOR PROJECT CIP 12-410
OWNER: ADAMS COUNTY
ADAMS COUNTY PARCEL NUMBER 0157111301035

PREPARED BY TOM STARKWEATHER UNDER THE DIRECT SUPERVISION OF STEVEN A. DYNES, PLS 24949
FOR AND ON BEHALF OF THE CITY OF THORNTON

THIS EXHIBIT DOES NOT REPRESENT A MONUMENTED SURVEY BY THE CITY OF THORNTON SURVEY SECTION. IT IS INTENDED ONLY TO DEPICT THIS DESCRIPTION	CITY OF THORNTON 12450 Washington Street Thornton, CO 80241 SURVEY SECTION 720-977-6210	SCALE 1" = 100' 50' 100' 200' JOB #: DATE: 2019-03-14 FILE NAME: TCI Access Easement Outlot A PAGE 3 OF 3

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Adams County's Scientific and Cultural Facilities District Funding Distribution Plan
FROM: Byron Fanning, Director
AGENCY/DEPARTMENT: Parks, Open Space and Cultural Arts
HEARD AT STUDY SESSION ON July 23, 2018
AUTHORIZATION TO MOVE FORWARD: ☒ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners Approves Adams County's Scientific and Cultural Facilities District Funding Distribution Plan for 2019/2020

BACKGROUND:

SCFD has distributed funds from a 1/10 of 1% sales and use tax to qualified cultural organizations throughout the seven-county Denver, Colorado metropolitan area. The funds support cultural facilities whose primary purpose is to enlighten and entertain the public through the production, presentation, exhibition, advancement and preservation of art, music, theatre, dance, zoology, botany, natural history and cultural history.

ACCC interviews and evaluates the qualified organizations each year to provide the recommendations to the Board of County Commissioners on how to distribute the 2019-20 SCFD allocation. The SCFD district board provided Adams County with $1,757,482.19 for the 2019-20 funding allocation. ACCC provided funding to 107 projects, 4 visual art projects, and fund 19 general operating support organizations within Adams County.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Adams County Cultural Council

ATTACHED DOCUMENTS:

Resolution
Adams County's Scientific and Cultural Facilities District Funding Distribution Plan for 2019/2020
Resolution

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

SCFD provides all the funding through the 1/10 of 1% sales tax revenue each year.

RESOLUTION APPROVING ADAMS COUNTY'S SCIENTIFIC AND CULTURAL FACILITIES DISTRICT FUNDING DISTRIBUTION PLAN FOR 2019/2020

WHEREAS, $1,757,482.19 is currently available from the Scientific and Cultural Facilities District tax for distribution to qualified organizations in Adams County; and,

WHEREAS, the Adams County Cultural Council solicited applications for said funds; and,

WHEREAS, after careful review of those applications, the Adams County Cultural Council has made recommendations to the Board of County Commissioners for distribution of $1,757,424.73.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the recommendations on the Adams County Cultural Council's Funding Plan, which are attached hereto and incorporated herein, are herby approved and adopted.

SCFD 2019 Tier III Funding Plan - Adams County

From District Office		
	Previously Committed Funds	**Available for 2019 Distribution**
2019 Funds Available		**$ 1,749,855.98**
Uncommitted/Returned Funds from Previous Years		**$ 7,626.21**
Committed Visual Arts Yet To Be Distributed:		
Adams County Visual Arts Commission (Human Service Buidling)	$ 25,650.00	
Commerce City Cultural Council (Rec Center)	$ 12,566.00	
Commerce City Cultural Council (Public Art for Fronterra Park)	$ 7,500.00	
Northglenn Arts and Humanities Foundation (Arts on Parade 2017)	$ 3,086.88	
Northglenn Arts and Humanities Foundation (Arts on Parade 2018)	$ 5,051.25	
Northglenn Arts and Humanities Foundaiton (Arts on Parade 2019	$ 5,612.50	
South Westminster Arts Group (Sculpture on 73rd 2016)	$ 1,125.00	
South Westminster Arts Group (Sculpture on 73rd 2017)	$ 725.00	
South Westminster Arts Group (Sculpture on 73rd 2018)	$ 562.50	
Thornton Arts, Sciences, and Humanities Council (Outside the Box: Traffic Box Mural Project)	$ 8,456.25	
Total Available from District Office	**$ 70,335.38**	**$ 1,757,482.19**

Organization	General Operating Support	Recommended
A Child's Song	GOS	$ 30,000.00
Adams County Historical Society	GOS	$ 20,656.20
Adams County Visual Arts Commission	GOS	$ 30,000.00
Brighton Cultural Arts Commission	GOS	$ -
Brightonmusic Choir and Orchestra Inc.	GOS	$ 2,065.50
Colorado Educational Theatre	GOS	$ 3,006.29
Commerce City Cultural Council	GOS	$ 5,445.73
Inside the Orchestra	GOS	$ 30,000.00
Kim Robards Dance, Inc.	GOS	$ 30,000.00
Life/Art Dance Ensemble	GOS	$ 2,357.79
Northglenn Arts and Humanities Foundation	GOS	$ 30,000.00
Northland Fine Arts Association	GOS	$ 3,263.34
Paletteers Art Club	GOS	$ 981.12
Platte Valley Players	GOS	$ 6,808.34
South Westminster Arts Group	GOS	$ 3,576.87
Thornton Arts, Sciences and Humanities Council	GOS	$ 7,981.92
Thornton Community Band	GOS	$ 4,015.26
Thornton Community Chorus	GOS	$ 1,062.18
Westminster Area Historical And Museum Society	GOS	$ 1,111.67
Westminster Community Artist Series	GOS	$ 7,669.52
	GOS TOTAL	**$ 220,001.72**

Organization	Project	Requested	Recommended
A Child's Song	Musical Experiences for Educational Achievement (MEEA)	$ 25,000.00	$ 19,500.00
A Child's Song	Reach and Teach (R&T)	$ 15,000.00	$ 12,150.00
Adams County Historical Society	School & Organized Youth Heritage Tours	$ 8,775.00	$ 7,634.25
Adams County Historical Society	Historic Holidays	$ 28,000.00	$ 24,360.00
Art as Action	Reconnect with your Body	$ 1,100.00	$ 1,001.00
Art from Ashes Inc	Creative Youth Empowerment Program Through Poetry and Art	$ 15,500.00	$ 13,485.00
Augustana Arts Inc	City Strings and Stratus in Adams County	$ 20,000.00	$ 16,200.00
Aurora Symphony Orchestra	Three (3) Free Bi-lingual Family & Children's Concerts	$ 10,000.00	$ 8,700.00
Aurora Symphony Orchestra	Ode to Joy!	$ 7,500.00	$ 6,525.00

BackStory Theatre	Theatre Education for Gifted & Talented Youth	$ 550.00	$ 517.00
Ballet Ariel	Sleeping Beauty Prologue and Peter and the Wolf	$ 5,000.00	$ 3,900.00
Ballet Ariel	Mother Goose Fairy Tales	$ 2,000.00	$ 1,560.00
Bluff Lake Nature Center	Elementary STEM Education Programs	$ 23,500.00	$ 21,150.00
Boulder Ballet	Educational Outreach	$ 7,500.00	$ 6,075.00
Boulder Museum of Contemporary Art	Contemporary Classroom	$ 27,000.00	$ 23,490.00
Boulder Museum of Contemporary Art	Art Stop on the Go	$ 12,000.00	$ 10,440.00
Boulder Philharmonic Orchestra	Boulder Phil at Pinnacle Arts Center	$ 70,000.00	$ 54,600.00
Boulder Philharmonic Orchestra	2019-2020 Discovery Concert Education Program	$ 9,500.00	$ 7,410.00
Brighton Cultural Arts Commission	Sights and Sounds 2020	$ 90,856.80	$ 73,594.01
Brighton Cultural Arts Commission	Brighton Bee Skep	$ 5,700.00	$ 5,700.00
Brightonmusic Choir and Orchestra Inc.	Brightonmusic 2020 Concert Season	$ 6,276.00	$ 5,083.56
Brightonmusic Choir and Orchestra Inc.	Homespun - A Local Celebration	$ 2,015.00	$ 1,894.10
Celebrate the Beat	Celebrate the Beat-Adams County Performance and Program Project	$ 20,000.00	$ 15,600.00
Colorado Celebration of African American Arts and Culture	History of African American Music	$ 4,395.00	$ 4,395.00
Colorado Celebration of African American Arts and Culture	Colorado Black Arts Festival	$ 9,800.00	$ 8,820.00
Colorado Chamber Players	Incessant Hum in Adams County: Beethoven 2020	$ 3,000.00	$ 3,000.00
Colorado Chamber Players	Border Crossings in Adams County	$ 2,000.00	$ 2,000.00
Colorado Conservatory of Dance	Colorado Conservatory of Dance Adams County Community Education	$ 24,270.00	$ 18,930.60
Colorado Conservatory of Dance	Colorado Conservatory of Dance Performance Series at Pinnacle	$ 60,000.00	$ 46,800.00
Colorado Educational Theatre	Theatre in the Schools 2020	$ 20,000.00	$ 15,600.00
Colorado Fine Arts Association	A Showcase of South Asian Classical Dance in the USA - Small Project	$ 10,000.00	$ 8,100.00
Colorado Fine Arts Association	Eastern Classical Music Project - Large Project	$ 17,000.00	$ 13,260.00
Colorado Hebrew Chorale	Colorado Hebrew Chorale Outreach Project	$ 1,000.00	$ 940.00
Colorado Repertory Singers	Missa in Angustiis ("Lord Nelson Mass") Franz Joseph Hayden Education	$ 2,000.00	$ 1,560.00
Colorado United Irish Societies, Inc.	Irish in Latin America Exhibit	$ 8,000.00	$ -
Colorado Youth Symphony Orchestras	Pinnacle Charter School Concert	$ 10,000.00	$ 8,700.00
Colorado Youth Symphony Orchestras	CYSO Guitar Outreach	$ 6,480.00	$ 5,637.60
Commerce City Cultural Council	Commerce City Cultural Council Adult Art Show	$ 1,650.00	$ 1,501.50
Commerce City Cultural Council	Music in the Park	$ 4,000.00	$ 3,240.00
Community Minded Dance	CMD 2020 Vintage Dance and Music Showcase	$ 9,950.00	$ 7,761.00
Community Minded Dance	Rocky Mountain Balboa Blowout	$ 24,000.00	$ 18,720.00
Control Group Productions	THE END (Adams County)	$ 10,000.00	$ 8,100.00
Control Group Productions	Sempervirens - a dance and science experiment by Observer Collective	$ 9,700.00	$ -
Curious Theatre Company	The Thanksgiving Play' by Larissa FastHorse: An Eye-Opening Satire	$ 5,000.00	$ 3,900.00
David Taylor's Zikr Dance Ensemble	Lifting the Veil	$ 4,500.00	$ 3,645.00
Denver Firefighters Museum	Fire Safety for All	$ 6,500.00	$ 5,070.00
Denver Municipal Band	Educational Services & Public Concert	$ 6,500.00	$ 5,655.00
Denver Municipal Band	Westminster Latino Festival	$ 2,600.00	$ 2,600.00
Denver Urban Gardens	Community Gardening and Horticultural Education in Adams County	$ 45,000.00	$ 36,450.00
Downtown Aurora Visual Arts	DAVA Young Artists: Taking Flight	$ 50,000.00	$ 45,000.00
Downtown Aurora Visual Arts	DAVA Outreach	$ 18,000.00	$ 14,580.00
Dragon 5280	Cultural Edutainment Programs	$ 13,180.34	$ 11,862.31
Environmental Learning for Kids (ELK)	Commerce City Youth Naturally	$ 25,000.00	$ 21,750.00
Fiesta Colorado Inc.	El Dia de Los Muertos	$ 3,000.00	$ 2,820.00
Fiesta Colorado Inc.	Fiesta Colorado Celebration	$ 3,000.00	$ 2,820.00
Flamenco Fantasy Theatre, Incorporated	Flamenco Fantasy Dance Theater	$ 3,000.00	$ 2,820.00
Four Mile Historic Park	Field Trips for Adams County Schools	$ 27,386.40	$ 21,361.39
Four Mile Historic Park	The Outreach Impact Project	$ 18,135.00	$ 14,145.30
Friends of Dinosaur Ridge	Educational Programs at Dinosaur Ridge	$ 30,088.00	$ 24,371.28
Golden Eagle Concert Band	Concerts in Adams County	$ 1,038.22	$ 975.93
Grand Design, Inc.	Sing, Step, Dance and Act Program	$ 9,000.00	$ 7,830.00
Historic Denver/ Molly Brown House Museum	Education Programs to Adams County Learners	$ 3,750.00	$ 3,750.00
Inside the Orchestra	Inside the Orchestra for Schools and Families	$ 10,000.00	$ 8,100.00
Inside the Orchestra	Tiny Tots	$ 10,000.00	$ 8,700.00
Kim Robards Dance, Inc.	An Ode To Joy	$ 25,000.00	$ 20,250.00
Life/Art Dance Ensemble	The Dance Suites	$ 2,200.00	$ 2,068.00
Mirror Image	Your Voice	$ 13,000.00	$ 10,530.00
Museo de las Americas	Exhibit & Education Programs	$ 26,000.00	$ 20,280.00
New Dance Theatre, Inc.	CPRDE Performances	$ 45,000.00	$ 40,500.00

New Dance Theatre, Inc.	Arts-in-Education	$ 47,000.00	$ 40,890.00
Northglenn Arts and Humanities Foundation	Performance Theatre	$ 51,250.00	$ 46,125.00
Northglenn Arts and Humanities Foundation	Summer Concert and Movie Series	$ 11,000.00	$ 9,900.00
Northland Fine Arts Association	50th Anniversary Show!	$ 7,950.00	$ 6,916.50
Northland Fine Arts Association	A Spooky Halloween!	$ 7,500.00	$ 6,075.00
Paideia School	Adams City High School Project	$ 2,500.00	$ 2,350.00
Paletteers Art Club	Art From the Heart Show	$ 3,600.00	$ 3,276.00
Paletteers Art Club	North Metro Artists Studio Tour	$ 4,200.00	$ 3,822.00
Phamaly Theatre Company	Phamaly Theatre Company Video Series	$ 19,800.00	$ 15,444.00
Platte Valley Players	Urinetown The Musical	$ 7,500.00	$ 6,525.00
Platte Valley Players	The Importance of Being Earnest	$ 6,700.00	$ 6,030.00
PlatteForum	ArtLab: Arts-education programming for under-resourced high youth	$ 5,896.00	$ 5,896.00
RedLine	RedLine/Anythink Libraries Collaborative Programming	$ 3,120.00	$ 2,932.80
Rocky Mountain Arts Association	The Denver Women's Chorus Presents "Make Them Hear You 2020"	$ 4,200.00	$ 3,948.00
Rocky Mountain Arts Association	The Denver Gay Men's Chorus 2020 Spring Concert	$ 4,500.00	$ 3,645.00
Rocky Mountain Brassworks-A British Brass Band	Joint Concerts with school bands.	$ 1,927.00	$ 1,811.38
South Westminster Arts Group	Free Children's Art Clinic	$ 896.00	$ -
St. Andrew Society of Colorado	Colorado Scottish Festival	$ 1,200.00	$ 936.00
Stories on Stage	Stories on Stage Season Programming & "Cuentame un Cuentito"	$ 6,000.00	$ 4,860.00
Su Teatro	War of the Flowers: Tercera Parte	$ 19,000.00	$ 15,390.00
Su Teatro	Education Outreach	$ 10,000.00	$ 8,100.00
Tesoro Foundation	19th Annual Indian Market and Powwow	$ 7,000.00	$ 6,090.00
Tesoro Foundation	1840s Rendezvous and Spanish Colonial Art Market	$ 5,000.00	$ 4,050.00
The Denver Brass, Inc.	Denver Brass Reaching Out	$ 15,000.00	$ 13,050.00
The Urban Farm at Stapleton	Aurora Public Schools After-School and Summer Programs	$ 10,415.00	$ 8,123.70
Think 360 Arts for Learning	Arts for All: Schools, Communities and Beyond	$ 20,000.00	$ 16,200.00
Thorne Ecological Institute	Thorne Nature Experience - In-School Program	$ 13,435.00	$ 11,688.45
Thornton Arts, Sciences and Humanities Council	Acoustic Tuesdays	$ 4,700.00	$ 4,700.00
Thornton Arts, Sciences and Humanities Council	The Beat Goes On	$ 17,435.00	$ 15,168.45
Vintage Theatre Productions, Inc	Bennett County Performances	$ 4,450.00	$ 3,871.50
Vintage Theatre Productions, Inc	Engaging Adams County-Arts Pass	$ 20,000.00	$ 16,200.00
Westminster Area Historical And Museum Society	Hometown Christmas- Victorian Open House	$ 2,600.00	$ 2,366.00
Westminster Area Historical And Museum Society	Vintage Baseball & Ice Cream Social	$ 1,185.00	$ 1,078.35
Westminster Community Artist Series	Education in the Arts	$ 15,550.00	$ 13,528.50
Westminster Community Artist Series	Arts in the Community	$ 11,880.00	$ 10,335.60
Wonderbound	Adams County 2019-20 Performance Series	$ 136,000.00	$ 122,400.00
Wonderbound	Adams County 2019-20 Community Education Programs	$ 37,000.00	$ 33,300.00
WOW! Children's Museum World of Wonder LTD	WOW! Children's Museum Serving Adams County Residents	$ 22,320.00	$ 18,079.20
WOW! Children's Museum World of Wonder LTD	Adams County Education Outreach Programs for Low-income Students	$ 1,848.00	$ 1,848.00
YOUNG VOICES OF COLORADO	East Adams County PrairieVoices	$ 4,815.00	$ 4,815.00
YOUNG VOICES OF COLORADO	West Adams County WinterSong	$ 6,225.00	$ 5,415.75
	PROJECT TOTAL	**$ 1,638,492.76**	**$ 1,366,650.00**

Organization	Visual Art	Requested	Recommended	75% Disbursed Oct 2019	25% Disbursed Upon Completion
Brighton Cultural Arts Commission	Sculpture Walk/Art on Loan	$ 21,950.00	$ 21,950.00	$ 16,462.50	$ 5,487.50
Commerce City Cultural Council	The Path to Vitality	$ 14,323.00	$ 14,323.00	$ 10,742.25	$ 3,580.75
Northglenn Arts and Humanities Foundation	Parsons TheatreLobby Sculpture Project	$ 100,000.00	$ 100,000.00	$ 75,000.00	$ 25,000.00
Thornton Arts, Sciences and Humanities Council	Outside the Box:Traffic Box Mural Project	$ 34,500.00	$ 34,500.00	$ 25,875.00	$ 8,625.00
	TOTAL VISUAL ART	**$ 170,773.00**	**$ 170,773.00**	**$ 128,079.75**	**$ 42,693.25**

Adams County Requests		Adams County Allocation		Recommended for Future Disbursement
GOS	**$ 220,001.72**	GOS	**$ 220,001.72**	
Project	**$ 1,638,492.76**	Project	**$ 1,366,650.00**	
Visual Art	**$ 170,773.00**	Visual Art	**$ 170,773.00**	**$ 42,693.25**
TOTAL REQUESTED/ RECOMMENDED	**$ 2,029,267.48**		**$ 1,757,424.73**	

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Letter of Support for The Conservation Fund's grant application to Great Outdoors Colorado
FROM: Byron Fanning, Director of Parks and Open Space and Shannon McDowell
AGENCY/DEPARTMENT: Parks, Open Space, and Cultural Arts
HEARD AT STUDY SESSION ON N/A
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO N/A
RECOMMENDED ACTION: That the Board of County Commissioners approves the letter of support for The Conservation Fund's grant application to Great Outdoors Colorado for a conservation easement in Historic Splendid Valley.

BACKGROUND:

The Conservation Fund has worked with Adams County since 2007 to establish relationships with landowners in the area now known as Historic Splendid Valley. They were instrumental in recent farmland acquisitions for both Adams County and the City of Brighton. The Conservation Fund is seeking a grant from Great Outdoors Colorado to purchase a conservation easement on another farm in Historic Splendid Valley. The Conservation Fund's grant application to Great Outdoors Colorado requires a letter of support or no opposition from the jurisdiction with land use authority over the property.

This particular property is located at the southwest corner of 144th Avenue and Sable Boulevard in unincorporated Adams County. The 79-acre property is one targeted by the District Plan for preservation due to its high quality soils, water resources, and history of farming. The property is also highly visible in Historic Splendid Valley given its location along Sable.

Other than an Open Space Sales Tax grant that will be submitted in the Fall 2019 cycle by the City of Brighton, Adams County is not contributing financially to the purchase of this conservation easement. However, the Parks, Open Space, and Cultural Arts Department will hold the conservation easement and monitor it in perpetuity.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

The Conservation Fund
Great Outdoors Colorado
City of Brighton

ATTACHED DOCUMENTS:

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING A LETTER OF SUPPORT FOR THE CONSERVATION FUND'S GRANT APPLICATION TO GREAT OUTDOORS COLORADO FOR A CONSERVATION EASEMENT IN HISTORIC SPLENDID VALLEY

WHEREAS, Adams County and the City of Brighton are partnering with The Conservation Fund to preserve farmland in Historic Splendid Valley; and,

WHEREAS, The Conservation Fund is working with a landowner in Historic Splendid Valley and plans to submit a grant application to Great Outdoors Colorado (GOCO) to purchase a conservation easement on the property; and,

WHEREAS, the Great Outdoors Colorado application requires a letter from the jurisdiction with land use authority on the property, indicating either support or no objection to the application; and,

WHEREAS, in 2016, Adams County adopted an amendment to the Comprehensive Plan titled the District Plan, which prioritizes the preservation of farmland in Historic Splendid Valley, including the property that is the subject of The Conservation Fund's grant application; and,

WHEREAS, The Conservation Fund's grant application would assist in preserving an important property in the heart of Historic Splendid Valley; and,

WHEREAS, Adams County fully supports The Conservation Fund's grant application to Great Outdoors Colorado and will submit a letter of support for the grant application.

NOW, THEREFORE, BE IT HEREBY RESOLVED, by the Board of County Commissioners of the County of Adams, State of Colorado, that the Chair is authorized to sign the letter of support for this grant application on behalf of Adams County.

August 6, 2019

Great Outdoors Colorado
1900 Grant Street, Suite 725
Denver, CO 80203

RE: Support for The Conservation Fund's acquisition in Historic Splendid Valley

Dear Staff, Reviewers, and Board:

Since 2012, Adams County and the City of Brighton have shared a vision to protect productive farmland in the southern area of Brighton, now known as Historic Splendid Valley. These fertile, irrigated farmlands near the South Platte River are what drew the first settlers to Brighton and have helped sustain the population there since Brighton's founding in 1881. Currently, these lands are under pressure to be developed, or for water rights to be sold and the land dried up.

In 2016, the city and county adopted the District Plan, a joint comprehensive plan that studied the feasibility of preserving farmland for food production, while allowing compatible development and agri-tourism activities to be established to generate a vibrant agricultural area. The preservation of farmland in the southern area of Brighton also serves as a green belt that distinguishes Brighton from other suburban areas. Since the adoption of the plan, and with The Conservation Fund's help, the city and county have successfully protected 366 acres of farmland in this area either through fee ownership or conservation easement. There are 1,140 more acres targeted for preservation, with 640 of those acres considered critical for preservation.

The Conservation Fund's current application, for protection of the 79-acre Morimitsu property, is among the lands considered critical for preservation due to its soils, associated water rights, and long history of farming. Another key importance of preserving the Morimitsu property is its location in the heart of the Historic Splendid Valley. This property is a key part of the agricultural viewshed, particularly as you drive along Sable Boulevard into or out of Brighton as more than 11,000 vehicles do each day. If the property were developed into housing, the farmland in this area would become fragmented and the viewshed would no longer exist.

As you might imagine, preserving farmland and water rights in an area heavily influenced by development is a complicated and expensive endeavor. The Conservation Fund is a key partner of ours as they have significant land protection expertise as well as experience in fostering and maintaining landowner relationships. The Conservation Fund is seeking funding to support a conservation easement on the Morimitsu property, which is perfectly in line with the goals of the District Plan and Historic Splendid Valley. Adams County holds plans to hold the conservation easement on the property to further support conservation efforts in this important area. We strongly support their application for the Morimitsu property and we hope you will as well.

Sincerely,

Steven J. O’Dorisio
Chair

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Weed Advisory Board
FROM: Heidi Miller, County Attorney
AGENCY/DEPARTMENT: County Attorney's Office
HEARD AT STUDY SESSION ON: July 23, 2019 during AIR
AUTHORIZATION TO MOVE FORWARD: ☒ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners approves the resolution.

BACKGROUND:

Appointment of the Board of County Commissioners as the Local Weed Advisory Board for Adams County, Colorado

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

County Manager's Office
County Attorney's Office

ATTACHED DOCUMENTS:

Resolution

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPOINTING THE BOARD OF COUNTY COMMISSIONERS TO ACT AS THE LOCAL WEED ADVISORY BOARD FOR ADAMS COUNTY, COLORADO

WHEREAS, pursuant to C.R.S. § 35-5.5-107, each county in Colorado shall appoint a local weed advisory board; and,

WHEREAS, pursuant to C.R.S. § 35-5.5-107, the Board of County Commissioners may appoint itself to act as the local weed advisory board for Adams County; and,

WHEREAS, the Board of County Commissioners desires to appoint itself to act as the local weed advisory board for Adams County.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the Board of County Commissioners is hereby appointed to act as the local weed advisory board for Adams County.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Boards and Commissions Appointments
FROM: Katie Burczek
AGENCY/DEPARTMENT: BoCC
HEARD AT STUDY SESSION ON: July 23, during AIR
AUTHORIZATION TO MOVE FORWARD: ☒ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners appoints the below board members to their respective boards.

BACKGROUND:

Appoint the following to the Family Preservation Commission:
Lindsay Lierman
Deborah E Hunt
Brian Kenna
Ellen Sandoval
Mary Doran
Candice Leimkuhler

Appoint the following to the Library District Board of Trustees
Gretchen K Lapham

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

ATTACHED DOCUMENTS:

Resolutions

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPOINTING MARY DORAN TO THE FAMILY PRESERVATION COMMISSION AS A TRI-COUNTY HEALTH DEPARTMENT REPRESENTATIVE

WHEREAS, a vacancy currently exists for a member for the Family Preservation Commission; and,

WHEREAS, Mary Doran has expressed an interest in serving on the Family Preservation Commission; and,

WHEREAS, the Board of County Commissioners have reviewed all candidates deemed qualified; and,

WHEREAS, the Board of County Commissioners selected Mary Doran to fill this vacancy as a Tri-County Health Department Representative.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Mary Doran shall be appointed as a member of the Family Preservation Commission as a Tri-County Health Department Representative for the term as listed below:

	Term Expires
Mary Doran	August 6, 2021

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Boards and Commissions Appointments
FROM: Katie Burczek
AGENCY/DEPARTMENT: BoCC
HEARD AT STUDY SESSION ON: July 23, during AIR
AUTHORIZATION TO MOVE FORWARD: ☒ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners appoints the below board members to their respective boards.

BACKGROUND:

Appoint the following to the Family Preservation Commission:
Lindsay Lierman
Deborah E Hunt
Brian Kenna
Ellen Sandoval
Mary Doran
Candice Leimkuhler

Appoint the following to the Library District Board of Trustees
Gretchen K Lapham

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

ATTACHED DOCUMENTS:

Resolutions

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPOINTING DEBORAH HUNT TO THE FAMILY PRESERVATION COMMISSION AS A COMMUNITY MEMBER REPRESENTATIVE

WHEREAS, a vacancy currently exists for a member for the Family Preservation Commission; and,

WHEREAS, Deborah Hunt has expressed an interest in serving on the Family Preservation Commission; and,

WHEREAS, the Board of County Commissioners have reviewed all candidates deemed qualified; and,

WHEREAS, the Board of County Commissioners selected Deborah Hunt to fill this vacancy as a Community Member Representative.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Deborah Hunt shall be appointed as a member of the Family Preservation Commission as a Community Member Representative for the term as listed below:

	Term Expires
Deborah Hunt	August 6, 2021

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Boards and Commissions Appointments
FROM: Katie Burczek
AGENCY/DEPARTMENT: BoCC
HEARD AT STUDY SESSION ON: July 23, during AIR
AUTHORIZATION TO MOVE FORWARD: ☒ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners appoints the below board members to their respective boards.

BACKGROUND:

Appoint the following to the Family Preservation Commission:
Lindsay Lierman
Deborah E Hunt
Brian Kenna
Ellen Sandoval
Mary Doran
Candice Leimkuhler

Appoint the following to the Library District Board of Trustees
Gretchen K Lapham

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

ATTACHED DOCUMENTS:

Resolutions

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPOINTING BRIAN KENNA TO THE FAMILY PRESERVATION COMMISSION AS AN ADAMS COUNTY HUMAN SERVICES REPRESENTATIVE

WHEREAS, a vacancy currently exists for a member for the Family Preservation Commission; and,

WHEREAS, Brian Kenna has expressed an interest in serving on the Family Preservation Commission; and,

WHEREAS, the Board of County Commissioners have reviewed all candidates deemed qualified; and,

WHEREAS, the Board of County Commissioners selected Brian Kenna to fill this vacancy as an Adams County Human Services Representative

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Brian Kenna shall be appointed as a member of the Family Preservation Commission as an Adams County Human Services Representative for the term as listed below:

	Term Expires
Brian Kenna	August 6, 2021

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Boards and Commissions Appointments
FROM: Katie Burczek
AGENCY/DEPARTMENT: BoCC
HEARD AT STUDY SESSION ON: July 23, during AIR
AUTHORIZATION TO MOVE FORWARD: ☒ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners appoints the below board members to their respective boards.

BACKGROUND:

Appoint the following to the Family Preservation Commission:
Lindsay Lierman
Deborah E Hunt
Brian Kenna
Ellen Sandoval
Mary Doran
Candice Leimkuhler

Appoint the following to the Library District Board of Trustees
Gretchen K Lapham

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

ATTACHED DOCUMENTS:

Resolutions

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPOINTING GRETCHEN LAPHAM TO THE LIBRARY DISTRICT BOARD OF TRUSTEES

WHEREAS, a vacancy currently exists for a member for the Library District Board of Trustees; and,

WHEREAS, Gretchen Lapham has expressed an interest in serving on the Library District Board of Trustees; and,

WHEREAS, the Board of County Commissioners have reviewed all candidates deemed qualified; and,

WHEREAS, the Board of County Commissioners selected Gretchen Lapham to fill this vacancy.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Gretchen Lapham shall be appointed as a member of the Library District Board of Trustees for the term as listed below:

	Term Expires
Gretchen Lapham	February 1, 2024

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Boards and Commissions Appointments
FROM: Katie Burczek
AGENCY/DEPARTMENT: BoCC
HEARD AT STUDY SESSION ON: July 23, during AIR
AUTHORIZATION TO MOVE FORWARD: ☒ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners appoints the below board members to their respective boards.

BACKGROUND:

Appoint the following to the Family Preservation Commission:
Lindsay Lierman
Deborah E Hunt
Brian Kenna
Ellen Sandoval
Mary Doran
Candice Leimkuhler

Appoint the following to the Library District Board of Trustees
Gretchen K Lapham

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

ATTACHED DOCUMENTS:

Resolutions

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPOINTING CANDICE LEIMKUHLER TO THE FAMILY PRESERVATION COMMISSION AS A COMMUNITY REACH CENTER REPRESENTATIVE

WHEREAS, a vacancy currently exists for a member for the Family Preservation Commission; and,

WHEREAS, Candice Leimkuhler has expressed an interest in serving on the Family Preservation Commission; and,

WHEREAS, the Board of County Commissioners have reviewed all candidates deemed qualified; and,

WHEREAS, the Board of County Commissioners selected Candice Leimkuhler to fill this vacancy as a Community Reach Center Representative.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Candice Leimkuhler shall be appointed as a member of the Family Preservation Commission as a Community Reach Center Representative for the term as listed below:

	Term Expires
Candice Leimkuhler	August 6, 2021

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Boards and Commissions Appointments
FROM: Katie Burczek
AGENCY/DEPARTMENT: BoCC
HEARD AT STUDY SESSION ON: July 23, during AIR
AUTHORIZATION TO MOVE FORWARD: ☒ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners appoints the below board members to their respective boards.

BACKGROUND:

Appoint the following to the Family Preservation Commission:
Lindsay Lierman
Deborah E Hunt
Brian Kenna
Ellen Sandoval
Mary Doran
Candice Leimkuhler

Appoint the following to the Library District Board of Trustees
Gretchen K Lapham

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

ATTACHED DOCUMENTS:

Resolutions

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPOINTING LINDSAY LIERMAN TO THE FAMILY PRESERVATION COMMISSION AS A COURT APPOINTED SPECIAL ADVOCATE REPRESENTATIVE

WHEREAS, a vacancy currently exists for a member for the Family Preservation Commission; and,

WHEREAS, Lindsay Lierman has expressed an interest in serving on the Family Preservation Commission; and,

WHEREAS, the Board of County Commissioners have reviewed all candidates deemed qualified; and,

WHEREAS, the Board of County Commissioners selected Lindsay Lierman to fill this vacancy as a Court Appointed Special Advocate Representative.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Lindsay Lierman shall be appointed as a member of the Family Preservation Commission as a Court Appointed Special Advocate Representative for the term as listed below:

	Term Expires
Lindsay Lierman	August 6, 2021

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Boards and Commissions Appointments
FROM: Katie Burczek
AGENCY/DEPARTMENT: BoCC
HEARD AT STUDY SESSION ON: July 23, during AIR
AUTHORIZATION TO MOVE FORWARD: ☒ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners appoints the below board members to their respective boards.

BACKGROUND:

Appoint the following to the Family Preservation Commission:
Lindsay Lierman
Deborah E Hunt
Brian Kenna
Ellen Sandoval
Mary Doran
Candice Leimkuhler

Appoint the following to the Library District Board of Trustees
Gretchen K Lapham

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

ATTACHED DOCUMENTS:

Resolutions

FISCAL IMPACT:

Please check if there is no fiscal impact ☒. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☐ **NO**

Future Amendment Needed: ☐ **YES** ☐ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPOINTING ELLEN SANDOVAL TO THE FAMILY PRESERVATION COMMISSION AS AN ADAMS COUNTY HUMAN SERVICES REPRESENTATIVE

WHEREAS, a vacancy currently exists for a member for the Family Preservation Commission; and,

WHEREAS, Ellen Sandoval has expressed an interest in serving on the Family Preservation Commission; and,

WHEREAS, the Board of County Commissioners have reviewed all candidates deemed qualified; and,

WHEREAS, the Board of County Commissioners selected Ellen Sandoval to fill this vacancy as an Adams County Human Services Representative.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Ellen Sandoval shall be appointed as a member of the Family Preservation Commission as an Adams County Human Services Representative for the term as listed below:

	Term Expires
Ellen Sandoval	August 6, 2021

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Mill Levy Funding for Persons with Developmental Disabilities
FROM: Raymond H. Gonzales, County Manager Alisha Reis, Deputy County Manager Benjamin Dahlman, Finance Director Jen Tierney-Hammer, Procurement and Contracts Manager
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners approves Amendment One with North Metro Community Services Inc., to add funding to the existing agreement.

BACKGROUND:

Colorado counties are authorized to levy up to one mill to purchase services and support for the benefit of their residents with developmental disabilities, pursuant to C.R.S. § 27-10.5-104(6). Adams County annually levies 0.257 mills for developmentally disabled services and deposits the funds in the County's Developmentally Disabled Fund. The State of Colorado maintains a list of Community Centered Boards that are designated in statute as the single-entry point for long-term service and support systems for developmentally disabled persons. North Metro Community Services, Inc., a private, non-profit corporation offering these services has been designated as the Community Centered Board by the Colorado Department of Human Services ("CDHS"), pursuant to C.R.S. § 27-10.5-105 for Adams County. The majority of these funds are allocated to North Metro Community Services without a competitive process because they are our Community Centered Board organization. North Metro Community Services is the County's Community Centered Board, the County annually enters into a contract with them for services and programs for the developmentally disabled persons in our community.

In March 2019, the Board of County Commissioners approved an agreement with North Metro Community Services to provide services for developmentally disabled for Adams County. In May 2019, a budget Amendment was approved to add an additional $267,463.00 to the agreement for North Metro to pay Developmental Pathways. The original agreement was $1,512,634.00 with the additional $267,463.00 the total not to exceed amount is $1,780,097.00.

The recommendation is to approve Amendment One to the agreement with North Metro Community Services to add the additional $267,463.00 for a total not to exceed agreement in the amount of $1,780,097.00.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Finance
County Managers Office

ATTACHED DOCUMENTS:

Resolution

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund: 1

Cost Center: 4031

	Object Account	Subledger	Amount
Current Budgeted Revenue:	5010		$1,668,715.00
Additional Revenue not included in Current Budget:			
Total Revenues:			$1,668,715.00

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:	5010		$1,512,634.00
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING AMENDMENT ONE BETWEEN ADAMS COUNTY AND NORTH METRO COMMUNITY SERVICES INC., FOR SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

WHEREAS, the County is authorized to levy up to one mill to purchase services and support for the benefit of its residents with developmental disabilities, pursuant to C.R.S. § 27-10.5-104(6); and,

WHEREAS, in March 2019, the Board of County Commissioners approved an agreement with North Metro Community Services Inc., to provide services and programs for developmentally disabled persons in Adams County; and,

WHEREAS, in May 2019, the Board of County Commissioners approved a budget amendment to add $267,463.00 to the agreement; and,

WHEREAS, North Metro Community Services, Inc., has agreed to provide these services with the additional $267,463.00, for a total not to exceed agreement price of $1,780,097.00; and,

WHEREAS, North Metro Community Services, Inc., is a private, non-profit corporation offering service programs to persons with developmental disabilities, and has been designated as a community-centered board by the Colorado Department of Human Services (“CDHS”), pursuant to C.R.S. § 27-10.5-105.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Amendment One to the Agreement between Adams County and North Metro Community Services, Inc., for services for persons with developmental disabilities is hereby approved.

BE IT FURTHER RESOLVED, that the Chair is hereby authorized to sign said Amendment One after negotiation and approval as to form is completed by the County Attorney's Office.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Disposition of Real Estate – 7373 Birch Street
FROM: Seán Braden, Manager - Planning, Design & Construction **Nicci Beauprez, Project Manager - Land & Assets**
AGENCY/DEPARTMENT: Facilities & Fleet Management
HEARD AT STUDY SESSION ON: Multiple times
AUTHORIZATION TO MOVE FORWARD: ☒ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners Approves the Contract to Buy and Sell Real Estate between Adams County and Adams County Communications Center Authority, a political subdivision of the State of Colorado for 7373 Birch Street, Commerce City, CO

BACKGROUND:

Adams County purchased 7373 Birch Street on March 29, 2017 from Arapahoe House in order to continue to provide alcohol treatment services to the community and neighboring stakeholders. Arapahoe House was subsequently dissolved, and Community Reach Center took over and performed such services. Community Reach Center (CRC) has relocated its alcohol treatment and detox services to old St. Anthony's near 84th and Federal Blvd. As a result of this relocation, CRC and the County mutually terminated the lease related to the property at 7373 Birch Street in Commerce City. Adams County Communications Center (AdCom) expressed needs to expand its operations. It was determined that 7373 Birch could offer expansion benefits to AdCom. Further, AdCom's occupancy would return a beneficial use to the site and a continued benefit to the area and its stakeholders. The purchase price is reflective of a comparative market study offset by cost associated to demolition and construction of the site.

Staff recommends approval of the Contract to Buy and Sell Real Estate Between Adams County and Adams County Communications Center for Adams County Facility at 7373 Birch Street Dated July 29, 2019.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

County Manager's Office, Facilities & Fleet Management

ATTACHED DOCUMENTS:

- Contract to Buy and Sell Real Estate including Addendum to Contract to Buy and Sell Real Estate.
- Resolution

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund:	
Cost Center:	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			0
Additional Revenue not included in Current Budget:			88,259.00
Total Revenues:			88,259.00

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			0

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:
Net proceeds are to be determined varying closing costs and County's agent commission.

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING THE CONTRACT TO BUY AND SELL REAL ESTATE BETWEEN ADAMS COUNTY AND THE ADAMS COUNTY COMMUNICATIONS CENTER AUTHORITY REGARDING 7373 BIRCH STREET

WHEREAS, Adams County ("County") owns a parcel of land located at 7373 Birch Street, Commerce City, CO (the "Property"), that became a surplus county property once the alcohol treatment and detox facilities previously occupying the Property moved to their new location near 84th Avenue and Pecos Street; and,

WHEREAS, Adams County Communications Center Authority (AdCom) desires to expand their operations into the Property; and,

WHEREAS, County & AdCom wish to enter into a Contract to Buy and Sell Real Estate for a net sum of $88,259.00; and,

WHEREAS, the expansion of AdCom's operations will provide increased serviceability to its operations and stakeholders.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the Contract to Buy and Sell Real Estate between Adams County and the Adams County Communications Center Authority regarding 7373 Birch Street, a copy of which is attached hereto and incorporated herein by this reference, is hereby approved.

BE IT FURTHER RESOLVED, that the Chair is hereby authorized to execute said Contract on behalf of Adams County.

The printed portions of this form, except differentiated additions, have been approved by the Colorado Real Estate Commission.
(CBS3-5-19) (Mandatory 7-19)

THIS FORM HAS IMPORTANT LEGAL CONSEQUENCES AND THE PARTIES SHOULD CONSULT LEGAL AND TAX OR OTHER COUNSEL BEFORE SIGNING.

CONTRACT TO BUY AND SELL REAL ESTATE (COMMERCIAL)

(☒ Property with No Residences)

(☐ Property with Residences-Residential Addendum Attached)

Date: *July 29, 2019*.

AGREEMENT

1. AGREEMENT. Buyer agrees to buy and Seller agrees to sell, the Property described below on the terms and conditions set forth in this contract (Contract).

2. PARTIES AND PROPERTY.

2.1. Buyer. *Adams County Communications Center Authority, a political subdivision of the State of Colorado* (Buyer) will take title to the Property described below as ☐ **Joint Tenants** ☐ **Tenants In Common** ☐ **Other** _____.

2.2. No Assignability. This Contract **IS NOT** assignable by Buyer unless otherwise specified in **Additional Provisions.**

2.3. Seller. *Adams County, Colorado* (Seller) is the current owner of the Property described below.

2.4. Property. The Property is the following legally described real estate in the County of *Adams*, Colorado:

See Exhibit A, attached hereto and incorporation hereby.

known as No. *7373 Birch Street, Commerce City, CO 80022*
Street Address City State Zip

together with the interests, easements, rights, benefits, improvements and attached fixtures appurtenant thereto, and all interest of Seller in vacated streets and alleys adjacent thereto, except as herein excluded (Property).

2.5. Inclusions. The Purchase Price includes the following items (Inclusions):

2.5.1. Inclusions – Attached. If attached to the Property on the date of this Contract, the following items are included unless excluded under **Exclusions:** lighting, heating, plumbing, ventilating and air conditioning units, TV antennas, inside telephone, network and coaxial (cable) wiring and connecting blocks/jacks, plants, mirrors, floor coverings, intercom systems, built-in kitchen appliances, sprinkler systems and controls, built-in vacuum systems (including accessories), garage door openers (including _____ remote controls). If checked, the following are owned by the Seller and included (leased items should be listed under **Due Diligence Documents**): ☒ **None** ☐ **Solar Panels** ☐ **Water Softeners** ☐ **Security Systems** ☐ **Satellite Systems** (including satellite dishes). If any additional items are attached to the Property after the date of this Contract, such additional items are also included in the Purchase Price.

2.5.2. Inclusions – Not Attached. If on the Property, whether attached or not, on the date of this Contract, the following items are included unless excluded under **Exclusions:** storm windows, storm doors, window and porch shades, awnings, blinds, screens, window coverings and treatments, curtain rods, drapery rods, fireplace inserts, fireplace screens, fireplace grates, heating stoves, storage sheds, carbon monoxide alarms, smoke/fire detectors and all keys.

2.5.3. Personal Property – Conveyance. Any personal property must be conveyed at Closing by Seller free and clear of all taxes (except personal property taxes for the year of Closing), liens and encumbrances, except *none*. Conveyance of all personal property will be by bill of sale or other applicable legal instrument.

2.5.4. Other Inclusions. The following items, whether fixtures or personal property, are also included in the Purchase Price: *none.*

2.5.5. Parking and Storage Facilities. The us or ownership of the following parking facilities: *All surface parking spaces on Property*; and the use or ownership of the following storage facilities: *None*.
Note to Buyer: If exact rights to the parking and storage facilities is a concern to Buyer, Buyer should investigate.

2.5.6. Trade Fixtures. With respect to trade fixtures, Seller and Buyer agree as follows: *None.*

The trade fixtures to be conveyed at Closing will be conveyed by Seller free and clear of all taxes (except personal property taxes for the year of Closing), liens and encumbrances, except _____. Conveyance will be by bill of sale or other applicable legal instrument.

2.6. Exclusions. The following items are excluded (Exclusions): *None.*

2.7. Water Rights, Well Rights, Water and Sewer Taps.

☐ **2.7.1. Deeded Water Rights.** The following legally described water rights:

Any deeded water rights will be conveyed by a good and sufficient_____ deed at Closing.

☐ **2.7.2. Other Rights Relating to Water.** The following rights relating to water not included in §§ 2.7.1, 2.7.3, 2.7.4 and 2.7.5, will be transferred to Buyer at Closing:

☒ **2.7.3. Well Rights.** Seller agrees to supply required information to Buyer about the well. Buyer understands that if the well to be transferred is a "Small Capacity Well" or a "Domestic Exempt Water Well," used for ordinary household purposes, Buyer must, prior to or at Closing, complete a Change in Ownership form for the well. If an existing well has not been registered with the Colorado Division of Water Resources in the Department of Natural Resources (Division), Buyer must complete a registration of existing well form for the well and pay the cost of registration. If no person will be providing a closing service in connection with the transaction, Buyer must file the form with the Division within sixty days after Closing. The Well Permit # is *90744 (October 26, 1978)*.

☐ **2.7.4. Water Stock Certificates.** The water stock certificates to be transferred at Closing are as follows:

2.7.5. Conveyance. If Buyer is to receive any rights to water pursuant to § 2.7.2 (Other Rights Relating to Water), § 2.7.3 (Well Rights), or § 2.7.4 (Water Stock Certificates), Seller agrees to convey such rights to Buyer by executing the applicable legal instrument at Closing.

3. DATES, DEADLINES AND APPLICABILITY.

3.1. Dates and Deadlines.

Item No.	Reference	Event	Date or Deadline
1	§ 4.3	Alternative Earnest Money Deadline	*5 business days after MEC*
		Title	
2	§ 8.1, 8.4	Record Title Deadline	*15 days after MEC*
3	§ 8.2, 8.4	Record Title Objection Deadline	*120 days after MEC*
4	§ 8.3	Off-Record Title Deadline	*15 days after MEC*
5	§ 8.3	Off-Record Title Objection Deadline	*120 days after MEC*
6	§ 8.5	Title Resolution Deadline	*125 days after MEC*
7	§ 8.6	Right of First Refusal Deadline	*N/A*
		Owners' Association	
8	§ 7.2	Association Documents Deadline	*N/A*
9	§ 7.4	Association Documents Termination Deadline	*N/A*
		Seller's Property Disclosure	
10	§ 10.1	Seller's Property Disclosure Deadline	*15 days after MEC*
		Loan and Credit	
11	§ 10.10	Lead-Based Paint Disclosure Deadline (if Residential Addendum attached)	*N/A*

Item No.	Reference	Event	Date or Deadline
12	§ 5.1	New Loan Application Deadline	*N/A*
13	§ 5.2	New Loan Termination Deadline	*N/A*
14	§ 5.3	Buyer's Credit Information Deadline	*N/A*
15	§ 5.3	Disapproval of Buyer's Credit Information Deadline	*N/A*
16	§ 5.4	Existing Loan Deadline	*N/A*
17	§ 5.4	Existing Loan Termination Deadline	*N/A*
18	§ 5.4	Loan Transfer Approval Deadline	*N/A*
19	§ 4.7	Seller or Private Financing Deadline	*N/A*
		Appraisal	
20	§ 6.2	Appraisal Deadline	*N/A*
21	§ 6.2	Appraisal Objection Deadline	*N/A*
22	§ 6.2	Appraisal Resolution Deadline	*N/A*
		Survey	
23	§ 9.1	New ILC or New Survey Deadline	*60 days after MEC*
24	§ 9.3	New ILC or New Survey Objection Deadline	*120 days after MEC*
25	§ 9.3	New ILC or New Survey Resolution Deadline	*125 days after MEC*
		Inspection and Due Diligence	
26	§ 10.3	Inspection Objection Deadline	*120 days after MEC*
27	§ 10.3	Inspection Termination Deadline	*125 days after MEC*
28	§ 10.3	Inspection Resolution Deadline	*125 days after MEC*
29	§ 10.5	Property Insurance Termination Deadline	*120 days after MEC*
30	§ 10.6	Due Diligence Documents Delivery Deadline	*20 days after MEC*
31	§ 10.6	Due Diligence Documents Objection Deadline	*120 days after MEC*
32	§ 10.6	Due Diligence Documents Resolution Deadline	*125 days after MEC*
33	§ 10.6	Environmental Inspection Termination Deadline	*120 days after MEC*
34	§ 10.6	ADA Evaluation Termination Deadline	*120 days after MEC*
35	§ 10.7	Conditional Sale Deadline	*N/A*
36	§ 10.10	Lead-Based Paint Termination Deadline (if Residential Addendum attached)	*N/A*
37	§ 11.1, 11.2	Estoppel Statements Deadline	*N/A*
38	§ 11.3	Estoppel Statements Termination Deadline	*N/A*
		Closing and Possession	
39	§ 12.3	Closing Date	*130 days after MEC*
40	§ 17	Possession Date	*Closing Date*
41	§ 17	Possession Time	*Delivery of Deed*
42	§ 28	**Acceptance Deadline Date**	*August 16, 2019*
40	§ 28	**Acceptance Deadline Time**	*5 P.M. M.T.*

3.2. Applicability of Terms. Any box checked in this Contract means the corresponding provision applies. If any deadline blank § 3.1 (Dates and Deadlines) is left blank or completed with the abbreviation "N/A", or the word "Deleted" such deadline is not applicable and the corresponding provision containing the deadline is deleted. If no box is checked in a provision that contains a selection of "None", such provision means that "None" applies.

The abbreviation "MEC" (mutual execution of this Contract) means the date upon which both parties have signed this Contract.

4. PURCHASE PRICE AND TERMS.

4.1. Price and Terms. The Purchase Price set forth below is payable in U.S. Dollars by Buyer as follows:

Item No.	Reference	Item	Amount	Amount
1	§ 4.1	Purchase Price	$ *333,915.00*	
2	§ 4.3	Earnest Money		$ *10,000.00*
3	§ 4.5	New Loan		$
4	§ 4.6	Assumption Balance		$

5	§ 4.7	Private Financing		$
6	§ 4.7	Seller Financing		$
7		*Seller Credit at Closing*		*$235,656.00*
8				
9	§ 4.4	Cash at Closing		$ *88,259.00*
10		**TOTAL**	$ *333,915.00*	$ *333,915.00*

4.2. Seller Concession. *Intentionally Omitted – Not Applicable.*

4.3. Earnest Money. The Earnest Money set forth in this Section, in the form of a *cashier's check or wire transfer* , will be payable to and held by *North American Title Company* (Earnest Money Holder), in its trust account, on behalf of both Seller and Buyer. The Earnest Money deposit must be tendered, by Buyer, with this Contract unless the parties mutually agree to an **Alternative Earnest Money Deadline** for its payment. The parties authorize delivery of the Earnest Money deposit to the company conducting the Closing (Closing Company), if any, at or before Closing. In the event Earnest Money Holder has agreed to have interest on Earnest Money deposits transferred to a fund established for the purpose of providing affordable housing to Colorado residents, Seller and Buyer acknowledge and agree that any interest accruing on the Earnest Money deposited with the Earnest Money Holder in this transaction will be transferred to such fund.

4.3.1. Alternative Earnest Money Deadline. The deadline for delivering the Earnest Money, if other than at the time of tender of this Contract, is as set forth as the **Alternative Earnest Money Deadline.**

4.3.2. Return of Earnest Money. If Buyer has a Right to Terminate and timely terminates, Buyer is entitled to the return of Earnest Money as provided in this Contract. If this Contract is terminated as set forth in § 25 and, except as provided in § 24, (Earnest Money Dispute), if the Earnest Money has not already been returned following receipt of a Notice to Terminate, Seller agrees to execute and return to Buyer or Broker working with Buyer, written mutual instructions (e.g., Earnest Money Release form), within three days of Seller's receipt of such form.

4.4. Form of Funds; Time of Payment; Available Funds.

4.4.1. Good Funds. All amounts payable by the parties at Closing, including any loan proceeds, Cash at Closing and closing costs, must be in funds that comply with all applicable Colorado laws, including electronic transfer funds, certified check, savings and loan teller's check and cashier's check (Good Funds).

4.4.2. Time of Payment; Available Funds. All funds, including the Purchase Price to be paid by Buyer, must be paid before or at Closing or as otherwise agreed in writing between the parties to allow disbursement by Closing Company at Closing **OR SUCH NONPAYING PARTY WILL BE IN DEFAULT.** Buyer represents that Buyer, as of the date of this Contract, ☒ **Does** ☐ **Does Not** have funds that are immediately verifiable and available in an amount not less than the amount stated as Cash at Closing in § 4.1.

4.5. New Loan. *Intentionally Omitted – Not Applicable.*

4.6. Assumption. *Intentionally Omitted – Not Applicable.*

4.7. Seller or Private Financing. *Intentionally Omitted – Not Applicable.*

TRANSACTION PROVISIONS

5. FINANCING CONDITIONS AND OBLIGATIONS. *Intentionally Omitted – Not Applicable.*

6. APPRAISAL PROVISIONS. *Intentionally Omitted – Not Applicable.*

7. OWNERS' ASSOCIATION. *Intentionally Omitted – Not Applicable.*

8. TITLE INSURANCE, RECORD TITLE AND OFF-RECORD TITLE.

8.1. Evidence of Record Title.

☒ **8.1.1. Seller Selects Title Insurance Company.** If this box is checked, Seller will select the title insurance company to furnish the owner's title insurance policy at Seller's expense. On or before **Record Title Deadline**, Seller must furnish to Buyer, a current commitment for an owner's title insurance policy (Title Commitment), in an amount equal to the Purchase Price, or if this box is checked, ☐ an **Abstract of Title** certified to a current date. Seller will cause the title insurance policy to be issued and delivered to Buyer as soon as practicable at or after Closing.

☐ **8.1.2. Buyer Selects Title Insurance Company.** If this box is checked, Buyer will select the title insurance company to furnish the owner's title insurance policy at Buyer's expense. On or before **Record Title Deadline**, Buyer must furnish to Seller, a current commitment for owner's title insurance policy (Title Commitment), in an amount equal to the Purchase Price. If neither box in § 8.1.1 or § 8.1.2 is checked, § 8.1.1 applies.

8.1.3. Owner's Extended Coverage (OEC). The Title Commitment ☒ **Will** ☐ **Will Not** contain Owner's Extended Coverage (OEC). If the Title Commitment is to contain OEC, it will commit to delete or insure over the standard exceptions which relate to: (1) parties in possession, (2) unrecorded easements, (3) survey matters, (4) unrecorded mechanics' liens, (5) gap period (period between the effective date and time of commitment to the date and time the deed is recorded), and (6) unpaid taxes, assessments and unredeemed tax sales prior to the year of Closing. Any additional premium expense to obtain OEC will be paid by ☐ **Buyer** ☒ **Seller** ☐ **One-Half by Buyer and One-Half by Seller** ☐ **Other** _____. Regardless of whether the Contract requires OEC, the Title Insurance Commitment may not provide OEC or delete or insure over any or all of the standard exceptions for OEC. The Title Insurance Company may require a New Survey or New ILC, defined below, among other requirements for OEC. If the Title Insurance Commitment is not satisfactory to Buyer, Buyer has a right to object under § 8.45 (Right to Object to Title, Resolution).

8.1.4. Title Documents. Title Documents consist of the following: (1) copies of any plats, declarations, covenants, conditions and restrictions burdening the Property, and (2) copies of any other documents (or, if illegible, summaries of such documents) listed in the schedule of exceptions (Exceptions) in the Title Commitment furnished to Buyer (collectively, Title Documents).

8.1.5. Copies of Title Documents. Buyer must receive, on or before **Record Title Deadline**, copies of all Title Documents. This requirement pertains only to documents as shown of record in the office of the clerk and recorder in the county where the Property is located. The cost of furnishing copies of the documents required in this Section will be at the expense of the party or parties obligated to pay for the owner's title insurance policy.

8.1.6. Existing Abstracts of Title. Seller must deliver to Buyer copies of any abstracts of title covering all or any portion of the Property (Abstract of Title) in Seller's possession on or before **Record Title Deadline**.

8.2. Record Title. Buyer has the right to review and object to the Abstract of Title or Title Commitment and any of the Title Documents as set forth in § 8.45 (Right to Object to Title, Resolution) on or before **Record Title Objection Deadline**. Buyer's objection may be based on any unsatisfactory form or content of Title Commitment or Abstract of Title, notwithstanding § 13, or any other unsatisfactory title condition, in Buyer's sole subjective discretion. If the Abstract of Title, Title Commitment or Title Documents are not received by Buyer, on or before the **Record Title Deadline**, or if there is an endorsement to the Title Commitment that adds a new Exception to title, a copy of the new Exception to title and the modified Title Commitment will be delivered to Buyer. Buyer has until the earlier of Closing or ten days after receipt of such documents by Buyer to review and object to: (1) any required Title Document not timely received by Buyer, (2) any change to the Abstract of Title, Title Commitment or Title Documents, or (3) any endorsement to the Title Commitment. If Seller receives Buyer's Notice to Terminate or Notice of Title Objection, pursuant to this § 8.2 (Record Title), any title objection by Buyer is governed by the provisions set forth in § 8.4 (Right to Object to Title, Resolution). If Seller has fulfilled all Seller's obligations, if any, to deliver to Buyer all documents required by § 8.1 (Evidence of Record Title) and Seller does not receive Buyer's Notice to Terminate or Notice of Title Objection by the applicable deadline specified above, Buyer accepts the condition of title as disclosed by the Abstract of Title, Title Commitment and Title Documents as satisfactory.

8.3. Off-Record Title. Seller must deliver to Buyer, on or before **Off-Record Title Deadline**, true copies of all existing surveys in Seller's possession pertaining to the Property and must disclose to Buyer all easements, liens (including, without limitation, governmental improvements approved, but not yet installed) or other title matters (including, without limitation, rights of first refusal and options) not shown by public records, of which Seller has actual knowledge (Off-Record Matters). This Section excludes any **New ILC** or **New Survey** governed under § 9 (New ILC, New Survey). Buyer has the right to inspect the Property to investigate if any third party has any right in the Property not shown by public records (e.g., unrecorded easement, boundary line discrepancy or water rights). Buyer's Notice to Terminate or Notice of Title Objection of any unsatisfactory condition (whether disclosed by Seller or revealed by such inspection, notwithstanding § 8.2 (Record Title) and § 13 (Transfer of Title)), in Buyer's sole subjective discretion, must be received by Seller on or before **Off-Record Title Objection Deadline**. If an Off-Record Matter is received by Buyer after the **Off-Record Title Deadline**, Buyer has until the earlier of Closing or ten days after receipt by Buyer to review and object to such Off-Record Matter. If Seller receives Buyer's Notice to Terminate or Notice of Title Objection pursuant to this § 8.3 (Off-Record Title), any title objection by Buyer is governed by the provisions set forth in § 8.45 (Right to Object to Title, Resolution). If Seller does not receive Buyer's Notice to Terminate or Notice of Title Objection by the applicable deadline specified above, Buyer accepts title subject to such Off-Record Matters and rights, if any, of third parties not shown by public records of which Buyer has actual knowledge.

8.4. Special Taxing Districts. SPECIAL TAXING DISTRICTS MAY BE SUBJECT TO GENERAL OBLIGATION INDEBTEDNESS THAT IS PAID BY REVENUES PRODUCED FROM ANNUAL TAX LEVIES ON THE TAXABLE PROPERTY WITHIN SUCH DISTRICTS. PROPERTY OWNERS IN SUCH DISTRICTS MAY BE PLACED AT RISK FOR INCREASED MILL LEVIES AND TAX TO SUPPORT THE SERVICING OF SUCH DEBT WHERE CIRCUMSTANCES ARISE RESULTING IN THE INABILITY OF SUCH A DISTRICT TO DISCHARGE SUCH INDEBTEDNESS WITHOUT SUCH AN INCREASE IN MILL LEVIES. BUYERS SHOULD INVESTIGATE THE SPECIAL TAXING DISTRICTS IN WHICH THE PROPERTY IS LOCATED BY CONTACTING THE COUNTY TREASURER, BY REVIEWING THE CERTIFICATE OF TAXES DUE FOR THE PROPERTY, AND BY OBTAINING FURTHER INFORMATION FROM THE BOARD OF COUNTY COMMISSIONERS, THE COUNTY CLERK AND RECORDER, OR THE COUNTY ASSESSOR.

A tax certificate from the respective county treasurer listing any special taxing districts that effect the Property (Tax Certificate) must be delivered to Buyer on or before **Record Title Deadline**. If the Property is located within a special taxing district and such inclusion is unsatisfactory to Buyer, in Buyer's sole subjective discretion, Buyer may object, on or before **Record Title Objection Deadline**. If the Tax Certificate shows that the Property is included in a special taxing district and is received by Buyer after the **Record Title Deadline**, Buyer has until the earlier of Closing or ten days after receipt by Buyer to review and object to the Property's inclusion in a special taxing district as unsatisfactory to Buyer.

8.5 Right to Object to Title, Resolution. Buyer's right to object, in Buyer's sole subjective discretion, to any title matters includes, those matters set forth in § 8.2 (Record Title), § 8.3 (Off-Record Title), § 8.4 (Special Taxing District) and §13 (Transfer of Title), in Buyer's sole subjective discretion. If Buyer objects to any title matter, on or before the applicable deadline, Buyer has the following options:

8. 5.1. Title Objection, Resolution. If Seller receives Buyer's written notice objecting to any title matter (Notice of Title Objection) on or before the applicable deadline, and if Buyer and Seller have not agreed to a written settlement thereof on or before **Title Resolution Deadline**, this Contract will terminate on the expiration of **Title Resolution Deadline**, unless Seller receives Buyer's written withdrawal of Buyer's Notice of Title Objection (i.e., Buyer's written notice to waive objection to such items and waives the Right to Terminate for that reason), on or before expiration of **Title Resolution Deadline**. If either the Record Title Deadline or the Off-Record Title Deadline, or both, are extended pursuant to § 8.2 (Record Title)), § 8.3 (Off-Record Title) or § 8.4 (Special Taxing Districts), the Title Resolution Deadline also will be automatically extended to the earlier of Closing or fifteen days after Buyer's receipt of the applicable documents; or

8.5.2. Title Objection, Right to Terminate. Buyer may exercise the Right to Terminate under § 25.1, on or before the applicable deadline, based on any title matter unsatisfactory to Buyer, in Buyer's sole subjective discretion.

8.6. Right of First Refusal or Contract Approval. If there is a right of first refusal on the Property or a right to approve this Contract, Seller must promptly submit this Contract according to the terms and conditions of such right. If the holder of the right of first refusal exercises such right or the holder of a right to approve disapproves this Contract, this Contract will terminate. If the right of first refusal is waived explicitly or expires, or the Contract is approved, this Contract will remain in full force and effect. Seller must promptly notify Buyer in writing of the foregoing. If expiration or waiver of the right of first refusal or approval of this Contract has not occurred on or before **Right of First Refusal Deadline**, this Contract will then terminate.

8.7. Title Advisory. The Title Documents affect the title, ownership and use of the Property and should be reviewed carefully. Additionally, other matters not reflected in the Title Documents may affect the title, ownership and use of the Property, including, without limitation, boundary lines and encroachments, set-back requirements, area, zoning, building code violations, unrecorded easements and claims of easements, leases and other unrecorded agreements, water on or under the Property, and various laws and governmental regulations concerning land use, development and environmental matters.

8.7.1. OIL, GAS, WATER AND MINERAL DISCLOSURE. THE SURFACE ESTATE OF THE PROPERTY MAY BE OWNED SEPARATELY FROM THE UNDERLYING MINERAL ESTATE AND TRANSFER OF THE SURFACE ESTATE MAY NOT NECESSARILY INCLUDE TRANSFER OF THE MINERAL ESTATE OR WATER RIGHTS. THIRD PARTIES MAY OWN OR LEASE INTERESTS IN OIL, GAS, OTHER MINERALS, GEOTHERMAL ENERGY OR WATER ON OR UNDER THE SURFACE OF THE PROPERTY, WHICH INTERESTS MAY GIVE THEM RIGHTS TO ENTER AND USE THE SURFACE OF THE PROPERTY TO ACCESS THE MINERAL ESTATE, OIL, GAS OR WATER.

8.7.2. SURFACE USE AGREEMENT. THE USE OF THE SURFACE ESTATE OF THE PROPERTY TO ACCESS THE OIL, GAS OR MINERALS MAY BE GOVERNED BY A SURFACE USE AGREEMENT, A MEMORANDUM OR OTHER NOTICE OF WHICH MAY BE RECORDED WITH THE COUNTY CLERK AND RECORDER.

8.7.3. OIL AND GAS ACTIVITY. OIL AND GAS ACTIVITY THAT MAY OCCUR ON OR ADJACENT TO THE PROPERTY MAY INCLUDE, BUT IS NOT LIMITED TO, SURVEYING, DRILLING, WELL COMPLETION OPERATIONS, STORAGE, OIL AND GAS, OR PRODUCTION FACILITIES, PRODUCING WELLS, REWORKING OF CURRENT WELLS AND GAS GATHERING AND PROCESSING FACILITIES.

8.7.4. ADDITIONAL INFORMATION. BUYER IS ENCOURAGED TO SEEK ADDITIONAL INFORMATION REGARDING OIL AND GAS ACTIVITY ON OR ADJACENT TO THE PROPERTY, INCLUDING DRILLING PERMIT APPLICATIONS. THIS INFORMATION MAY BE AVAILABLE FROM THE COLORADO OIL AND GAS CONSERVATION COMMISSION.

8.7.5. Title Insurance Exclusions. Matters set forth in this Section, and others, may be excepted, excluded from, or not covered by the owner's title insurance policy.

8.8. Consult an Attorney. Buyer is advised to timely consult legal counsel with respect to all such matters as there are strict time limits provided in this Contract (e.g., **Record Title Objection Deadline** and **Off-Record Title Objection Deadline**).

9. NEW ILC, NEW SURVEY.

9.1. New ILC or New Survey. If the box is checked, a: 1) ☐ **New Improvement Location Certificate (New ILC)**; or, 2) ☒ **New Survey** in the form ~~of~~ *selected by Buyer may be ordered by Buyer* ~~is required~~ and the following will apply:

9.1.1. Ordering of New ILC or New Survey. ☐ **Seller** ☒ **Buyer** will order the New ILC or New Survey. The New ILC or New Survey may also be a previous ILC or survey that is in the above-required form, certified and updated as of a date after the date of this Contract.

9.1.2. Payment for New ILC or New Survey. The cost of the New ILC or New Survey will be paid, on or before Closing, by: ☐ **Seller** ☒ **Buyer** or:

9.1.3. Delivery of New ILC or New Survey. Buyer, Seller, the issuer of the Title Commitment (or the provider of the opinion of title if an Abstract of Title,), and N/A will receive a New ILC or New Survey on or before **New ILC or New Survey Deadline.**

9.1.4. Certification of New ILC or New Survey. The New ILC or New Survey will be certified by the surveyor to all those who are to receive the New ILC or New Survey.

9.2. Buyer's Right to Waive or Change New ILC or New Survey Selection. Buyer may select a New ILC or New Survey different than initially specified in this Contract if there is no additional cost to Seller or change to the **New ILC or New Survey Objection Deadline**. Buyer may, in Buyer's sole subjective discretion, waive a New ILC or New Survey if done prior to Seller incurring any cost for the same.

9.3. New ILC or New Survey Objection. Buyer has the right to review and object to the **New** ILC or New Survey. If the New ILC or New Survey is not timely received by Buyer or is unsatisfactory to Buyer, in Buyer's sole subjective discretion, Buyer may, on or before **New ILC or New Survey Objection Deadline,** notwithstanding § 8.3 or § 13:

9.3.1. Notice to Terminate. Notify Seller in writing, pursuant to § 25.1 that this Contract is terminated; or

9.3.2. New ILC or New Survey Objection. Deliver to Seller a written description of any matter that was to be shown or is shown in the New ILC or New Survey that is unsatisfactory and that Buyer requires Seller to correct.

9.3.3. New ILC or New Survey Resolution. If a **New ILC or New Survey Objection** is received by Seller, on or before **New ILC or New Survey Objection Deadline,** and if Buyer and Seller have not agreed in writing to a settlement thereof on or before **New ILC or New Survey Resolution Deadline,** this Contract will terminate on expiration of the **New ILC or New Survey Resolution Deadline,** unless Seller receives Buyer's written withdrawal of the New ILC or New Survey Objection before such termination, i.e., on or before expiration of **New ILC or New Survey Resolution Deadline.**

DISCLOSURE, INSPECTION AND DUE DILIGENCE

10. PROPERTY DISCLOSURE, INSPECTION, INDEMNITY, INSURABILITY AND DUE DILIGENCE.

10.1. Seller's Property Disclosure. On or before **Seller's Property Disclosure Deadline,** Seller agrees to deliver to Buyer the most current version of the applicable Colorado Real Estate Commission's Seller's Property Disclosure form completed by Seller to Seller's actual knowledge, and current as of the date of this Contract.

10.2. Disclosure of Adverse Material Facts; Subsequent Disclosure Present Condition. Seller must disclose to Buyer any adverse material facts actually known by Seller as of the date of this Contract. Seller agrees that disclosure of adverse material facts will be in writing. In the event Seller discovers an adverse material fact after the date of this Contract, Seller must timely disclose such adverse fact to Buyer. Buyer has the Right to Terminate based on the Seller's new disclosure on the earlier of Closing or five days after Buyer's receipt of the new disclosure. Except as otherwise provided in this Contract, Buyer acknowledges that Seller is conveying the Property to Buyer in an "**As Is**" condition, "**Where Is**" and "**With All Faults.**"

10.3. Inspection. Unless otherwise provided in this Contract, Buyer, acting in good faith, has the right to have inspections (by one or more third parties, personally or both) of the Property and Inclusions (Inspection), at Buyer's expense. If (1) the physical condition of the Property, including, but not limited to, the roof, walls, structural integrity of the Property, the electrical, plumbing, HVAC and other mechanical systems of the Property, (2) the physical condition of the Inclusions, (3) service to the Property (including utilities and communication services), systems and components of the Property (e.g., heating and plumbing), (4) any proposed or existing transportation project, road, street or highway, or (5) any other activity, odor or noise (whether on or off the Property) and its effect or expected effect on the Property or its occupants is unsatisfactory, in Buyer's sole subjective discretion, Buyer may:

10.3.1. Inspection Objection. On or before the Inspection Objection Deadline, deliver to Seller a written description of any unsatisfactory condition that Buyer requires Seller to correct; or

10.3.2. Terminate. On or before the Inspection Termination Deadline, notify Seller in writing, pursuant to § 25.1, that this Contract is terminated due to any unsatisfactory condition. Inspection Termination Deadline will be on the earlier of Inspection Resolution Deadline or the date specified in § 3.1 for Inspection Termination Deadline.

10.3.3. Inspection Resolution. If an Inspection Objection is received by Seller, on or before Inspection Objection Deadline and if Buyer and Seller have not agreed in writing to a settlement thereof on or before Inspection Resolution Deadline, this Contract will terminate on Inspection Resolution Deadline unless Seller receives Buyer's written withdrawal of the Inspection Objection before such termination, i.e., on or before expiration of Inspection Resolution Deadline.

10.4. Damage, Liens and Indemnity. Buyer, except as otherwise provided in this Contract or other written agreement between the parties, is responsible for payment for all inspections, tests, surveys, engineering reports, or other reports performed at Buyer's request (Work) and must pay for any damage that occurs to the Property and Inclusions as a result of such Work. Buyer must not permit claims or liens of any kind against the Property for Work performed on the Property. Buyer agrees to indemnify, protect and hold Seller harmless from and against any liability, damage, cost or expense incurred by Seller and caused by any such Work, claim, or lien. This indemnity includes Seller's right to recover all costs and expenses incurred by Seller to defend against any such liability, damage, cost or expense, or to enforce this Section, including Seller's reasonable attorney fees, legal fees and expenses. The provisions of this Section survive the termination of this Contract. This § 10.4 does not apply to items performed pursuant to an Inspection Resolution.

10.5. Insurability. Buyer has the right to review and object to the availability, terms and conditions of and premium for property insurance (Property Insurance). Buyer has the Right to Terminate under § 25.1, on or before **Property Insurance Termination Deadline**, based on any unsatisfactory provision of the Property Insurance, in Buyer's sole subjective discretion.

10.6. Due Diligence.

10.6.1. Due Diligence Documents. ***If in Seller's possession, if*** ~~If~~ the respective box is checked, Seller agrees to deliver copies of the following documents and information pertaining to the Property (Due Diligence Documents) to Buyer on or before **Due Diligence Documents Delivery Deadline:**

☒ **10.6.1.1.** All contracts relating to the operation, maintenance and management of the Property;

☐ **10.6.1.2.** Property tax bills for the last _____ years;

☐ **10.6.1.3.** As-built construction plans to the Property and the tenant improvements, including architectural, electrical, mechanical, and structural systems; engineering reports; and permanent Certificates of Occupancy, to the extent now available;

☐ **10.6.1.4.** A list of all Inclusions to be conveyed to Buyer;

☒ **10.6.1.5.** Operating statements for the past ***two (2)*** years;

☐ **10.6.1.6.** A rent roll accurate and correct to the date of this Contract;

☐ **10.6.1.7.** All current leases, including any amendments or other occupancy agreements, pertaining to the Property. Those leases or other occupancy agreements pertaining to the Property that survive Closing are as follows (Leases):

☐ **10.6.1.8.** A schedule of any tenant improvement work Seller is obligated to complete but has not yet completed and capital improvement work either scheduled or in process on the date of this Contract;

☐ **10.6.1.9.** All insurance policies pertaining to the Property and copies of any claims which have been made for the past _____ years;

☒ **10.6.1.10.** Soils reports, surveys and engineering reports or data pertaining to the Property (if not delivered earlier under § 8.3);

☒ **10.6.1.11.** Any and all existing documentation and reports regarding Phase I and II environmental reports, letters, test results, advisories, and similar documents respective to the existence or nonexistence of asbestos, PCB transformers, or other toxic, hazardous or contaminated substances, and/or underground storage tanks and/or radon gas. If no reports are in Seller's possession or known to Seller, Seller warrants that no such reports are in Seller's possession or known to Seller;

☐ **10.6.1.12.** Any *Americans with Disabilities Act* reports, studies or surveys concerning the compliance of the Property with said Act;

☒ **10.6.1.13.** All permits, licenses and other building or use authorizations issued by any governmental authority with jurisdiction over the Property and written notice of any violation of any such permits, licenses or use authorizations, if any; and

☐ **10.6.1.14.** Other documents and information:

10.6.2. Due Diligence Documents Review and Objection. Buyer has the right to review and object to Due Diligence Documents. If the Due Diligence Documents are not supplied to Buyer or are unsatisfactory in Buyer's sole subjective discretion, Buyer may, on or before **Due Diligence Documents Objection Deadline:**

10.6.2.1. Notice to Terminate. Notify Seller in writing, pursuant to § 25.1 that this Contract is terminated; or

10.6.2.2. Due Diligence Documents Objection. Deliver to Seller a written description of any unsatisfactory Due Diligence Documents that Buyer requires Seller to correct.

10.6.2.3. Due Diligence Documents Resolution. If a Due Diligence Documents Objection is received by Seller, on or before **Due Diligence Documents Objection Deadline**, and if Buyer and Seller have not agreed in writing to a settlement thereof on or before **Due Diligence Documents Resolution Deadline**, this Contract will terminate on **Due Diligence Documents Resolution Deadline** unless Seller receives Buyer's written withdrawal of the Due Diligence Documents Objection before such termination, i.e., on or before expiration of **Due Diligence Documents Resolution Deadline.**

10.6.3. Zoning. Buyer has the Right to Terminate under § 25.1, on or before **Due Diligence Documents Objection Deadline**, based on any unsatisfactory zoning and any use restrictions imposed by any governmental agency with jurisdiction over the Property, in Buyer's sole subjective discretion.

10.6.4. Due Diligence – Environmental, ADA. Buyer has the right to obtain environmental inspections of the Property including Phase I and Phase II Environmental Site Assessments, as applicable. ☐ **Seller** ☒ **Buyer** will order or provide ☒ **Phase I Environmental Site Assessment,** ☒ **Phase II Environmental Site Assessment** (compliant with most current version of the applicable ASTM E1527 standard practices for Environmental Site Assessments) and/or ☐ _____, at the expense of ☐ **Seller** ☒ **Buyer** (Environmental Inspection). In addition, Buyer, at Buyer's expense, may also conduct an evaluation whether the Property complies with the *Americans with Disabilities Act* (ADA Evaluation). All such inspections and evaluations must be conducted at such times as are mutually agreeable to minimize the interruption of Seller's and any Seller's tenants' business uses of the Property, if any.

If Buyer's Phase I Environmental Site Assessment recommends a Phase II Environmental Site Assessment, the **Environmental Inspection Objection Deadline** will be extended by *thirty (30)* days (Extended Environmental Inspection Objection Deadline) and if such Extended Environmental Inspection Objection Deadline extends beyond the **Closing Date**, the **Closing Date** will be extended a like period of time. In such event, ☐ **Seller** ☒ **Buyer** must pay the cost for such Phase II Environmental Site Assessment.

Notwithstanding Buyer's right to obtain additional environmental inspections of the Property in this § 10.6.4, Buyer has the Right to Terminate under § 25.1, on or before **Environmental Inspection Termination Deadline**, or if applicable, the Extended Environmental Inspection Objection Deadline, based on any unsatisfactory results of Environmental Inspection, in Buyer's sole subjective discretion.

Buyer has the Right to Terminate under § 25.1, on or before **ADA Evaluation Objection Deadline**, based on any unsatisfactory ADA Evaluation, in Buyer's sole subjective discretion.

10.7. Conditional Upon Sale of Property. *Intentionally Omitted – Not Applicable.*

10.8. Source of Potable Water (Residential Land and Residential Improvements Only). [Intentionally Deleted *– Not Applicable.***]**

10.9. Existing Leases; Modification of Existing Leases; New Leases. *Intentionally Omitted – Not Applicable.*

11. ESTOPPEL STATEMENTS. *Intentionally Omitted – Not Applicable.*

CLOSING PROVISIONS

12. CLOSING DOCUMENTS, INSTRUCTIONS AND CLOSING.

12.1. Closing Documents and Closing Information. Seller and Buyer will cooperate with the Closing Company to enable the Closing Company to prepare and deliver documents required for Closing to Buyer and Seller and their designees. If Buyer is obtaining a loan to purchase the Property, Buyer acknowledges Buyer's lender is required to provide the Closing Company, in a timely manner, all required loan documents and financial information concerning Buyer's loan. Buyer and Seller will furnish any additional information and documents required by Closing Company that will be necessary to complete this transaction. Buyer and Seller will sign and complete all customary or reasonably required documents at or before Closing.

12.2. Closing Instructions. Colorado Real Estate Commission's Closing Instructions ☐ **Are** ☒ **Are Not** executed with this Contract.

12.3. Closing. Delivery of deed from Seller to Buyer will be at closing (Closing). Closing will be on the date specified as the **Closing Date** or by mutual agreement at an earlier date. The hour and place of Closing will be as designated by *mutual agreement of the parties*.

12.4. Disclosure of Settlement Costs. Buyer and Seller acknowledge that costs, quality, and extent of service vary between different settlement service providers (e.g., attorneys, lenders, inspectors and title companies).

13. TRANSFER OF TITLE. Subject to Buyer's compliance with the terms and provisions of this Contract, including the tender of any payment due at Closing, Seller must execute and deliver the following good and sufficient deed to Buyer, at Closing:

☒ special warranty deed *that expressly warrants title against all persons whose claim thereto arises on or after March 29, 2017*
☐ general warranty deed ☐ bargain and sale deed ☐ quit claim deed ☐ personal representative's deed
☐ _____deed. Seller, provided another deed is not selected, must execute and deliver a good and sufficient special warranty deed to Buyer, at Closing.

Unless otherwise specified in §30 (Additional Provisions), if title will be conveyed using a special warranty deed or a general warranty deed, title will be conveyed "subject to statutory exceptions" as defined in §38-30-113(5)(a), C.R.S.

14. PAYMENT OF LIENS AND ENCUMBRANCES. Unless agreed to by Buyer in writing, any amounts owed on any liens or encumbrances securing a monetary sum, including, but not limited to, any governmental liens for special improvements installed as of the date of Buyer's signature hereon, whether assessed or not and previous years' taxes, will be paid at or before Closing by Seller from the proceeds of this transaction or from any other source.

15. CLOSING COSTS, CLOSING FEE, ASSOCIATION FEES AND TAXES.

15.1. Closing Costs. Buyer and Seller must pay, in Good Funds, their respective closing costs and all other items required to be paid at Closing, except as otherwise provided herein.

15.2. Closing Services Fee. The fee for real estate closing services must be paid at Closing by ☐ **Buyer** ☐ **Seller** ☒ **One-Half by Buyer and One-Half by Seller** ☐ **Other** _____.

15.3. Status Letter and Record Change Fees. At least fourteen days prior to **Closing Date**, Seller agrees to promptly request the Association to deliver to Buyer a current Status Letter. Any fees incident to the issuance of Association's Status Letter must be paid by ☒ **None** ☐ **Buyer** ☐ **Seller** ☐ **One-Half by Buyer and One-Half by Seller**. Association's Record Change Fee must be paid by ☒ **None** ☐ **Buyer** ☐ **Seller** ☐ **One-Half by Buyer and One-Half by Seller**.

15.4. Local Transfer Tax. ☐ **The Local Transfer Tax** of _____ % of the Purchase Price must be paid at Closing by ☒ **None** ☐ **Buyer** ☐ **Seller** ☐ **One-Half by Buyer and One-Half by Seller**.

15.5. Private Transfer Fee. Private transfer fees and other fees due to a transfer of the Property, payable at Closing, such as community association fees, developer fees and foundation fees, must be paid at Closing by ☒ **None** ☐ **Buyer** ☐ **Seller** ☐ **One-Half by Buyer and One-Half by Seller**. The Private Transfer fee, whether one or more, is for the following association(s): _____ in the total amount of _____% of the Purchase Price or $___.

15.6. Water Transfer Fees. The Water Transfer Fees can change. The fees, as of the date of this Contract, do not exceed $_____ for:

☐ Water Stock/Certificates ☐ Water District
☐ Augmentation Membership ☐ Small Domestic Water Company ☐ _____

and must be paid at Closing by ☐ **None** ☒ **Buyer** ☐ **Seller** ☐ **One-Half by Buyer and One-Half by Seller**.

15.7. Sales and Use Tax. Any sales and use tax that may accrue because of this transaction must be paid when due by ☒ **None** ☐ **Buyer** ☐ **Seller** ☐ **One-Half by Buyer and One-Half by Seller**.

15.8. FIRPTA and Colorado Withholding.

15.8.1. FIRPTA. The Internal Revenue Service (IRS) may require a substantial portion of the Seller's proceeds be withheld after Closing when Seller is a foreign person. If required withholding does not occur, the Buyer could be held liable for the amount of the Seller's tax, interest and penalties. If the box in this Section is checked, Seller represents that Seller ☐ IS a foreign person for purposes of U.S. income taxation. If the box in this Section is not checked, Seller represents that Seller is not a foreign person for purposes of U.S. income taxation. Seller agrees to cooperate with Buyer and Closing Company to provide any reasonably requested documents to verify Seller's foreign person status. If withholding is required, Seller authorizes Closing Company to withhold such amount from Seller's proceeds. Seller should inquire with Seller's tax advisor to determine if withholding applies or if an exemption exists.

15.8.2. Colorado Withholding. The Colorado Department of Revenue may require a portion of the Seller's proceeds be withheld after Closing when Seller will not be a Colorado resident after Closing, if not otherwise exempt. Seller agrees to cooperate with Buyer and Closing Company to provide any reasonably requested documents to verify Seller's status. If withholding is required, Seller authorizes Closing Company to withhold such amount from Seller's proceeds. Seller should inquire with Seller's tax advisor to determine if withholding applies or if an exemption exists.

16. PRORATIONS AND ASSOCIATION ASSESSMENTS. The following will be prorated to the **Closing Date**, except as otherwise provided:

16.1. Taxes. Personal property taxes, if any, special taxing district assessments, if any, and general real estate taxes for the year of Closing, based on ☐ **Taxes for the Calendar Year Immediately Preceding Closing** ☐ **Most Recent Mill Levy and Most Recent Assessed Valuation**, adjusted by any applicable qualifying seniors property tax exemption, qualifying disabled veteran exemption or ☒ **Other** ***Seller is a tax exempt entity – there will be no proration at Closing*** .

16.2. Rents. ***Intentionally Omitted – Not Applicable.***

16.3. Association Assessments. ***Intentionally Omitted – Not Applicable.***

16.4. Other Prorations. Water and sewer charges, propane, interest on continuing loan, and ***all other customary*** .

16.5. Final Settlement. Unless otherwise agreed in writing, these prorations are final.

17. POSSESSION. Possession of the Property will be delivered to Buyer on **Possession Date** at **Possession Time**, subject to the Leases as set forth in § 10.6.1.7.

If Seller, after Closing, fails to deliver possession as specified, Seller will be subject to eviction and will be additionally liable to Buyer for payment of $ _____ per day (or any part of a day notwithstanding § 18.1) from **Possession Date** and **Possession Time** until possession is delivered.

GENERAL PROVISIONS

18. DAY; COMPUTATION OF PERIOD OF DAYS, DEADLINE.

18.1. Day. As used in this Contract, the term "day" means the entire day ending at 11:59 p.m., United States Mountain Time (Standard or Daylight Savings as applicable).

18.2. Computation of Period of Days, Deadline. In computing a period of days (e.g., three days after MEC), when the ending date is not specified, the first day is excluded and the last day is included. If any deadline falls on a Saturday, Sunday or federal or Colorado state holiday (Holiday), such deadline ☒ **Will** ☐ **Will Not** be extended to the next day that is not a Saturday, Sunday or Holiday. Should neither box be checked, the deadline will not be extended.

19. CAUSES OF LOSS, INSURANCE; DAMAGE TO INCLUSIONS AND SERVICES; CONDEMNATION; AND WALK-THROUGH. Except as otherwise provided in this Contract, the Property, Inclusions or both will be delivered in the condition existing as of the date of this Contract, ordinary wear and tear excepted.

19.1. Causes of Loss, Insurance. In the event the Property or Inclusions are damaged by fire, other perils or causes of loss prior to Closing (Property Damage) in an amount of not more than ten percent of the total Purchase Price, and if the repair of the damage will be paid by insurance (other than the deductible to be paid by Seller), then Seller, upon receipt of the insurance proceeds, will use Seller's reasonable efforts to repair the Property before **Closing Date**. Buyer has the Right to Terminate under § 25.1, on or before **Closing Date** if the Property is not repaired before **Closing Date** or if the damage exceeds such sum. Should Buyer elect to carry out this Contract despite such Property Damage, Buyer is entitled to a credit at Closing for all insurance proceeds that were received by Seller (but not the Association, if any) resulting from damage to the Property and Inclusions, plus the amount of any deductible provided for in the insurance policy. This credit may not exceed the Purchase Price. In the event Seller has not received the insurance proceeds prior to Closing, the parties may agree to extend the **Closing Date** to have the Property repaired prior to Closing or, at the option of Buyer, (1) Seller must assign to Buyer the right to the proceeds at Closing, if acceptable to Seller's insurance company and Buyer's lender; or (2) the parties may enter into a written agreement prepared by the parties or their attorney requiring the Seller to escrow at Closing from Seller's sale proceeds the amount Seller has received and will receive due to such damage, not exceeding the total Purchase Price, plus the amount of any deductible that applies to the insurance claim.

19.2. Damage, Inclusions and Services. Should any Inclusion or service (including utilities and communication services), system, component or fixture of the Property (collectively Service) (e.g., heating or plumbing), fail or be damaged between the date of this Contract and Closing or possession, whichever is earlier, then Seller is liable for the repair or replacement of such Inclusion or Service with a unit of similar size, age and quality, or an equivalent credit, but only to the extent that the maintenance or replacement of such Inclusion or Service is not the responsibility of the Association, if any, less any insurance proceeds received by Buyer covering such repair or replacement. If the failed or damaged Inclusion or Service is not repaired or replaced on or before Closing or possession, whichever is earlier, Buyer has the Right to Terminate under § 25.1, on or before **Closing Date**, or, at the option of Buyer, Buyer is entitled to a credit at Closing for the repair or replacement of such Inclusion or Service. Such credit must not exceed the Purchase Price. If Buyer receives such a credit, Seller's right for any claim against the Association, if any, will survive Closing.

19.3. Condemnation. In the event Seller receives actual notice prior to Closing that a pending condemnation action may result in a taking of all or part of the Property or Inclusions, Seller must promptly notify Buyer, in writing, of such condemnation action. Buyer has the Right to Terminate under § 25.1, on or before **Closing Date**, based on such condemnation action, in Buyer's sole subjective discretion. Should Buyer elect to consummate this Contract despite such diminution of value to the Property and Inclusions, Buyer is entitled to a credit at Closing for all condemnation proceeds awarded to Seller for the diminution in the value of the Property or Inclusions but such credit will not include relocation benefits or expenses, or exceed the Purchase Price.

19.4. Walk-Through and Verification of Condition. Buyer, upon reasonable notice, has the right to walk through the Property prior to Closing to verify that the physical condition of the Property and Inclusions complies with this Contract.

20. RECOMMENDATION OF LEGAL AND TAX COUNSEL. By signing this Contract, Buyer and Seller acknowledge that the respective broker has advised that this Contract has important legal consequences and has recommended the examination of title and consultation with legal and tax or other counsel before signing this Contract.

21. TIME OF ESSENCE, DEFAULT AND REMEDIES. Time is of the essence for all dates and deadlines in this Contract. This means that all dates and deadlines are strict and absolute. If any payment due, including Earnest Money, is not paid, honored or tendered when due, or if any obligation is not performed timely as provided in this Contract or waived, the non-defaulting party has the following remedies:

21.1. If Buyer is in Default:

☐ **21.1.1. Specific Performance.** Seller may elect to cancel this Contract and all Earnest Money (whether or not paid by Buyer) will be paid to Seller and retained by Seller. It is agreed that the Earnest Money is not a penalty, and the Parties agree the amount is fair and reasonable. Seller may recover such additional damages as may be proper. Alternatively, Seller may elect to treat this Contract as being in full force and effect and Seller has the right to specific performance or damages, or both.

21.1.2. Liquidated Damages, Applicable. This § 21.1.2 applies unless the box in § 21.1.1 is checked. Seller may cancel this Contract. All Earnest Money (whether or not paid by Buyer) will be paid to Seller, and retained by Seller. It is agreed that the Earnest Money specified in § 4.1 is LIQUIDATED DAMAGES, and not a penalty, which amount the parties agree is fair and reasonable and (except as provided in §§ 10.4, 22, 23 and 24), said payment of Earnest Money is SELLER'S ONLY REMEDY for Buyer's failure to perform the obligations of this Contract. Seller expressly waives the remedies of specific performance and additional damages.

21.2. If Seller is in Default: Buyer may elect to treat this Contract as canceled, in which case all Earnest Money received hereunder will be returned to Buyer and Buyer may recover such damages as may be proper. ~~Alternatively, Buyer may elect to treat this Contract as being in full force and effect and Buyer has the right to specific performance or damages, or both.~~

22. LEGAL FEES, COST AND EXPENSES. Anything to the contrary herein notwithstanding, in the event of any ~~arbitration or~~ litigation relating to this Contract, prior to or after **Closing Date**, the ~~arbitrator or~~ court must award to the prevailing party all reasonable costs and expenses, including attorney fees, legal fees and expenses.

23. MEDIATION. ***Intentionally Omitted – Not Applicable.***

24. EARNEST MONEY DISPUTE. Except as otherwise provided herein, Earnest Money Holder must release the Earnest Money following receipt of written mutual instructions, signed by both Buyer and Seller. In the event of any controversy regarding the Earnest Money, Earnest Money Holder is not required to release the Earnest Money. Earnest Money Holder, in its sole subjective discretion, has several options: (1) wait for any proceeding between Buyer and Seller; (2) interplead all parties and deposit Earnest Money into a court of competent jurisdiction (Earnest Money Holder is entitled to recover court costs and reasonable attorney and legal fees incurred with such action); or (3) provide notice to Buyer and Seller that unless Earnest Money Holder receives a copy of the Summons and Complaint or Claim (between Buyer and Seller) containing the case number of the lawsuit (Lawsuit) within one hundred twenty days of Earnest Money Holder's notice to the parties, Earnest Money Holder is authorized to return the Earnest Money to Buyer. In the event Earnest Money Holder does receive a copy of the Lawsuit and has not interpled the monies at the time of any Order, Earnest Money Holder must disburse the Earnest Money pursuant to the Order of the Court. ~~The parties reaffirm the obligation of § 23 (Mediation).~~ This Section will survive cancellation or termination of this Contract.

25. TERMINATION.

25.1. Right to Terminate. If a party has a right to terminate, as provided in this Contract (Right to Terminate), the termination is effective upon the other party's receipt of a written notice to terminate (Notice to Terminate), provided such written notice was received on or before the applicable deadline specified in this Contract. If the Notice to Terminate is not received on or before the specified deadline, the party with the Right to Terminate accepts the specified matter, document or condition as satisfactory and waives the Right to Terminate under such provision.

25.2. Effect of Termination. In the event this Contract is terminated, all Earnest Money received hereunder will be returned to Buyer and the parties are relieved of all obligations hereunder, subject to §§ 10.4, 22, ~~23~~ and 24.

26. ENTIRE AGREEMENT, MODIFICATION, SURVIVAL; SUCCESSORS. This Contract, its exhibits and specified addenda, constitute the entire agreement between the parties relating to the subject hereof, and any prior agreements pertaining thereto, whether oral or written, have been merged and integrated into this Contract. No subsequent modification of any of the terms of this Contract is valid, binding upon the parties, or enforceable unless made in writing and signed by the parties. Any right or obligation in this Contract that, by its terms, exists or is intended to be performed after termination or Closing survives the same. Any successor to a party receives the predecessor's benefits and obligations of this Contract.

27. NOTICE, DELIVERY, AND CHOICE OF LAW.

27.1. Physical Delivery and Notice. Any document, or notice to Buyer or Seller must be in writing, except as provided in § 27.2, and is effective when physically received by such party, any individual named in this Contract to receive documents or notices for such party, Broker, or Brokerage Firm of Broker working with such party (except any notice or delivery after Closing must be received by the party, not Broker or Brokerage Firm).

27.2. Electronic Notice. As an alternative to physical delivery, any notice, may be delivered in electronic form to Buyer or Seller, any individual named in this Contract to receive documents or notices for such party, the Broker or Brokerage Firm of Broker working with such party (except any notice or delivery after Closing must be received by the party; not Broker or Brokerage Firm) at the electronic address of the recipient by facsimile, email or ***none other*** _____.

27.3. Electronic Delivery. Electronic Delivery of documents and notice may be delivered by: (1) email at the email address of the recipient, (2) a link or access to a website or server provided the recipient receives the information necessary to access the documents, or (3) facsimile at the facsimile number (Fax No.) of the recipient.

27.4. Choice of Law. This Contract and all disputes arising hereunder are governed by and construed in accordance with the laws of the State of Colorado that would be applicable to Colorado residents who sign a contract in Colorado for real property located in Colorado.

28. NOTICE OF ACCEPTANCE, COUNTERPARTS. This proposal will expire unless accepted in writing, by Buyer and Seller, as evidenced by their signatures below, and the offering party receives notice of such acceptance pursuant to § 27 on or before **Acceptance Deadline Date** and **Acceptance Deadline Time**. If accepted, this document will become a contract between Seller and Buyer. A copy of this Contract may be executed by each party, separately, and when each party has executed a copy thereof, such copies taken together are deemed to be a full and complete contract between the parties.

29. GOOD FAITH. Buyer and Seller acknowledge that each party has an obligation to act in good faith including, but not limited to, exercising the rights and obligations set forth in the provisions of **Financing Conditions and Obligations, Title Insurance, Record Title and Off-Record Title, New ILC, New Survey;** and **Property Disclosure, Inspection, Indemnity, Insurability and Due Diligence.**

ADDITIONAL PROVISIONS AND ATTACHMENTS

30. ADDITIONAL PROVISIONS. (The following additional provisions have not been approved by the Colorado Real Estate Commission.)

31. OTHER DOCUMENTS.

31.1. The following attachments **are a part** of this Contract:

Exhibit A – Legal Description
Addendum to Contract to Buy and Sell Real Estate (Commercial) effective as of MEC

31.2. The following documents have been provided but are **not** a part of this Contract:

None.

SIGNATURES

Buyer's Name: *Adams County Communications Center Authority, a political subdivision of the State of Colorado*	Buyer's Name:
By: Jul D Eitel 7/29/19	
Buyer's Signature Date	Buyer's Signature Date
Name: Jud D Eitel	
Its: Executive Director	
Address:	Address:
Phone No.:	Phone No.:
Fax No.:	Fax No.:
Email Address:	Email Address:

[NOTE: If this offer is being countered or rejected, do not sign this document.

Seller's Name: *Adam's County, Colorado*

By: _____
Seller's Signature Date
Name: _____
Its: Chair- _____

Address: *4430 South Adams County Parkway*
Brighton, CO 80601
Phone No.: *303.659.2120*
Fax No.:
Email Address:

Seller's Name: _____

_____
Seller's Signature Date

Address: _____
_____
Phone No.: _____
Fax No.: _____
Email Address:

618 **END OF CONTRACT TO BUY AND SELL REAL ESTATE**

32. BROKER'S ACKNOWLEDGMENTS AND COMPENSATION DISCLOSURE. *Intentionally Omitted – Not Applicable.*

33. BROKER'S ACKNOWLEDGMENTS AND COMPENSATION DISCLOSURE.
(To be completed by Broker working with Seller)

Broker ☐ **Does** ☒ **Does Not** acknowledge receipt of Earnest Money deposit. Broker agrees that if Brokerage Firm is the Earnest Money Holder and, except as provided in § 24, if the Earnest Money has not already been returned following receipt of a Notice to Terminate or other written notice of termination, Earnest Money Holder will release the Earnest Money as directed by the written mutual instructions. Such release of Earnest Money will be made within five days of Earnest Money Holder's receipt of the executed written mutual instructions, provided the Earnest Money check has cleared.

~~Although Broker is not a party to the Contract, Broker agrees to cooperate, upon request, with any mediation requested under § 23.~~

Broker is working with Seller as a ☒ **Seller's Agent** ☐ **Transaction-Broker** in this transaction. ☐ This is a **Change of Status.**

☐ **Customer.** Broker has no brokerage relationship with Buyer. See § 33 for Broker's brokerage relationship with Seller.

Brokerage Firm's compensation or commission is to be paid by ☒ **Seller** ☐ **Buyer** ☐ **Other** _____.

Brokerage Firm's Name: *Guidance Corporate Realty Advisors*
Brokerage Firm's License #: *EC 100006464*
Broker's Name: *Norman S. DeHart*
Broker's License #: *ER 040002466*

_____
Broker's Signature Date

Address: *521 Valley View Drive*
Boulder, CO 80304
Phone No.: *303-570-7744*
Fax No.:
Email Address: *ndehart@guidancebrokers.com*

EXHIBIT "A"
Legal Description

COMMENCING AT THE SOUTH QUARTER CORNER OF SECTION 31, TOWNSHIP 2 SOUTH RANGE 67 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO; THENCE WESTERLY ALONG THE SOUTH LINE OF SAID SECTION 31, A DISTANCE OF 1321.50 FEET TO THE SOUTHEAST CORNER OF THE SOUTHWEST QUARTER, SOUTHWEST QUARTER OF SAID SECTION 31; THENCE ON A DEFLECTION ANGLE TO THE RIGHT OF 90 DEGREES 06 MINUTES 33 SECONDS ALONG THE EAST LINE OF THE SOUTHWEST QUARTER OF THE SOUTHWEST QUARTER OF SECTION 31 A DISTANCE OF 989.63 FEET; THENCE ON A DEFLECTION ANGLE TO THE LEFT OF 90 DEGREES A DISTANCE OF 40.00 FEET TO THE WESTERLY RIGHT-OF-WAY OF BIRCH STREET TO THE TRUE POINT OF BEGINNING

THENCE NORTHERLY ALONG THE WESTERLY RIGHT-OF-WAY OF BIRCH STREET, A DISTANCE OF 208.71 FEET TO A POINT ON THE SOUTHERLY RIGHT-OF-WAY OF 74TH AVENUE;

THENCE ON A DEFLECTION ANGLE TO THE LEFT OF 90 DEGREES A DISTANCE OF 208.71 FEET ALONG THE SOUTHERLY RIGHT-OF-WAY OF 74TH AVENUE TO A POINT; THENCE ON A DEFLECTION ANGLE TO THE LEFT OF 90 DEGREES, A DISTANCE OF 208.71 FEET;

THENCE ON A DEFLECTION ANGLE TO THE LEFT OF 90 DEGREES A DISTANCE OF 208.71 FEET TO THE TRUE POINT OF BEGINNING.

ADDENDUM TO CONTRACT TO BUY AND SELL REAL ESTATE (COMMERCIAL)
By and Between

ADAMS COUNTY, COLORADO,
a Colorado Governmental Entity
("Seller")

and

ADAMS COUNTY COMMUNICATIONS CENTER AUTHORITY,
a political subdivision of the State of Colorado, or its assigns
("Buyer")

THIS ADDENDUM TO CONTRACT TO BUY AND SELL REAL ESTATE is entered into simultaneously with and is part of that certain Contract to Buy and Sell Real Estate (Commercial) dated July 29, 2019 between Buyer and Seller (this Addendum and the foregoing Contract, collectively the "Contract"). In the event of any conflict or inconsistency between the provisions of the Contract to Buy and Sell Real Estate and the provisions of this Addendum, the provisions of this Addendum shall govern and control. Capitalized terms used in this Addendum which are not defined herein shall have the meanings ascribed to such terms in the Contract to Buy and Sell Real Estate (Commercial).

Inspections.

(a) The inspections referenced in Section 10.3 of the Contract shall include such environmental, noise level, engineering and property inspections, and any requested engineering, Water Well and soils tests upon the Property as Buyer may reasonably request. However, prior to performing its inspections, (a) Buyer shall provide at least one (1) business day's prior written notice thereof to Seller; (b) Seller and/or its agent may be present for all such Inspections; and (c) Buyer shall secure and keep in full force and effect throughout the term of this Contract, the following insurance coverage, at Buyer's sole cost and expense: (i) commercial general liability insurance, including contractual liability (to specifically include coverage for Buyer's indemnification obligations under this Contract), with such coverage and such limits as may be reasonably requested by Seller; (ii) worker's compensation insurance for the employees of Buyer and Buyer's agents and contractors in accordance with applicable state law; and (iii) such other insurance coverage and limits as may reasonably be requested by Seller; *provided, however,* that limits of liability can be provided in a combination of comprehensive general liability and umbrella liability policies. Buyer shall also cause all of its agents and contractors to secure and keep in full force and effect during the period in which they have access to the Property insurance coverage of customary types and limits.

(b) Notwithstanding anything in this Contract to the contrary, Buyer shall not be permitted to perform any invasive tests on the Property without Seller's prior written consent, which consent shall not be unreasonably withheld, conditioned or delayed. If Buyer desires to perform any invasive tests, then Buyer shall give prior written notice thereof to Seller, which notice shall be accompanied by a description and plan of the invasive tests Buyer desires to perform.

Notwithstanding any provision in this Contract, in no event shall Buyer have any liability relating to the mere discovery of adverse conditions on the Property not created by Buyer. Seller shall be responsible to obtain any third-party consent required to accommodate Buyer's inspections.

(c) All products and materials resulting from Buyer's inspections (collectively, the "Materials"), shall be the property of Buyer; *provided, however,* that if Buyer terminates this Contract, upon Seller's sole option and its reimbursement to Buyer of the out-of-pocket costs incurred by Buyer for procurement of the Materials, Buyer shall deliver all of the Materials to Seller and, to the extent assignable, Buyer shall promptly assign to Seller all of Buyer's right, title and interest in and to such Materials. Notwithstanding the foregoing, if this Contract is terminated due to a Buyer default, at Seller's election, Buyer shall deliver and assign the Materials to Seller without reimbursement by Seller.

(d) Buyer shall have until the Inspection Objection Deadline, or the Inspection Objection Extension Deadline (as that term is defined below) in which to conduct its due diligence activities. Buyer may terminate this Contract for any reason, or for no reason, by providing written notice thereof to Seller on or before the expiration of the Inspection Objection Deadline or the Inspection Objection Extension Deadline, whereupon the Earnest Money, including any additional Earnest Money, as applicable, shall be promptly returned to Buyer.

(e) So long as Buyer is not in default under this Contract, Buyer shall be permitted a one-time forty-five (45) day extension of the Inspection Objection Deadline ("Inspection Objection Extension Deadline") by (i) delivering written notice thereof to Seller and Seller's Agent no later than ten (10) days prior to the Inspection Objection Deadline, and (ii) within five (5) business days after giving such notice, delivering to Earnest Money Holder the amount of $5,000.00 ("Additional Earnest Money"), which amount when received by Earnest Money Holder shall be added to the Earnest Money, applicable toward the Purchase Price, and shall be held, credited and disbursed in the same manner as provided hereunder with respect to the Earnest Money. In the event Buyer exercises its right to the Inspection Objection Extension Deadline, the Closing Date shall be extended by forty-five (45) days.

Notices. All notices required or permitted to be given under this Contract shall be given in the manner set forth in Section 27 of the Contract, addressed as follows or to such other address as the party entitled to receive such notice may, from time to time hereinafter, designate by giving written notice pursuant hereto:

Seller: Adams County, Colorado
Facilities & Fleet Management

4430 South Adams County Parkway
Suite C1700
Brighton, Colorado 80601
Attention: Nicci Beauprez

Phone: 720-523-6060
Email: nbeauprez@adcogov.org

with a copy to:	County Attorney's Office 4430 S. Adams County Parkway | 5th Floor Suite C5000B | Brighton, CO 80601-8206 Attention: Doug Edelstein Phone: 720.523.6116 Email: DEdelstein@adcogov.org
Buyer:	Adams County Communications Center Authority, 7321 Birch Street Commerce City, CO 80022 Attention: Joel Estes Phone: 303.289.2235 Email: jestes@adcom911.org
with a copy to:	Ireland Stapleton Pryor & Pascoe, PC 717 17th Street Suite 2800 Denver, CO 80202 Attention: Kelley B. Duke and Elizabeth P. Woodward Phone: 303.623.2700 Email: kduke@irelandstapleton.com and ewoodward@irelandstapleton.com

Personal Liability. Notwithstanding anything to the contrary provided in this Contract, it is specifically understood and agreed, such agreement being a primary consideration for the execution of this Contract by the parties, that (a) there shall be absolutely no personal liability on the part of any shareholder, director, officer, manager, member or employee of any party hereto with respect to any of the terms, covenants and conditions of this Contract; and (b) each party hereby waives any and all claims, demands and causes of action against the shareholders, directors, officers, managers, members or employees of the other party hereto in the event of any breach by any such party of any of the terms, covenants and conditions of this Contract to be performed by such other party.

Environmental. Notwithstanding any provision contained in Section 10.6, if Buyer's Phase I Environmental Site Assessment recommends, or Buyer desires to obtain, a Phase II Environmental Site Assessment ("Phase II Report"), the Environmental Inspection Objection Deadline (10.6) shall be extended by thirty (30) days; *provided, however,* if Buyer has timely ordered the Phase II Report but the Phase II Report has not been delivered to Buyer at least five (5) days prior to the extended Environmental Inspection Objection Deadline, upon written notice by Buyer to Seller, Buyer may extend the Environmental Inspection Objection Deadline (10.6) by an additional thirty (30) days (for a total extension of sixty (60) days). In the event that Buyer extends the Environmental Inspection Objection Deadline as provided in this Section, all references to "Environmental Inspection Deadline" shall be deemed to be references to the Environmental Inspection Objection Deadline as extended by Buyer, and if such extended Environmental Inspection Objection Deadline (10.6) extends beyond the Closing Date (12.3), the Closing Date shall be extended a like period of time.

Closing. Closing can be scheduled earlier than outlined is Section 3.1 of the Contract upon mutual agreement and so as to not create a default on either party in the ability to obtain necessary approvals and or signatures in time for such to take place.

Post Closing Pre-Development & Demolition. After Closing on its purchase of the Property, Buyer shall be fully responsible for any and all required costs for site Pre-Development and/or Demolition activities, as required for its planned future use of the Property, including but not limited to: demolition and disposal of the existing building, the safe-offs of any existing utility feeds, abatement of any hazardous materials, which are customary given the age of the building, including but not limited to: asbestos and refrigerant removal, topographic surveying and leveling of the site and any other pre-development activities. Seller shall provide the credit at closing set forth in Section 4.1 foritems including but not limited to: Post-Closing Pre-Development and/or Demolition activities as necessary for its planned future use, which activities shall be the sole responsibility of Buyer.

Water Well. The Property contains an existing water well, (the "Water Well"). However, it is currently unknown how, or if, the Water Well can be utilized for the irrigation of the Property or for other purposes of Buyer or if the water rights associated with the Water Well can be transferred. Prior to the Inspection Objection Deadline, as it may be extended by Buyer, Buyer may investigate the opportunities associated with the Water Well relative to its desired use, condition and status. Notwithstanding the foregoing, if it is determined that the Water Well cannot be utilized by Buyer, the parties agree in advance that there shall be no adjustment in the Purchase Price paid by Buyer.

Seller's Representations and Warranties. Seller warrants, represents, and covenants, as of MEC and as of Closing, as follows:

(a) To the best of Seller's knowledge, Seller knows of no claim of right, easements, or other rights of third parties affecting the Property, other than those matters reflected and disclosed in the Title Documents to be delivered to Buyer pursuant to § 8 of the Contract.

(b) Until Closing or termination of the Contract, Seller shall promptly notify Buyer if it receives any notice, written or otherwise, from any Governmental Authority, requiring the correction of any condition with respect to the Property, or information about any pending or contemplated litigation or condemnation action with respect to the Property or any part thereof. As used herein, the term "Governmental Authority" shall mean the United States, the State of Colorado, Adams County, Commerce City or any other city in the State of Colorado, and any agency, department, commission, board, bureau or instrumentality of any of them.

Leases. It shall be a condition to Closing, for the benefit of Buyer, that the property is delivered free and clear of any leases and that any leases currently encumbering the Property shall have been terminated to the satisfaction of Buyer and the Earnest Money Holder such that no leases or memoranda of leases shall appear as exceptions in the final Title Commitment delivered to Buyer pursuant to Section 8 of the Contract or the deed delivered to Buyer pursuant to Section 13 of the Contract.

Assignment. Buyer may assign this contract to any affiliate or related entity to Buyer, upon the prior written approval of Seller, which approval shall not be unreasonably withheld.

Counterparts. This Contract may be executed in counterparts which, when taken together, shall constitute but one and the same document. A signature of a party on this Contract provided electronically or by telecopy shall have the same effect as an original signature.

Brokers. Seller has engaged and is responsible for payment of any commission or fee payable to, Guidance Corporate Realty Advisors ("Seller's Broker").

Entire Agreement. This Contract (including Addenda and Exhibits) contains the entire agreement of the parties concerning its subject matter and supersedes any prior or concurrent understandings, agreements or negotiations concerning its subject matter. It shall not be modified except by additional written agreement signed by both Buyer and Seller.

SELLER:

ADAMS COUNTY, COLORADO,
a Colorado Governmental Entity

By:_____

Name:_____

Title:_____

BUYER:

ADAMS COUNTY COMMUNICATIONS CENTER AUTHORITY,
a political subdivision of the State of Colorado, or its assigns

By: _____

Name: Joel D. Estes

Title: Executive Director

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: County Wide Managed Print Services
FROM: Raymond H. Gonzales, County Manager Alisha Reis, Deputy County Manager Benjamin Dahlman, Finance Director Jennifer Tierney Hammer, Procurement and Contracts Manager
AGENCY/DEPARTMENT: All County Departments
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners approves the use of a Cooperative Agreement with Toshiba America Business Solutions, Inc., to provide Managed Print Services.

BACKGROUND:

The National IPA Cooperative formally solicited and awarded Managed Print Services to Toshiba America Business Solutions, Inc. (Toshiba). The use of cooperative agreements is pre-approved in Purchasing's Single Source Policy, Appendix E – Cooperative, Single, and Sole Source Purchases.

The County currently spends an estimated $553,700.00 annually; however, with the use of the National IPA Cooperative Agreement, the County is estimated to spend approximately $431,000.00 for a savings of $122,700.00 annually for managed print services. Toshiba has been a valuable partner in helping the County to save money and maintain our managed print program.

It is recommended that the Board of County Commissioners approves the use of the National IPA Cooperative Agreement with Toshiba America Business Solutions, Inc., to provide managed print services to all County departments and elected offices over the next three years in the estimated annual amount of $431,000.00.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

All County Departments

ATTACHED DOCUMENTS:

Resolution

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund: various	
Cost Center: various	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:	7920		$910,274
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			$910,274

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

Current Budgeted Operating Expenditure is for object account 7920 County wide. This object account is for equipment rental and is primarily used for managed print services from Toshiba but can also be used for other equipment rental services.

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING A COOPERATIVE AGREEMENT BETWEEN ADAMS COUNTY AND TOSHIBA AMERICA BUSINESS SOLUTIONS, INC., FOR COUNTY WIDE MANAGED PRINT SERVICES

WHEREAS, Toshiba America Business Solutions, Inc., submitted a proposal to the National IPA Cooperative on July 18, 2017, to provide managed print services; and,

WHEREAS, the use of cooperative agreements is pre-approved in Purchasing's Single Source Policy, Appendix E – Cooperative, Single, and Sole Source Purchases; and,

WHEREAS, Toshiba America Business Solutions, Inc., provides managed print services through a cooperative agreement; and,

WHEREAS, Toshiba America Business Solutions, Inc., agrees to provide County wide managed print services over the next three years in the estimated annual amount of $431,000.00.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the agreement with Toshiba America Business Solutions, Inc., for County wide managed print services is hereby approved.

BE IT FURTHER RESOLVED, that the Chair is hereby authorized to sign said agreement on behalf of Adams County, after negotiation and approval as to form is completed by the County Attorney's Office.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Government Center and Justice Center Carpet Replacement
FROM: Raymond H. Gonzales, County Manager Alisha Reis, Deputy County Manager Benjamin Dahlman, Finance Director Jennifer Tierney Hammer, Procurement and Contracts Manager
AGENCY/DEPARTMENT: Facilities Operations and Fleet Management Department
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners approves an agreement with Colorado Carpet Center, Inc., for carpet replacement in the Government Center and Justice Center buildings.

BACKGROUND:

As part of ongoing maintenance and repairs for various County buildings, the Facilities Operations and Fleet Management Department budgeted for worn carpet replacement. Carpet will be replaced at the Justice Center café, Judge's chambers, jury rooms, and offices. In the Government Center, carpet will be replaced in Elections, Motor Vehicle, and the Recording areas.

A formal Invitation to Bid (IFB) was solicited through BidNet for carpet replacement for the Government Center and Justice Center buildings. The County received one response on July 10, 2019.
Colorado Carpet Center, Inc., bid the following:

- $176,665.00 Government Center building
- $162,860.00 Justice Center building
- Project total is $339,525.00

The Facilities Operations and Fleet Management Department recommends that Colorado Carpet Center, Inc., be approved to provide carpet replacement for the Government Center and Justice Center buildings in the not to exceed amount of $339,525.00.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Facilities Operations and Fleet Management Department

ATTACHED DOCUMENTS:

Resolution

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund: 01

Cost Center: 1131

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:	7845		$500,000.00
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			$500,000.00

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING AN AGREEMENT BETWEEN ADAMS COUNTY AND COLORADO CARPET CENTER, INC., FOR CARPET REPLACEMENT AT THE GOVERNMENT CENTER AND JUSTICE CENTER BUILDINGS

WHEREAS, Colorado Carpet Center, Inc., submitted a bid on July 10, 2019, to provide carpet replacement at the Government Center and Justice Center buildings; and,

WHEREAS, it was deemed that Colorado Carpet Center, Inc., was the most responsive and responsible bidder; and,

WHEREAS, Colorado Carpet Center, Inc. agrees to provide the carpet replacement at the Government Center and Justice Center buildings in the not to exceed amount of $339,525.00.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the agreement with Colorado Carpet Center, Inc., to replace carpet at the Government Center and Justice Center is hereby approved.

BE IT FURTHER RESOLVED that the Chair is hereby authorized to sign said agreement on behalf of Adams County, after negotiation and approval as to form is completed by the County Attorney's Office.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: 2019 Group Agreement with Kaiser Permanente
FROM: Terri Lautt, Director
AGENCY/DEPARTMENT: People and Culture Services
HEARD AT STUDY SESSION ON: August 28, 2018
AUTHORIZATION TO MOVE FORWARD: ☒ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners Approve the 2019 Group Agreement with Kaiser Permanente.

BACKGROUND: The Adams County Board of County Commissioners entered into a contract with Kaiser Permanente in 1981 to provide a quality health care plan to Adams County employees and retirees and continues to offer this option in 2019, thereby providing additional health plan choices.

The attached Group Agreements, Amendments, Letters of Understanding, Rate Sheets and Evidences of Coverage outline the current benefits with Kaiser Permanente as approved through Study Session.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
People and Culture Services
County Manager's Office
Budget Office
County Attorney's Office

ATTACHED DOCUMENTS:
2019 Evidence of Coverage
2019 Medicare Evidence of Coverage
2019 Large Group Agreement
Amendment to Group Agreement – Contribution and Participation Requirements

Amendment to Group Agreement – Dues
January 1, 2019 Letter of Understanding
January 1, 2019 Letter re: Late Enrollment Penalty
Amendment One 2019 Group Agreement Non-Medicare
Amendment Two 2019 Group Agreement Medicare Employees
Amendment Three 2019 Group Agreement Senior Advantage Medicare
Amendment Four 2019 Group Agreement Medicare Employees (LIS)
ADCO Rate Sheet

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund: 19

Cost Center: 8615

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:	Various		$16,683,455
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			$16,683,455

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note: Current Budgeted Operating Expenditure includes both medical plans, United HealthCare and Kaiser Permanente.

RESOLUTION ADOPTING AMENDMENTS TO ADAMS COUNTY'S GROUP AGREEMENTS WITH KAISER PERMANENTE

WHEREAS, the Adams County Board of County Commissioners recognizes the importance of providing quality health insurance plans with variable options for county employees at a reasonable cost; and,

WHEREAS, Adams County has had an agreement with Kaiser Permanente since January 1, 1981 to provide a quality health care plan to Adams County employees and their families; and,

WHEREAS, the Adams County Board of County Commissioners intends to continue to contract with Kaiser Permanente for the provision of quality health care for Adams County employees and their families, thereby providing additional health plan choices at a reasonable cost; and,

WHEREAS, the attached documents constitute the Amendments to Adams County's agreement with Kaiser Permanente for the provision of health care to Adams County employees and will remain in effect through December 31, 2019:

1. 2019 Evidence of Coverage
2. 2019 Medicare Evidence of Coverage
3. 2019 Large Group Agreement
4. Amendment to Group Agreement – Contribution and Participation Requirements
5. Amendment to Group Agreement – Dues
6. January 1, 2019 Letter of Understanding
7. January 1, 2019 Letter re: Late Enrollment Penalty
8. Amendment One 2019 Group Agreement Non-Medicare
9. Amendment Two 2019 Group Agreement Medicare Employees
10. Amendment Three 2019 Group Agreement Senior Advantage Medicare
11. Amendment Four 2019 Group Agreement Medicare Employees (LIS)
12. ADCO Rate Sheet

NOW, THEREFORE, BE IT RESOLVED, that the Board of County Commissioners, County of Adams, State of Colorado, hereby adopts the attached Amendments to Adams County's Group Agreements with Kaiser Permanente.

BE IT FURTHER RESOLVED, that the Chair is hereby authorized to execute said Amendments.

AMENDMENT TO GROUP AGREEMENT

Alternate Payment Plan
(45-days Late Payment)

This document amends your Group Agreement. The section titled "**Dues**" is hereby amended with the addition of the following language:

Alternate Payment Plan

At the request of Group, Kaiser Foundation Health Plan of Colorado (Health Plan) hereby agrees to accept receipt of monthly Dues 15 days after the 30-day grace period permitted by Colorado law, for a total late payment of 45 days. An administrative fee will be loaded into Group's monthly Dues for the late-payment period following the statutory grace period.

AMENDMENT ONE
2019 GROUP AGREEMENT
NON-MEDICARE

This document amends the January 1, 2019, Group Agreement (*"Agreement"*) between **Kaiser Foundation Health Plan of Colorado** (*"Health Plan"*) and **County of Adams** (*"Group"*).

The section titled **"Contribution and Participation Requirements"** is hereby amended with the addition of the following language:

An Eligible Person is defined as –

A regular full-time employee or project designated employee of the Group who is scheduled to work at his or her job at least 40 hours per week or a regular part-time employee or project designated employee of the Group who is scheduled to work at his or her job at least 30 hours per week.

Designated elected officials who are serving in an active capacity.

Economic Development employees working at least 30 hours per week.

A retired person, as defined by the Group, who resides within the state of Colorado or maintains a permanent residency within the state of Colorado.

Retirees over 65 years of age, actively enrolled in Medicare, are not eligible for coverage.

Eligible Dependent(s) are defined as –

Your legal spouse through marriage, civil union or common law (a notarized common law affidavit is required).

Your or your Spouse's child/children under the age of 26.

A child born as a result of a Member acting as a gestational carrier is not an eligible Dependent under the terms of this plan unless the Subscriber or Spouse is the legal guardian of the child. Proof of legal guardianship must be submitted to the Group's benefit administrator.

Children placed for adoption or for whom you have permanent legal guardianship.

An unmarried dependent child of any age, who is medically certified as disabled, and dependent upon you in compliance with Colorado state law.

A child for whom health care coverage is required through a Qualified Medical Child Support Order.

The section titled "**Miscellaneous Provisions**" is hereby amended with the addition of the following language:

Group is not subject to ERISA guidelines.

Enrollment applications must be submitted to the Group within 31 days of eligibility.

Group must be notified within 31 days of a newborn's birth, adoption of a child or placement for adoption of a child.

If the addition of the newborn or newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn or newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to (A) pay the new amount due for coverage within the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.

Termination for Noncompliance with Medicare Membership Requirements is not applicable to Group.

Group requires retirees covered under the commercial plan; who live in Colorado, but reside outside the Denver/Boulder Service Area, to obtain all routine care at Kaiser Permanente Medical Office Buildings located in Denver/Boulder, Southern Colorado, Northern Colorado or Mountain Colorado Service Areas only. Group requires these retirees to receive hospital services at contracted hospitals in the Denver/Boulder Service Area.

Deductible language is not applicable to Group.

Dependent student limiting age requirement language is not applicable to Group.

Medicare is primary after 30 months from the date of the first dialysis, for active employees and dependents of active employees who qualify for Medicare due to End Stage Renal Disease (ESRD), therefore Medicare Combo Rates are included in the contract.

In the case of the death of a retired Participant, continued coverage is available for eligible dependents who are enrolled in the plan prior to the death of the retired Participant.

THIS AMENDMENT IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2019
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE: _____, 2019

GROUP: County of Adams

BY: _____
GROUP REPRESENTATIVE

DATE: _____, 2019

HEALTH PLAN: Kaiser Foundation Health Plan of Colorado

BY: _____
HEALTH PLAN AUTHORIZED REPRESENTATIVE

PLEASE RETURN A SIGNED COPY OF THIS AMENDMENT TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

APPROVED AS TO FORM
COUNTY ATTORNEY

AMENDMENT TWO
2019 GROUP AGREEMENT
MEDICARE EMPLOYEES

This document amends the January 1, 2019, Group Agreement (*"Agreement"*) between **Kaiser Foundation Health Plan of Colorado** (*"Health Plan"*) and **County of Adams** (*"Group"*).

The section titled "**Contribution and Participation Requirements**" is hereby amended with the addition of the following language:

An Eligible Person is defined as –

A regular full-time employee or project designated employee of the Group who is scheduled to work at his or her job at least 40 hours per week or a regular part-time employee or project designated employee of the Group who is scheduled to work at his or her job at least 30 hours per week.

Designated elected officials who are serving in an active capacity.

Economic Development employees working at least 30 hours per week.

A retired person, as defined by the Group, who resides within the state of Colorado or maintains a permanent residency within the state of Colorado.

The section titled "**Miscellaneous Provisions**" is hereby amended with the addition of the following language:

Group is not subject to ERISA guidelines.

Enrollment applications must be submitted to the Group within 31 days of eligibility.

Termination for Noncompliance with Medicare Membership Requirements is not applicable to Group.

For Members entitled to Medicare, Medicare is the primary coverage except when federal law (TEFRA) requires that Group's health care plan be primary and Medicare coverage be secondary.

Medicare is primary after 30 months from the date of the first dialysis, for active employees and dependents of active employees who qualify for Medicare due to End Stage Renal Disease (ESRD), therefore Medicare Combo Rates are included in the contract.

In the case of the death of a retired Participant, continued coverage is available for eligible dependents who are enrolled in the plan prior to the death of the retired Participant.

THIS AMENDMENT IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2019
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE: _____, 2019

GROUP: County of Adams

BY: _____
GROUP REPRESENTATIVE

DATE: _____, 2019

HEALTH PLAN: Kaiser Foundation Health Plan of Colorado

BY: _____
HEALTH PLAN AUTHORIZED REPRESENTATIVE

PLEASE RETURN A SIGNED COPY OF THIS AMENDMENT TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

APPROVED AS TO FORM
COUNTY ATTORNEY
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AMENDMENT THREE
2019 GROUP AGREEMENT
SENIOR ADVANTAGE MEDICARE

This document amends the January 1, 2019, Group Agreement (*"Agreement"*) between **Kaiser Foundation Health Plan of Colorado** (*"Health Plan"*) and **County of Adams** (*"Group"*).

The section titled "**Contribution and Participation Requirements**" is hereby amended with the addition of the following language:

An Eligible Person is defined as –

A retired person, as defined by the Group, who resides within the Denver/Boulder service area as defined in the Evidence of Coverage for Senior Advantage, actively enrolled in Medicare A & B.

The section titled "**Miscellaneous Provisions**" is hereby amended with the addition of the following language:

Group is not subject to ERISA guidelines.

In the case of the death of a retired Participant, continued coverage is available for eligible dependents who are enrolled in the plan prior to the death of the retired Participant.

THIS AMENDMENT IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 01, 2019
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE: _____, 2019

GROUP: County of Adams

BY: _____
GROUP REPRESENTATIVE

DATE: _____, 2019

HEALTH PLAN: Kaiser Foundation Health Plan of Colorado

BY: _____
HEALTH PLAN AUTHORIZED REPRESENTATIVE

PLEASE RETURN A SIGNED COPY OF THIS AMENDMENT TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

APPROVED AS TO FORM
COUNTY ATTORNEY

AMENDMENT FOUR
2019 GROUP AGREEMENT
MEDICARE EMPLOYEES (LIS)

This document amends the January 1, 2019, Group Agreement (*"Agreement"*) between **Kaiser Foundation Health Plan of Colorado** (*"Health Plan"*) and **County of Adams** (*"Group"*).

The section titled "**Subscriber Contributions for Medicare Part D Coverage**" is hereby amended with the addition of the following language:

- Health Plan will mail monthly Low Income Subsidy refund payments for that portion of its Senior Advantage health care premium representing prescription drug coverage provided pursuant to Medicare Part D.
- These Low Income Subsidy payments will be mailed directly to Members enrolled in Kaiser Permanente Senior Advantage health plans.

THIS AMENDMENT IS EXECUTED AT DENVER, COLORADO TO TAKE EFFECT AS OF:
JANUARY 1, 2019
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE: _____, 2019

GROUP: County of Adams

BY: _____
GROUP REPRESENTATIVE

DATE: _____, 2019

HEALTH PLAN: Kaiser Foundation Health Plan of Colorado

BY: _____
HEALTH PLAN AUTHORIZED REPRESENTATIVE

PLEASE RETURN A SIGNED COPY OF THIS AMENDMENT TO KAISER PERMANENTE AND RETAIN ONE COPY FOR YOUR RECORDS.

APPROVED AS TO FORM
COUNTY ATTORNEY

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Kaiser Permanente," "Health Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

This EOC is for your Group's 2019 contract year.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-632-9700** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the identical heading in the "Benefits/Coverage (What Is Covered)" section and to the “Limitations/Exclusions (What Is Not Covered)” section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

Here is some important information to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the “Definitions” section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the “Benefits/Coverage (What is Covered)” section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. In addition to any Copayment or Coinsurance, you may be responsible for any amounts over usual, reasonable and customary charges.
6. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
7. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
8. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
9. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.
10. The family Deductible and OPM amounts are applicable for a newborn child, even if the newborn is covered only for the first 31 days that is required by state law.

I. DEDUCTIBLES

There is no medical Deductible. If your Group has purchased a supplemental prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply *only* to the pharmacy Deductible.

The pharmacy Deductible represents the full amount you must pay for prescription drugs before any Copayment or Coinsurance applies. Prescription drugs may or may not be subject to the pharmacy Deductible. It depends on the plan your Group has purchased.

A. For prescription drugs that **ARE** subject to the pharmacy Deductible:

   1. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.

   2. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements").

   3. Your applicable Copayment, Coinsurance, and pharmacy Deductible may not apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

B. For prescription drugs that **ARE NOT** subject to the pharmacy Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts over usual, reasonable and customary charges will not apply toward the OPM.

A. For covered Services that **APPLY** to the OPM.

   1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").

   2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

B. For covered Services that do **NOT APPLY** to the OPM.

   1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").

   2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

Tracking Pharmacy Deductible and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will send you an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your pharmacy Deductible and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call **Member Services**.

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Out-of-Pocket Maximum	
EMBEDDED OPM	$2,000/Individual per Accumulation Period $4,500/Family per Accumulation Period
An Embedded OPM means: • Each individual family Member has his or her own OPM. • If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. • After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.	

Office Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits *(Does not apply to Out-of-Pocket Maximum)*	$15 Copayment each visit
Specialty care visits *(Does not apply to Out-of-Pocket Maximum)*	$25 Copayment each visit
Consultations with clinical pharmacists *(Does not apply to Out-of-Pocket Maximum)*	$15 Copayment each visit
Allergy evaluation and testing *(Does not apply to Out-of-Pocket Maximum)*	$25 Copayment each visit
Allergy injections *(Does not apply to Out-of-Pocket Maximum)*	$15 Copayment each visit Copayment may apply for allergy serum
Gynecology care visits *(Does not apply to Out-of-Pocket Maximum)*	$25 Copayment each visit
Routine prenatal and postpartum visits *(Does not apply to Out-of-Pocket Maximum)*	No Charge
Office-administered drugs *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance (prostate cancer drugs only) All other office-administered drugs @ No Charge
• Travel immunizations	No Charge
Virtual Care Services	
• Email	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a doctor online via kp.org	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Telephone visits	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit

Outpatient Hospital and Surgical Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities *(Applies to Out-of-Pocket Maximum)*	$200 Copayment each surgery
Outpatient hospital Services *(Does not apply to Out-of-Pocket Maximum)*	No Charge

Hospital Inpatient Care	You Pay
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) *(Applies to Out-of-Pocket Maximum)*	$250 Copayment per admission
Inpatient professional Services *(See above line under "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See above line under "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Alternative Medicine	You Pay
Chiropractic care	
• Evaluation and/or manipulation *(Does not apply to Out-of-Pocket Maximum)*	$15 Copayment each visit Up to 20 visits per year See Additional Provisions
• Laboratory Services or x-rays required for chiropractic care *(See "X-ray, Laboratory, and X-ray Special Procedures" for Out-of-Pocket Maximum information.)*	See "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Ambulance Services	You Pay
(Applies to Out-of-Pocket Maximum)	20% Coinsurance Up to $500 per trip

Bariatric Surgery	You Pay
(Does not apply to Out-of-Pocket Maximum)	30% Coinsurance Includes inpatient and outpatient covered Services

Chemical Dependency Services	You Pay
Inpatient medical detoxification *(Applies to Out-of-Pocket Maximum)*	$250 Copayment per admission
Inpatient professional Services for medical detoxification *(See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for Out-of-Pocket Maximum information.)*	See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for applicable Copayment or Coinsurance.
Outpatient individual therapy *(Does not apply to Out-of-Pocket Maximum)*	$15 Copayment each visit $15 Copayment per partial hospitalization day
Outpatient group therapy *(Does not apply to Out-of-Pocket Maximum)*	50% of individual therapy Copayment
Residential rehabilitation *(Applies to Out-of-Pocket Maximum)*	$250 Copayment per inpatient admission

Dental Services following Accidental Injury	You Pay
(Does not apply to Out-of-Pocket Maximum)	Not Covered

Dialysis Care	You Pay
(Does not apply to Out-of-Pocket Maximum)	$25 Copayment each visit

Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
Durable Medical Equipment *(Does not apply to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
• Breast pumps *(Applies to Out-of-Pocket Maximum)*	Not Covered
Prosthetic devices	
• Internally implanted prosthetic devices *(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)*	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg *(Does not apply to Out-of-Pocket Maximum)*	20% Coinsurance
• All other prosthetic devices *(Does not apply to Out-of-Pocket Maximum)*	20% Coinsurance
Orthotic devices *(Does not apply to Out-of-Pocket Maximum)*	20% Coinsurance
Oxygen *(Does not apply to Out-of-Pocket Maximum)*	20% Coinsurance
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan and non-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Does not apply to Out-of-Pocket Maximum)*	$150 Copayment each visit Excludes X-ray special procedures. Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. If X-ray special procedures are excluded, see "X-ray, Laboratory, and X-ray Special Procedures" for applicable Copayment or Coinsurance.

Urgent Care	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan Facility within Service Area *(Does not apply to Out-of-Pocket Maximum)*	$50 Copayment each visit Urgent care may require additional Services described elsewhere in this Schedule of Benefits (for example: Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures). See the appropriate section for applicable Copayment, Coinsurance, and Deductible information.
Urgent care outside Service Area *(Does not apply to Out-of-Pocket Maximum)*	$50 Copayment each visit Urgent care may require additional Services described elsewhere in this Schedule of Benefits (for example: Office Services, Durable Medical Equipment, X-ray, Laboratory, and X-ray Special Procedures). See the appropriate section for applicable Copayment, Coinsurance, and Deductible information.
Covered only if <u>all</u> the following requirements are met: • The care is required to prevent serious decline of health • The need for care results from an unforeseen illness or injury when temporarily away from our Service Area • The care cannot be delayed until you return to our Service Area	

Family Planning and Sterilization Services	You Pay
Family planning counseling *(See "Office Services" for Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures *(See "Outpatient Hospital and Surgical Services" for Out-of-Pocket Maximum information).*	See "Outpatient Hospital and Surgical Services" for applicable Copayment or Coinsurance.

Health Education Services	You Pay
Training in self-care and preventive care *(See "Office Services" for Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist *(Does not apply to Out-of-Pocket Maximum)*	$15 Copayment each visit
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist *(Does not apply to Out-of-Pocket Maximum)*	$25 Copayment each visit
Hearing aids for Members up to age 18 *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
• Fitting and recheck Visits *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
Hearing aids for Members age 18 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and recheck Visits *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Physician *(Does not apply to Out-of-Pocket Maximum)*	No Charge

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care *(Does not apply to Out-of-Pocket Maximum)*	No Charge
Hospice care for terminally ill patients *(Home-Based does not apply to Out-of-Pocket Maximum* *Inpatient applies to Out-of-Pocket Maximum)*	No Charge for Home-Based

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Applies to Out-of-Pocket Maximum)*	$250 Copayment per admission
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization *(See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for Out-of-Pocket Maximum information.)*	See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for applicable Copayment or Coinsurance.
Outpatient individual therapy *(Does not apply to Out-of-Pocket Maximum)*	$15 Copayment each visit $15 Copayment per partial hospitalization day
Outpatient group therapy *(Does not apply to Out-of-Pocket Maximum)*	50% of individual therapy Copayment

Out-of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and chemical dependency, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections. Office vists do not include: allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, hearing aids, hearing tests, home health visits, hospice services, and applied behavioral analysis (ABA))* *Visit: (Applies to Out-of-Pocket Maximum)* *Other Services: (Do not apply to Out-of-Pocket Maximum)* *Preventive immunizations: (Applies to Out-of-Pocket Maximum)*	Visit: $15 Copayment Other Services received during an office visit: Not Covered Limited to 5 visits per Accumulation Period Preventive immunizations: No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance Limited to 5 diagnostic X-rays per Accumulation Period
Outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	Visit: $15 Copayment Limited to 5 therapy visits (any combination) per Accumulation Period
Outpatient prescription drugs *(Not subject to pharmacy Deductible)*	Limited to 5 prescription drug fills per Accumulation Period
• Copayment/Coinsurance (except as listed below) *(See "Prescription Drugs, Supplies, and Supplements" for Out-of-Pocket Maximum information.)*	See "Prescription Drugs, Supplies, and Supplements" for applicable Copayment or Coinsurance.
• Prescribed diabetic supplies *(See "Prescription Drugs, Supplies, and Supplements" for Out-of-Pocket Maximum information.)*	See "Prescription Drugs, Supplies, and Supplements" for applicable Copayment or Coinsurance.
• Preventive drugs o Contraceptive drugs *(See "Prescription Drugs, Supplies, and Supplements" for Out-of-Pocket Maximum information.)*	See "Prescription Drugs, Supplies, and Supplements" for applicable Copayment or Coinsurance.
o Over the counter (OTC) items: *(Includes federally mandated over the counter items)*	No Charge
o Tobacco cessation drugs	No Charge

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility *(Applies to Out-of-Pocket Maximum)*	No Charge Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational, and speech therapy visits *(Does not apply to Out-of-Pocket Maximum)*	
• Habilitative Services	$15 Copayment each visit Up to 20 visits per therapy per Accumulation Period
• Rehabilitative Services	$15 Copayment each visit Up to 20 visits per therapy per Accumulation Period
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder *(Does not apply to Out-of-Pocket Maximum)*	$15 Copayment each visit
Applied Behavioral Services	
• Applied Behavior Analysis (ABA) (*Does not apply to Out-of-Pocket Maximum)*	$15 Copayment each visit

Pulmonary rehabilitation *(Does not apply to Out-of-Pocket Maximum)*	$5 Copayment each visit

Prescription Drugs, Supplies, and Supplements	**You Pay**
Outpatient prescription drugs *(Does not apply to Out-of-Pocket Maximum)*	
• Pharmacy Deductible	Not Applicable
• Copayment/Coinsurance (except as listed below):	$15 Generic/$30 Brand name
• Infertility drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Over the counter (OTC) items: *(Includes federally mandated over the counter (OTC) items . OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)*	No Charge
• Prescribed supplies *(When obtained from sources designated by Kaiser Permanente)* *(Does not apply to Out-of-Pocket Maximum)*	20% Coinsurance
• Prescription contraceptives *(Supply limit according to applicable law)* *(Does not apply to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Preventive tier drugs	See applicable Outpatient prescription drug Copayment/Coinsurance
• Sexual dysfunction drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty drugs *(Do not apply to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Tobacco cessation drugs	No Charge
Supply Limit	
• Day supply limit	30 days
• Mail-order supply limit	$30 Generic/$60 Brand Up to 90 days See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits *(Does not apply to Out-of-Pocket Maximum)* • Adult preventive care exams and screenings • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge
Colorectal cancer screenings (*Does not apply to Out-of-Pocket Maximum)* • Colonoscopies • Flexible sigmoidoscopies	 No Charge No Charge
Preventive Virtual Care Services *(Applies to Out-of-Pocket Maximum)* • Email • Chat with a doctor online via kp.org • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam	See “Office Services” or “Laboratory Services” for applicable Copayment or Coinsurance

Reconstructive Surgery	You Pay
(See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for Out-of-Pocket Maximum information.)	See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility (including lab and X-ray) *(Does not apply to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
Intrauterine insemination (IUI) *(Does not apply to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
In Vitro Fertilization (IVF) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Gamete Intrafallopian Transfer (GIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Zygote Intrafallopian Transfer (ZIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Skilled Nursing Facility Care	You Pay
(Does not apply to Out-of-Pocket Maximum)	No Charge Up to 100 days per Accumulation Period

Transplant Services	You Pay
(See “Office Services”, “Outpatient Hospital and Surgical Services”, or “Hospital Inpatient Care” for Out-of-Pocket Maximum information.)	See “Office Services”, “Outpatient Hospital and Surgical Services”, or “Hospital Inpatient Care” for applicable Copayment or Coinsurance

Vision Services and Optical	You Pay
Eye exams for treatment of injuries and/or diseases	See "Office Services" for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Does not apply to Out-of-Pocket Maximum)* *Refraction test: (Does not apply to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit Test: $15 Copayment each visit
• Members age 19 and over *Visit: (Does not apply to Out-of-Pocket Maximum)* *Refraction test: (Does not apply to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit Test: $15 Copayment each visit
Routine eye exam when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *Visit: (Does not apply to Out-of-Pocket Maximum)* *Refraction test: (Does not apply to Out-of-Pocket Maximum)*	Visit: $25 Copayment each visit Test: $25 Copayment each visit
• Members age 19 and over *Visit: (Does not apply to Out-of-Pocket Maximum)* *Refraction test: (Does not apply to Out-of-Pocket Maximum)*	Visit: $25 Copayment each visit Test: $25 Copayment each visit
Optical hardware	
• Members up to the end of the calendar year he/she turns age 19 *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Members age 19 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory, and X-ray Special Procedures	You Pay
Diagnostic laboratory Services *(Does not apply to Out-of-Pocket Maximum)*	No Charge
Diagnostic X-ray Services *(Does not apply to Out-of-Pocket Maximum)*	No Charge
Therapeutic X-ray Services *(Does not apply to Out-of-Pocket Maximum)*	$25 Copayment each visit
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine *(Does not apply to Out-of-Pocket Maximum)* • Diagnostic procedures include administered drugs • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office-administered Drugs".)*	$100 Copayment per procedure Copayment waived if X-ray special procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with a non-Plan Provider *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and chemical dependency individual therapy, and short-term outpatient physical, occupational, or speech therapy visits with a non-Plan Provider. Visits include phone or email virtual care Services. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with a non-Plan Provider. Visits include phone or email virtual care Services. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Covered Services received during an office visit with a non-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Prescription Drug fill maximum per Accumulation Period	Not Applicable
• Outpatient prescription drugs filled at a non-Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Outpatient prescription drugs prescribed by a non-Plan Provider and filled at a Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the “Eligibility” section in the EOC.

Additional Provisions

Please see “Additional Provisions” for any supplemental information that applies to your coverage.

CONTACT US

Appointments and Medical Advice (Advice Nurses) – Available 24 hours a day, 7 days a week	
CALL	***Denver/Boulder*** Members: **303-338-4545** or toll-free **1-800-218-1059** ***Southern Colorado*** Members: **1-800-218-1059** ***Northern Colorado*** Members**: 970-207-7171** or toll-free **1-800-218-1059** ***Mountain Colorado*** Members: **970-207-7171** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health	
CALL	***Denver/Boulder*** Members: **303-471-7700** ***Southern Colorado*** Members: **1-866-702-9026** ***Northern Colorado*** Members: **303-471-7700** ***Mountain Colorado*** Members: **1-866-702-9026**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services	
CALL	***Denver/Boulder*** Members: **303-338-3800** or toll-free **1-800-632-9700** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-844-201-5824** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**kp.org**

Appeals Program	
CALL	**303-344-7933** or toll free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department	
CALL	***Denver/Boulder*** Members: **303-338-3600** or toll-free **1-800-382-4661** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-382-4661** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	***Denver/Boulder*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150** ***Southern Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 372910** **Denver, CO 80237-6910** ***Northern Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150** ***Mountain Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration	
WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Patient Financial Services	
CALL	***Denver/Boulder*** Members: **303-743-5900** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-844-201-5824** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Personal Physician Selection Services	
CALL	***Denver/Boulder*** Members: **303-338-4477** ***Southern Colorado*** Members: **1-855-208-7221** ***Northern Colorado*** Members**: 1-855-208-7221** ***Mountain Colorado*** Members: **1-855-208-7221**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WEBSITE	**kp.org/locations** for a list of providers and facilities

Transplant Administrative Offices	
CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
c. On the first day of membership, the Subscriber must live in our Service Area. Our Service Area is described in the "Definitions" section. You cannot live in another Kaiser regional health plan service area. For the purposes of this eligibility rule these other service areas may change on January 1 of each year. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services**.

2. Subscribers

You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)
b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."
c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).
d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
   i. They are dependent on you or your Spouse; and
   ii. You give us proof of the Dependent's disability and dependency annually if we request it.
e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of: (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

If your plan has different eligibility requirements, please see "Additional Provisions."

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date:

1. New Employees and their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.
For existing Subscribers:
   i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.
   ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.
For existing Subscribers:
   i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.
   ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment".

4. Special Enrollment
You or your Dependent may experience a triggering event that allows a change in your enrollment. Examples of triggering events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The triggering event results in a special enrollment period that usually (but not always) starts on the date of the triggering event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan or, in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's triggering event. To learn more about triggering events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, call **Member Services** to obtain a copy of Health Plan's *Special Enrollment Guide*.

5. Open Enrollment
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred from Enrolling
You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered Services from Plan Providers inside your home Service Area, except as described under the following headings:

- "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Cross Market Access" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.

- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

Your home Service Area is printed on your Health Plan Identification (ID) card. For more information about your ID card, please refer to the "Using Your Health Plan Identification Card" section.

Note: ***Denver/Boulder*** Members do not have access to Affiliated Providers within the ***Denver/Boulder*** Service Area unless authorized by Health Plan. ***Southern, Northern,*** and ***Mountain Colorado*** Members do have access to Affiliated Providers within their home Service Area.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine within your home Service Area. You may also receive a second medical opinion from a Plan Physician upon request. Please refer to the "Second Opinions" section.

   a. ***Denver/Boulder*** Service Area

      You may choose your PCP from our provider directory. To review a list of Plan Providers and their biographies, visit our website. Go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign in to your account online or call **Personal Physician Selection Services**. This team will help you choose a primary care provider, accepting new patients, based on your health care needs.

   b. ***Southern, Northern,*** and ***Mountain Colorado*** Service Areas

      You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, we will assign you one near your home.

      Medical Group contracts with a panel of Affiliated Physicians, specialists, and other health care professionals to provide medical Services in the ***Southern, Northern,*** and ***Mountain Colorado*** Service Areas. You may choose your PCP from our panel of ***Southern, Northern,*** and ***Mountain Colorado*** providers.

      You can find these physicians, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can review a list of ***Southern, Northern,*** and ***Mountain Colorado*** Plan Providers by visiting our website. Go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, call **Personal Physician Selection Services**. This team will help you choose a primary care provider, accepting new patients, based on your health care needs.

      If you are seeking routine or specialty care in ***Denver/Boulder***, you must have a referral from your local PCP with an Authorization from Health Plan. If you do not have an Authorization, you will be billed for the full amount of the office visit Charges. If you are visiting in the ***Denver/Boulder*** Service Area and need urgent or emergency care, you can visit a ***Denver/Boulder*** Plan Facility without a referral. For a referral from a specialist, see the "Access to Other Providers" section. For care in ***Denver/Boulder*** Plan Medical Offices, see "Cross Market Access".

2. Changing Your Primary Care Provider

   a. ***Denver/Boulder*** Service Area

      Please call **Personal Physician Selection Services** to change your PCP. You may also change your PCP online or when visiting a Plan Facility. You may change your PCP at any time.

   b. ***Southern, Northern,*** and ***Mountain Colorado*** Service Areas

      Please call **Personal Physician Selection Services** to change your PCP. Notify us of your new PCP choice by the 15th day of the month. Your selection will be effective on the first day of the following month.

B. Access to Other Providers

1. Referrals and Authorizations

   a. ***Denver/Boulder*** Service Area

      If your Medical Group physician decides that you need covered Services not available from us, he or she will request a referral for you to see a non-Medical Group physician inside or outside our Service Area. This referral request will result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

      An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid. Copayments or Coinsurance for authorized Services are the same as those required for Services provided by a Medical Group physician.

An Authorization is required for Services provided by non-Plan Providers, non-Medical Group physicians, or non-Plan Facilities. If your provider refers you to a non-Medical Group physician, non-Plan Provider, or non-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized by Health Plan and approved in advance. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

b. ***Southern, Northern,*** and ***Mountain Colorado*** Service Areas

If your Medical Group physician decides that you need covered Services not available from us, he or she will request a referral for you to see a non-Medical Group physician inside or outside our Service Area. This referral request will result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid. Copayments or Coinsurance for authorized Services are the same as those required for Services provided by a Medical Group physician.

An Authorization is required for Services provided by non-Plan Providers, non-Medical Group physicians, or non-Plan Facilities. If your provider refers you to a non-Medical Group physician, non-Plan Provider, or non-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized by Health Plan and approved in advance. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Self-Referrals

a. ***Denver/Boulder*** Service Area

In some cases you can refer yourself for consultation (routine office) visits to specialty-care departments within Kaiser Permanente, with the exception of certain specialty-care departments such as the anesthesia clinical pain department. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

You will find specialty-care providers in the Kaiser Permanente Provider Directory for your home Service Area. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

A self-referral provides coverage for routine office visits only. Certain Services other than those provided as part of a routine office visit will not be covered unless authorized by Kaiser Permanente before Services are rendered.

Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) non-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

b. ***Southern, Northern,*** and ***Mountain Colorado*** Service Areas

In some cases you can refer yourself for consultation (routine office) visits to specialty-care departments within Kaiser Permanente, with the exception of certain specialty-care departments such as the anesthesia clinical pain department. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

You will find specialty-care providers in the Kaiser Permanente Provider Directory for your home Service Area. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

A self-referral provides coverage for routine office visits only. Certain Services other than those provided as part of a routine office visit will not be covered unless authorized by Kaiser Permanente before Services are rendered.

Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) non-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

Southern, Northern, and ***Mountain Colorado*** Members may be able to self-refer to Kaiser Permanente Plan Medical Offices in the ***Denver/Boulder*** Service Area (see "Cross Market Access" in this section).

3. Second Opinions
   Upon request and subject to payment of any applicable Copayments or Coinsurance, you may get a second opinion from a Plan Physician about any proposed covered Services.

   If the recommendations of the first and second physician differ regarding the need for surgery (or other major procedure), a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

C. Plan Facilities

Plan Facilities are Plan Medical Offices or Plan Hospitals in our Service Area that we contract with to provide covered Services to our Members.

1. ***Denver/Boulder*** Service Area
   We offer health care at Plan Medical Offices conveniently located throughout the ***Denver/Boulder*** Service Area. At most of our Plan Facilities, you can usually receive all the covered Services you need. This includes specialized care. You are not restricted to a certain Plan Facility. We encourage you to use the Plan Facility in your home Service Area that will be most convenient for you.

   Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

2. ***Southern, Northern,*** and ***Mountain Colorado*** Service Areas
   When you select your PCP, you will receive your Services at that provider's office. You can find ***Southern, Northern,*** and ***Mountain Colorado*** Plan Physicians and their facilities, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can get a copy of the directory by calling **Member Services**. You can also get a list from our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a life or limb threatening emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. The Copayment or Coinsurance for urgent care received in Plan Facilities listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

Urgent care received at a non-Plan Facility inside your Service Area is **not covered**. If you receive care for minor medical problems at non-Plan Facilities inside your Service Area, you will be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized urgent care outside your Service Area. Please see "Urgent Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about urgent care Services outside the Service Area.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization, Deductible, Copayment, and/or Coinsurance, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. Moving Outside of Any Kaiser Regional Health Plan Service Area

If you move to an area not within any Kaiser regional health plan service area, you can keep your membership with Health Plan, if you continue to meet all other eligibility requirements. However, you must go to a Plan Facility in a Kaiser regional health plan service area in order to receive covered Services (except out-of-Plan Emergency Services and urgent care outside the Service Area). If you go to another Kaiser regional health plan service area for care, covered Services, Copayments or Coinsurance will be as described under "Visiting Other Regional Health Plan Service Areas" above.

G. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, claims for Emergency or non-emergency care Services from non-Plan Providers will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership upon 30 days written notice that will include the reason for termination.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

H. Cross Market Access

Members may access certain Services at Kaiser Permanente Colorado Plan Medical Offices outside of their home Service Area.

1. ***Denver/Boulder*** Members
   Denver/Boulder Members have access for certain Services at designated Kaiser Permanente Plan Medical Offices in the ***Southern, Northern,*** and ***Mountain Colorado*** Service Areas. ***Denver/Boulder*** Members do not have access to Affiliated Providers in ***Southern***, ***Northern,*** and ***Mountain Colorado*** unless authorized by Health Plan.

2. ***Southern, Northern,*** and ***Mountain Colorado*** Members
   Southern, Northern, and ***Mountain Colorado*** Members have access for certain Services at any Kaiser Permanente Plan Medical Office in the ***Denver/Boulder, Southern, Northern,*** and ***Mountain Colorado*** Service Areas. ***Southern, Northern***, and ***Mountain Colorado*** Members do not have access to Affiliated Providers outside their home Service Area unless authorized by Health Plan.

Services available to Members at Kaiser Permanente Plan Medical Offices outside of their home Service Area include: primary care; specialty care; urgent care; pharmacy; laboratory; X-ray; vision; and hearing Services. These Services may not be available at all Kaiser Permanente Plan Medical Offices and are subject to change. For more information on what Services you may access outside your designated home Service Area and at which Kaiser Permanente Plan Medical Offices you may receive Services please call **Member Services**.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where specifically noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)"; and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Self-Referrals"; and (b) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and

- You have met any Deductible requirements described in the "Schedule of Benefits (What is Covered)."

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Copayment and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits, Emergency Services, urgent care, and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists (***Denver/Boulder*** Members only).
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. Second opinion.
9. House calls when care can best be provided in your home as determined by a Plan Physician.
10. Medical social Services.
11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Virtual care Services.
13. Office-administered drugs.

    Note: If the following are administered in a Plan Medical Office or during home visits if administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to your Office Services Copayment or Coinsurance.

    Drugs and injectables; radioactive materials used for therapeutic purposes; vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Medical Group's criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at designated Plan Facilities, including an ambulatory surgical center, surgical suite, or outpatient hospital facility.

2. Outpatient hospital Services at designated facilities, including but not limited to: sleep study, stress test, pulmonary function test, any treatment room, or any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Medical Group's criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Areas:

a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
b. Intensive care and related hospital Services.
c. Professional Services of physicians and other health care professionals during a hospital stay.
d. General nursing care.
e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for child birth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn after your discharge are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
f. Meals and special diets.
g. Other hospital Services and supplies, such as:
   i. Operating, recovery, maternity and other treatment rooms.
   ii. Prescribed drugs and medicines.
   iii. Diagnostic laboratory tests and X-rays.
   iv. Blood, blood products and their administration.
   v. Dressings, splints, casts and sterile tray Services.
   vi. Anesthetics, including nurse anesthetist Services.
   vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your group has the bariatric surgery benefit, you must meet Medical Group's criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions
   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.
   b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services

1. Coverage
   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide.

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

E. Chemical Dependency Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Medical Services for alcohol and drug detoxification are covered in the same way as for other medical conditions. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation
   The determination of the need for services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Physician.

   We cover inpatient services and partial hospitalization in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services
   Outpatient rehabilitative Services for the treatment of alcohol and drug dependency are covered when referred by a Plan Physician.

   We cover chemical dependency services whether they are voluntary, or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

Mental health Services required in connection with the treatment of chemical dependency are covered as provided in the "Mental Health Services" section.

4. Chemical Dependency Services Exclusion
   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Physician.

F. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**
   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.
   b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

G. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet all medical criteria developed by Medical Group and by the facility providing the dialysis; and
3. The facility is certified by Medicare and contracts with Health Plan; and
4. A Plan Physician provides a written referral for care at the facility.

After the referral to a dialysis facility, we cover at no Charge: equipment; training; and medical supplies required for home dialysis.

H. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Physician as described below; when prescribed by a Plan Physician during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.

   b. Durable Medical Equipment Exclusions
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost equipment.
      iii. Repair, adjustments, or replacements necessitated by misuse.
      iv. Spare equipment or alternate use equipment.
      v. More than one piece of DME serving essentially the same function, except for replacements.

2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse or loss, when prescribed by a Plan Physician and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

   b. Prosthetic Devices Exclusions
      i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Physician can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
   Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

I. Early Childhood Intervention Services

1. Coverage
   Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are not subject to any Copayments or Coinsurance, or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

   Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
   The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

J. Emergency Services and Urgent Care

1. Emergency Services
   Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition, call 911 or go to the nearest hospital emergency department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and non-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them from Plan Providers.

   You are also covered for medical emergencies anywhere in the world. For information about emergency benefits away from home, please call **Member Services**.

   Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

   a. Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)
      "Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Physician. There may be times when you or a family member may receive Emergency Services from non-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Medical Offices or the emergency room of a Plan Hospital, or the patient may need Emergency Services while traveling outside our Service Area.

      Please refer to "ii. Emergency Services Limitation for non-Plan Providers" if you are hospitalized for Emergency Services.

      i. We cover out-of-Plan Emergency Services as follows:

         A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis, or premature delivery.

         B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if you reasonably believed that your life or limb was threatened in such a manner that the delay in going to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility for your treatment would result in death or serious impairment of health.

      ii. Emergency Services Limitation for non-Plan Providers
         If you are admitted to a non-Plan Hospital, non-Plan Facility, or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

         We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible.

   b. Emergency Services Exclusions
      Continuing or follow-up treatment. We cover only the out-of-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a Plan Facility we designate either inside or outside our Service Area. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

   c. Payment

Our payment is reduced by:

i. any applicable Copayment and/or Coinsurance for Emergency Services and X-ray special procedures performed in the emergency room. The emergency room and X-ray special procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
v. amounts you or your legal representative recover from motor vehicle insurance or because of third party liability.

Note: If you receive out-of-Plan Emergency Services, our payment is also reduced by any other payments you would have had to make if you received the same Services from our Plan Providers. The procedure for receiving reimbursement for out-of-Plan Emergency Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

2. Urgent Care

a. Urgent Care Provided by Plan Providers

i. ***Denver/Boulder*** Service Area

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, Medical Group may determine that urgent care can best be provided in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)". For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

ii. ***Southern, Northern, and Mountain Colorado*** Service Areas

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, Medical Group may determine that urgent care can best be provided in your home. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)". For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

b. Urgent Care Outside the Service Area

There may be situations when it is necessary for you to receive unauthorized urgent care outside your Service Area. Urgent care received from non-Plan Providers outside your Service Area is covered only if all of the following requirements are met:

i. The care is required to prevent serious deterioration of your health; and
ii. The need for care results from an unforeseen illness or injury when you are temporarily away from our Service Area; and
iii. The care cannot be delayed until you return to our Service Area.

c. Payment for Urgent Care Outside the Service Area

Health Plan's payment for covered urgent care Services outside the Service Area is based upon fees that we determine to be usual, reasonable and customary. This means a fee that:

i. does not exceed most Charges which providers in the same area charge for that Service; and
ii. does not exceed the usual Charge made by the provider for that Service; and

iii. is in accordance with standard coding guidelines and consistent with accepted health care reimbursement payment practices.

Note: In addition to any Copayment or Coinsurance, the Member is responsible for any amounts over usual, reasonable and customary charges.

Note: The procedure for receiving reimbursement for urgent care Services outside the Service Area is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals".

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

K. Family Planning and Sterilization Services

1. Coverage
   a. Family planning counseling. This includes counseling and information on birth control.
   b. Tubal ligations.
   c. Vasectomies.

   Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and X-ray Special Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced sterilization.
   b. Acupuncture for the treatment of infertility.
   c. Donor semen or eggs.
   d. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
   e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to intrauterine insemination or conception by artificial means. This includes, but is not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfer.

   Note: See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

L. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

M. Hearing Services

1. Members up to Age 18

   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Older
   a. Coverage

      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

N. Home Health Care

1. Coverage

   We cover skilled nursing care, home health aide Services, physical therapy, occupational therapy, speech therapy, and medical social Services:
   a. only on a Part-Time Care or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered by a Plan Physician and administered by a Plan Provider. Care must be provided under a home health care plan established by the Plan Physician and the approved Plan Provider; and
   d. only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

   Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services.

Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Service performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)".

Note: X-ray, laboratory, and X-ray special procedures are not covered under this section. See "X-ray, Laboratory, and X-ray Special Procedures".

2. Home Health Care Exclusions
   a. Custodial care.
   b. Homemaker Services.
   c. Care that Medical Group determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

O. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for the Special Services Program ("Program"). Coverage of hospice care is described below.

   Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

   The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

   We cover hospice care for terminally ill Members inside our Service Area. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

   If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

   We cover the following Services and other benefits when: (1) prescribed by a Plan Physician and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Kaiser Permanente:
   a. Physician care.
   b. Nursing care.
   c. Physical, occupational, speech, and respiratory therapy.
   d. Medical social Services.
   e. Home health aide and homemaker Services.
   f. Medical supplies, drugs, biologicals, and appliances.
   g. Palliative drugs in accordance with our drug formulary guidelines.
   h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
   i. Counseling and bereavement Services.
   j. Services of volunteers.

P. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Coverage includes evaluation and Services for conditions which, in the judgment of a Plan Physician, would respond to therapeutic management. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy

      We cover: diagnostic evaluation; individual therapy; psychiatric treatment; crisis intervention and stabilization for acute episodes; and psychiatrically oriented child and teenage guidance counseling.

      Visits for the purpose of monitoring drug therapy are covered.

      Psychological testing as part of diagnostic evaluation is covered.

   b. Inpatient Services

We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Physicians and mental health professionals and the following Services and supplies as prescribed by a Plan Physician while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

c. Partial Hospitalization
We cover partial hospitalization in a Plan Hospital-based program.

We cover mental health services whether they are voluntary, or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Court-ordered testing and testing for ability, aptitude, intelligence, or interest.
   c. Services which are custodial or residential in nature.

Q. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
The Out-of-Area Benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and prescription drug fills as covered under this EOC:
   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Chemical dependency visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).
   b. Diagnostic X-rays.
   c. Physical, occupational, and speech therapy visits.
   d. Prescription drug fills.

   See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but not limited to: procedures, laboratory tests, and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
   e. Allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, applied behavior analysis (ABA), hearing tests, hearing aids, home health visits, hospice services, and travel immunizations.
   f. X-ray special procedures, including but not limited to CT, PET, MRI, nuclear medicine.
   g. Any and all Services not listed in the "Coverage" section of this benefit.

R. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
   We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care

requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)".

b. Outpatient Care
We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."

c. Multidisciplinary Rehabilitation Services
We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility or a Skilled Nursing Facility. We also cover multidisciplinary rehabilitation Services without Charge while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

d. Pulmonary Rehabilitation
Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities.

e. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

f. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Physician and Medically Necessary, we cover:
   i. Outpatient physical, occupational, and speech therapy in a Plan Medical Office or other location approved by Health Plan. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.

   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

S. Prescription Drugs, Supplies, and Supplements

We use drug formularies. A drug formulary includes the list of prescription drugs that have been approved by our formulary committees for our Members. Our committees are comprised of Plan Physicians, pharmacists and a nurse practitioner. The committees select prescription drugs for our drug formularies based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. The committees meet regularly to consider adding and removing prescription drugs on the drug formularies. If you would like information about whether a particular drug is included in our drug formularies, please call **Member Services**.

If your prescription drug has a Copayment shown on the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer

medication; and post-surgical immunosuppressive drugs required after a transplant. These base drugs are available only when prescribed by a Plan Physician and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)".

Note: Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

i. We cover:
   (a) prescription contraceptives intended to last:
      (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
      (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
   (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

b. Outpatient Prescription Drugs

Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

i. Prescriptions by Mail

If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We are not licensed to mail medications out of state. Refills of maintenance drugs prescribed by Plan Physicians or Affiliated Physicians may be obtained for up to the day supply by mail order, at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs have a significant potential for waste and diversion. Those drugs are not available by mail-order service. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please contact **Member Services**.

ii. Specialty Drugs

Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

c. Food Supplements

We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Prescribed Supplies and Accessories

Prescribed supplies, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:

i. home glucose monitoring supplies;
ii. disposable syringes for the administration of insulin;
iii. glucose test strips;
iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

For more information, see the "Schedule of Benefits (Who Pays What)." If your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. Some drugs may require prior authorization.
   c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request an exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions".
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Individual drugs determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services".
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics".

T. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Copayment and Coinsurance for those Services.

U. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

V. Reproductive Support Services

Reproductive Support Services are not covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the Reproductive Support Services benefit, see the "Schedule of Benefits (Who Pays What)."

W. Skilled Nursing Facility Care

1. Coverage
   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:
   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products, and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

   Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray, laboratory, and X-ray special procedures, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Skilled Nursing Facility Care Exclusion
   Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

X. Transgender Services

We cover transgender Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet all medical criteria developed by Medical Group to be eligible for coverage. Coverage includes, but is not limited to: office Services, hormone therapy, outpatient surgery, and hospital inpatient care. You pay the applicable Copayment, Coinsurance, and/or Deductible shown on the "Schedule of Benefits (Who Pays What)". For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

Y. Transplant Services

1. Coverage
   Transplants are covered on a limited basis as follows:
   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

   b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.

   c. If all medical criteria developed by Medical Group are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.

2. Related Prescription Drugs
   Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance and are subject to any pharmacy Deductible shown in the "Schedule of Benefits (Who Pays What)."

3. Terms and Conditions
   a. Health Plan, Medical Group, and Plan Physicians do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accordance with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Physician identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

   b. Plan Physicians must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

   c. A Plan Physician must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Physician or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
   a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.
   b. Non-human and artificial organs and their implantation are excluded.
   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.
   d. Travel and lodging expenses are excluded, except that in some situations, when Medical Group or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

Z. Vision Services

1. Coverage
   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)". We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Physician or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Health Plan Medical Offices.

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
   e. Orthoptic (eye training) therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and X-ray Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, which includes but is not limited to isotopes, electrocardiograms, electroencephalograms, mammograms, and ultrasounds.
      ii. Laboratory tests, Services, and materials.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.
      iii. Therapeutic X-ray Services and materials.
      iv. X-ray special procedures such as MRI, CT, PET, and nuclear medicine.
      Note: For X-ray special procedures, you will be billed for each individual procedure performed. As such, if more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Copayment or Coinsurance for X-ray special procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, urgent care, and outpatient surgery. Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.
   b. Inpatient
      During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET, and nuclear medicine are covered without Charge.

2. X-ray, Laboratory, and X-ray Special Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services.
   b. Naturopathy Services.
   c. Massage therapy.
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Custodial or Residential Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine.

5. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Physician, unless the Member is covered for these Services under a dental insurance policy or contract; or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Physician for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

6. **Directed Blood Donations.**

7. **Disposable Supplies.** Disposable supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;
   d. Antiseptics;
   e. Dressings;
   f. Ace-type bandages; and
   g. Any other supplies, dressings, appliances or devices, not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

8. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.

9. **Experimental or Investigational Services:**
   a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
      i. Has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
      ii. Is the subject of a current new drug or new device application on file with the FDA; or
      iii. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or

iv. Is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
v. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
vi. The Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
vii. Is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
viii. Is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
i. The Member's medical records; and
ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

10. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Medical Group criteria.

11. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased additional supplemental coverage.

12. **Intermediate Care.** Care in an intermediate care facility.

13. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.

14. **Services for Members in the Custody of Law Enforcement Officers.** Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of- Plan Emergency Services or urgent care outside the Service Area.

15. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.

16. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.

17. **Special Education**. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or retardation, including but not limited to attention deficit disorder.

18. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
a. Employment;
b. Participation in employee programs;
c. Insurance;

d. Disability;
e. Licensing;
f. School events, sports, or camp;
g. Governmental agencies;
h. Court order, parole, or probation;
i. Travel.

19. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when Medical Group refers you to a non-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.

20. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.

21. **Weight Management Facilities.** Services received in a weight management facility.

22. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: major disaster; epidemic; war; riot; civil insurrection; disability of a large share of personnel at a Plan Facility; complete or partial destruction of facilities; and labor disputes not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
    i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
    ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.
ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii., a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:

i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order-of-benefits is determined as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
   - The **Plan** covering the **Custodial parent**;
   - The **Plan** covering the spouse of the **Custodial parent**;
   - The **Plan** covering **the non-custodial parent**; and then
   - The **Plan** covering the spouse of the **non-custodial parent**.

C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the

order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties

You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage; or (e) any other liability coverage.

Note: This "Injuries or Illnesses Alleged to be Caused by Other Parties" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against any other party, regardless of whether the other party admits fault. Proceeds of such judgment or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

Equian, LLC
Attn: Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send to Equian: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your attorney, any other party and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian or conservator and any settlement or judgment recovered by the estate, parent, guardian or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of a third party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Surrogacy

In situations where you receive monetary compensation to act as a surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Note: This "Surrogacy" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receives
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian, LLC
Attn: Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the "Schedule of Benefits (Who Pays What)." Payment responsibility information for Emergency Services and urgent care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from non–Plan Providers. If our contract with any Plan

Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by non-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Physicians have telephone access to interpreters in over 150 languages.
3. Plan Physicians can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507)

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from non-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

L. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

M. Group and Members are not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

N. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

O. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

P. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

Q. Out-of-Pocket Maximum Takeover Credit

Out-of-Pocket Maximum Takeover Credit is a one-time event which may occur at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.)
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.)

A credit may be applied toward your Out-of-Pocket Maximum with Health Plan for certain eligible expenses accumulated toward your out-of-pocket maximum under your prior coverage. In order for expenses to be considered for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser**

Permanente Claims Department. To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

R. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

S. Privacy Practices

Kaiser Permanente will protect the privacy of your Protected Health Information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, we may share your PHI with employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail. To request a copy, please call Member Services. You can also find the *Notice of Privacy Practices* on our website at kp.org.

T. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give the Member more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you only need to:

1. Show your Health Plan ID card; and
2. Pay the fee, if any, to the company that provides the value-added service.

Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our:

1. Quarterly member magazine*;* or
2. Website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Dues.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

U. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," and as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination of Membership" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Dues, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or
   b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Physician has made reasonable efforts to promote such a relationship; or
2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Dues from your Group. If your Group fails to pay us the appropriate Dues for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Dues, Health Plan may require payment of any outstanding Dues for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Dues, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)
   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law
   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Dues to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a Subscriber who dies, divorces or legally separates or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the "Eligibility" section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Dues, no later than 30 days after the date on which your Group coverage would otherwise terminate.

   Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Dues to your Group and terminates on the earlier of:
   a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
   b. The date you become covered under another group medical plan; or
   c. The date Health Plan terminates its contract with the Group.

   We may terminate your continuation coverage if payment is not received when due.

   If you have chosen an alternate health care plan offered through your Group, but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA
   If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Dues, Copayments and Coinsurance may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:

a. deny your claim, in whole or in part, including (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
b. terminate your membership retroactively except as the result of non-payment of premiums (also called rescission or cancellation retroactively), or
c. uphold our previous adverse benefit determination when you appeal.

3. An **appeal** is a request for us to review our initial adverse benefit determination.

In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from medical professional licensed pursuant to the Colorado Medical Practice Act acting within the scope of his or her license that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit, then such evidence establishes that the denial is subject to the appeals process.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section.

Language and Translation Assistance
You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative
If you would like someone to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal
You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim
If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal
When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect
If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission).

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals

   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered benefit may be the basis for our denial of your pre-service claim or a post-service claim for payment. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

      Tell Health Plan in writing that you want to make a claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

      If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal thereof, to permit you to pursue an expedited external review.

      We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within the initial 15-day decision period, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

      We will send written notice of our decision to you and, if applicable to your provider.

      If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

      If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

   b. Non-Urgent Pre-Service Appeal

      Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of

the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting; or (c) your attending provider requests that your appeal be treated as urgent. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.

Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our adverse benefit determination at least 24 hours before your ongoing course of covered treatment will end, then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim

Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot

be adequately managed without extending your course of covered treatment; or (c) your attending provider requests that your claim be treated as urgent. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends. If your authorized care ended before you submitted your claim, we will make our decision but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15-day decision period ends and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the timeframe we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment; or (c) your attending provider requests that your claim be treated as urgent. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the end of the initial 30-day decision period ends, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal

Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level Appeal

A Voluntary Second Level Appeal is another review by us that occurs after the mandatory internal appeal decision is communicated to you if you remain dissatisfied with our decision. This in-person review permits you to present evidence to the Second Level Appeal Panel and to ask questions. Choosing a Voluntary Second Level Appeal will not affect your right, if you have one, to request an independent external review.

Here is the procedure for a Voluntary Second Level of Appeal:

Within 30 days from the date of your receipt of our notice regarding your internal appeal, please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination (mandatory internal appeal decision), and (5) all supporting documents. Your request and the supporting documents constitute your request for a Voluntary Second Level of Appeal. You must mail your request to the **Appeals Program**.

Within sixty (60) calendar days following receipt of your request, Health Plan will hold a Second Level Appeal meeting. Health Plan shall notify you of the date on which the Second Level Appeal Panel will meet at least 20 days prior to the date of this in-person meeting. You may request to postpone this date, and your request cannot be unreasonably denied by Health Plan.

You may present your appeal in person before the Second Level Appeal Panel, or request a file review. If you would like to present your appeal in person, but an in-person meeting is not practical, you may present your appeal by telephone. Please indicate in your appeal request how you want to present your appeal. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review.

You may request in writing that Health Plan transmit all material that will be presented to the Second Level Appeal Panel at least five (5) days prior to the date of the Second Level Appeal meeting.

You may submit additional information with your appeal request, or afterwards but no later than five (5) days prior to the date of your Second Level Appeal meeting. Any additional new material developed after this deadline shall be provided to us as soon as practicable. You may present your case to the Second Level Appeal Panel and ask questions of the Panel. You may be assisted or represented by an appointed representative of your choice including an attorney (at your own expense), other advocate or health care professional. If you decide to have an attorney present at the Second Level Appeal meeting, then you must let us know that at least seven (7) days prior to that meeting. You must appoint this attorney as your representative in accordance with our procedures.

We will issue a written decision within seven (7) days of the completion of the Voluntary Second Level Appeal meeting.

If you would like further information about the Voluntary Second Level Appeal process, to assist you in making an informed decision about pursuing a Voluntary Second Level Appeal, please call the **Appeals Program**. Your decision to pursue a Voluntary Second Level Appeal will have no effect on your rights to any other Health Plan benefits, the process for selecting the decision maker and/or the impartiality of the decision maker.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review. However, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have an existing disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Medical Office, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Services**;
   b. Requesting to meet with a Member Services Liaison at the Health Plan Administrative Offices; or
   c. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A Member Services Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The Member Services Liaison or a Plan Physician evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Services**. **Member Services** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Physicians. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Dues, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Physician: Any doctor of medicine contracting with Medical Group to provide covered Services to Members under this EOC.

Authorization: A referral request that has received approval from Health Plan.

Charge(s):

1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan Pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or
4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment: The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Dues: Periodic membership charges paid by Group.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
1. Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: All of the following with respect to an Emergency Medical Condition:
1. A medical screening examination (as required under the *Emergency Medical Treatment and Active Labor Act*) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the *Emergency Medical Treatment and Active Labor Act* requires to Stabilize the patient.

Family Unit: A Subscriber and all of his or her Dependents.

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology, and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Kaiser Permanente: Health Plan and Medical Group.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:
- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan or non-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Dues. This EOC sometimes refers to a Member as "you" or "your."

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A Plan Medical Office or Plan Hospital.

Plan Hospital: Any hospital listed as a Plan Hospital in our provider directory. Plan Hospitals are subject to change at any time without notice.

Plan Medical Office: Any medical office listed in our provider directory, including any outpatient facility designated by Health Plan. Plan Medical Offices are subject to change at any time without notice.

Plan Optometrist: Any licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies are subject to change at any time without notice.

Plan Physician: Any licensed physician who is an employee of Medical Group, an Affiliated Physician or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, Plan Physician or other health care provider that we designate as Plan Provider, except that Plan Providers are subject to change at any time without notice.

Service Area:
The ***Denver/Boulder*** Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park, Teller and Weld counties within the following zip codes: 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231, 80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80252, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80437, 80439, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80514, 80516, 80520, 80530, 80533, 80540, 80544, 80601, 80602, 80603, 80614, 80621, 80640, 80642, 80643.

The ***Mountain Colorado*** Service Area is that portion of Eagle, Garfield, Grand, Routt and Summit counties within the following zip codes: 80423, 80424, 80426, 80435, 80443, 80463, 80497, 80498, 81620, 81631, 81632, 81637, 81645, 81649, 81655, 81657, 81658.

The ***Northern Colorado*** Service Area is that portion of Adams, Boulder, Larimer, Morgan, and Weld counties within the following zip codes: 69128, 69145, 80511, 80512, 80513, 80515, 80517, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80532, 80534, 80535, 80536, 80537, 80538, 80539, 80541, 80542, 80543, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80610, 80611, 80612, 80615, 80620, 80622, 80623, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 82063, 82082.

The ***Southern Colorado*** Service Area is that portion of Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller counties within the following zip codes: 80106, 80118, 80132, 80133, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for both same- and opposite-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same- and opposite-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMPA0AA (01-18)

GRANDFATHERED HEALTH PLAN

Health Plan believes this coverage is a ''grandfathered health plan'' under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call Member Services. (Not applicable to Senior Advantage Plans)

GRFD0AA (01-15)

SURVIVING DEPENDENTS

Your Group coverage includes health benefit coverage for surviving Dependents.

Surviving Spouse and eligible Dependent children may continue coverage in the Group, if they wish.

SRDC0AK (01-08)

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

You must live or work in Health Plan's Service Area at the time of enrollment.

WOR0AA (01-10)

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by contracted providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to contracted providers.

   Note: The following are covered, but not under this section: X-ray and laboratory tests, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.

k. Educational programs.
l. Non-medical self-care or self-help training.
m. All diagnostic testing related to these excluded Services.
n. MRI and/or other types of diagnostic radiology.
o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for Chiropractic Care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CHIR0AA (01-18)
DMES0AB

DURABLE MEDICAL EQUIPMENT (DME)
AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Physician and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional Charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device or orthotic device that adequately meets a Member's medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage:
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. When use is no longer prescribed by a Plan Physician, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.
   b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.
   c. Durable Medical Equipment Exclusions:
      i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
      ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
      iii. Non-medical items such as sauna baths or elevators.
      iv. Exercise or hygiene equipment.
      v. Comfort, convenience, or luxury equipment or features.
      vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings and ace-type bandages. *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
      vii. Replacement of lost equipment.
      viii. Repairs, adjustments or replacements necessitated by misuse.
      ix. More than one piece of DME serving essentially the same function, except for replacements.
      x. Spare equipment or alternate use equipment is not covered.
2. Prosthetic Devices
   a. Coverage
      Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.

iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and when obtained from sources designated by Health Plan.

b. Prosthetic Devices Exclusions:
i. Dental prostheses, except for Medically Necessary prosthodontic treatment for treatment of cleft lip and cleft palate, as described above.
ii. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction.
iii. More than one prosthetic device for the same part of the body, except for replacements.
iv. Spare devices or alternate use devices.
v. Replacement of lost prosthetic devices.
vi. Repairs, adjustments or replacements necessitated by misuse.

3. Orthotic Devices
a. Coverage
Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

b. Orthotic Devices Exclusions:
i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accord with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Physician, unless the Member is covered for these Services under a dental insurance policy or contract.
iii. Experimental and research braces.
iv. More than one orthotic device for the same part of the body, except for covered replacements.
v. Spare devices or alternate use devices.
vi. Replacement of lost orthotic devices.
vii. Repairs, adjustments or replacements necessitated by misuse.

DMES0AB (01-16)

REPRODUCTIVE SUPPORT SERVICES

1. Coverage
We cover the following Services as shown on the "Schedule of Benefits (Who Pays What)":

a. Services for diagnosis and treatment of involuntary infertility (including X-ray and laboratory tests).
b. Intrauterine insemination (IUI).
c. Office administered drugs supplied and used during an office visit for IUI.

Note: Prescription drugs are not covered under this section. See "Prescription Drugs, Supplies, and Supplements" in the "Schedule of Benefits (Who Pays What)" to determine if you have coverage for prescription drugs received from a Plan Pharmacy for IUI.

2. Limitations
a. IUI coverage is limited to three (3) treatment cycles per lifetime.
b. Services are covered only for the person who is the Member.

3. Exclusions
These exclusions apply to fertile as well as infertile individuals or couples.
a. Any and all Services to reverse voluntary, surgically induced infertility.
b. Acupuncture for the treatment of infertility, unless your Group has purchased additional coverage for this service. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has the acupuncture benefit.
c. Donor semen or eggs.
d. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy related to the procurement and/or storage of semen and/or eggs, except as listed in the "Coverage" section of this benefit.
e. Prescription drugs received from a pharmacy for infertility services unless prescription drug coverage for infertility is purchased.
f. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy that are related to conception by artificial means, except as listed in the "Coverage" section of this benefit.

This rider amends the EOC to provide limited coverage for Reproductive Support Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

INFT0AA (01-19)

PREVENTIVE SERVICES RIDER

The preventive care Services that are covered under this plan are defined by Health Plan. Please contact Member Services for a complete list of covered Preventive Services under this Plan.

PV0AC (01-13)

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage

   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at kp.org/formulary.

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests. If you are an active Member and the exception request is granted, Health Plan will provide coverage of the non-formulary drug for the duration of the prescription. If the exception request is denied, you, your designee, or your Plan Provider may request an external review of the decision by an independent review organization. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

   Prescribed supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.

   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

   For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs.

   Generic drugs that are available in the United States only from a single manufacturer and that are not listed as generic in the then-current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

   Prescription drugs are covered only when prescribed by a:
   a. Plan Physician and obtained at Plan Pharmacies; or
   b. Physician to whom a Member has been referred by a Plan Physician and obtained at Plan Pharmacies; or
   c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

   Covered drugs include:
   a. Drugs for which a prescription is required by law. Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Physician. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment or Coinsurance, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Physician and the requested brand-name drug. If the brand-name drug is prescribed due to Medical Necessity, you pay only the brand-name Copayment or Coinsurance.

   b. Insulin.

c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.

d. Compounded medications. **Note:** In all Service Areas, if you use a Kaiser Permanente pharmacy, compounded medications must be picked up or mailed from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on *kp.org*, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance. In the ***Southern, Northern,*** and ***Mountain Colorado*** Service Areas, you may fill or refill compounded medications at a network pharmacy.

2. Limitations
   a. Some drugs may require prior authorization.
   b. We may apply Step Therapy to certain drugs. You or your Plan Provider may request an exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)".
   f. Drugs to shorten the length of the common cold.
   g. Drugs to enhance athletic performance.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Individual drugs determined excluded by our Pharmacy and Therapeutics Committee.
   j. Drugs for the treatment of weight control.
   k. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   l. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   m. Drugs administered during a medical office visit.
   n. Medical Foods and Medical Devices.
   o. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the Evidence of Coverage or Membership Agreement to provide coverage for Prescription Drugs. All of the terms, conditions, limitations and exclusions of the Evidence of Coverage or Membership Agreement shall also apply to this rider except where specifically changed by this rider.

RX0BL (01-19)

ELECTIVE ABORTION EXCLUSION

Voluntary, elective abortions and any related Services, drugs or supplies are excluded. Exceptions to this are:

1. When an abortion is Medically Necessary to preserve the life or health of the mother if the pregnancy continues to term; or
2. When the pregnancy is the result of an act of rape or incest; or
3. Treatment of complications following an abortion.

TABS0AA (01-12)

NOTES

NOTES

NOTES

Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622
Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.

Aurora, CO 80014-1622

FORWARDING SERVICE REQUESTED

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U.S. POSTAGE
PAID
LOGAN, UT
PERMIT NO. 416

NONPROFIT ORG
U.S. POSTAGE PAID
LOS ANGELES, CA
PERMIT #300

USPS 1000 Approved Poly

664 **********AUTO**ALL FOR AADC 800

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CONTACT NAME
15034 COLUMBINE ST
THORNTON, CO 80602-7364

THORNTON, CO ADAMS

Important plan information

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Evidence of Coverage

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Kaiser Permanente Senior Advantage Group Plan (HMO)

This booklet gives you the details about your Medicare health care and prescription drug coverage during your group's 2019 contract year. It explains how to get coverage for the health care services and prescription drugs you need. This is an important legal document. Please keep it in a safe place.

This plan, Kaiser Permanente Senior Advantage, is offered by Kaiser Foundation Health Plan of Colorado (Health Plan). When this Evidence of Coverage says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage (Senior Advantage).

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

This document is available for free in Spanish. Please contact our Member Services number at **1-800-476-2167** for additional information. (TTY users should call **711.**) Hours are 8 a.m. to 8 p.m., 7 days a week.

Este documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestro Servicio a los Miembros al **1-800-476-2167**. (Los usuarios de la línea TTY deben llamar al **711**). El horario es de 8 a. m. a 8 p. m., siete días a la semana.

This document is available in Braille, large print, or CD if you need it by calling Member Services (phone numbers are printed on the back cover of this booklet).

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2020, and at other times in accordance with your group's agreement with us.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

EG19001DB (MC/11/2018)

KPSA-GROUP-PART D DEN(01-19)

KAISER PERMANENTE®

Medical Benefits Chart: Kaiser Permanente Group Senior Advantage (HMO)

COUNTY OF ADAMS
385 - 002

Services that are covered for you	What you must pay when you get these covered services
Annual out-of-pocket maximum	$2,500/Individual per year
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Alternative therapies *	
Acupuncture	Not Covered
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. • We also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the **911** emergency response system where available) if one of the following is true: ♦ You reasonably believe that you have an emergency medical condition and you reasonably believe that your condition requires the clinical support of ambulance transport services. ♦ Your treating physician determines that you must be transported to another facility because your emergency medical condition is not stabilized and the care you need is not available at the treating facility. • You may need to file a claim for reimbursement unless the provider agrees to bill us (see Chapter 7). • †Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	$195 Copayment per trip

†Your provider must obtain prior authorization from our plan.
***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Annual routine physical exams Routine physical exams are covered if the exam is medically appropriate preventive care in accord with generally accepted professional standards of practice. This exam is covered once every 12 months.	There is no coinsurance, copayment, or deductible for this preventive care. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Bone-mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39. • One screening mammogram every 12 months for women age 40 and older. • Clinical breast exams once every 24 months.	There is no coinsurance, copayment, or deductible for covered screening mammograms. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.

†Your provider must obtain prior authorization from our plan.
***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Cardiac rehabilitation services† Comprehensive programs for cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	
Individual therapy visits.	$15 Copayment each visit or $25 Copayment each visit Copayment dependent upon provider type
Group therapy visits.	Your primary care office visit copayment or $10, whichever is less.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	There is no coinsurance, copayment, or deductible for this cardiovascular disease testing that is covered once every five years. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past three years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Chiropractic services Covered services include: • We cover only Medicare-covered manual manipulation of the spine to correct subluxation. These Medicare-covered services are provided by a participating chiropractor. Please refer to the Provider Directory. If purchased by your group, supplemental chiropractic services. Laboratory Services or X-rays required for Chiropractic care	Your primary care office visit copayment or $20 whichever is less. Referral required. $15 Copayment each visit Up to 20 visits per year See Additional Provisions See Outpatient diagnostic tests and therapeutic services and supplies
Colorectal cancer screening • For people 50 and older, the following are covered: ♦ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • One of the following every 12 months: ♦ Guaiac-based fecal occult blood test (gFOBT). ♦ Fecal immunochemical test (FIT). • DNA-based colorectal screening every 3 years. • For people at high risk of colorectal cancer, we cover a screening colonoscopy (or screening barium enema as an alternative) every 24 months. • For people not at high risk of colorectal cancer, we cover a screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Dental services (from designated providers)*	Please see the Additional Provisions in the back of this booklet to see if your group has purchased coverage for dental services.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.

†Your provider must obtain prior authorization from our plan.
***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Diabetes self-management, training and diabetic services and supplies For all people who have diabetes (insulin and non-insulin users), covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	**No charge**
• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	20% Coinsurance
• Diabetes self-management training is covered under certain conditions. **Note:** You may choose to receive diabetes self-management training from a program outside our plan that is recognized by the American Diabetes Association and approved by Medicare.†	$15 Copayment each visit or $25 Copayment each visit copayment dependent upon provider
Durable medical equipment (DME) and related supplies† (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they	20% Coinsurance See Additional Provisions

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
can special order it for you. The most recent list of suppliers is available on our website at **kp.org/directory**.	
Emergency care	
Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. **You have worldwide emergency care coverage.**	$65 Copayment each visit Includes X-ray special procedures. This copayment does not apply if you are immediately admitted directly to the hospital as an inpatient (it does apply if you are admitted to the hospital as an outpatient; for example, if you are admitted for observation). †If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital.

†Your provider must obtain prior authorization from our plan.
***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Fitness benefit* A health and fitness benefit is provided through SilverSneakers® Fitness Program that includes the following: • A basic fitness membership with access to all participating fitness locations and their basic amenities. • SilverSneakers® group fitness classes, taught by certified instructors that focus on cardiovascular health, muscle strengthening, flexibility, agility, balance, and coordination. • Health education events and social activities focused on overall well-being. • Access to **www.silversneakers.com/member**, a secure online community for members only, with wellness advice and fitness support information. • You can enroll in SilverSneakers® Steps, a self-directed fitness program for members that includes one home kit to help you get fit at home or on the go. The following are not covered: programs, services, and facilities that carry additional charges, such as racquetball, tennis, and some court sports, massage therapy, lessons related to recreational sports, tournaments, and similar fee-based activities. For more information about SilverSneakers® and the list of participating fitness locations in your area, call toll-free **1-888-423-4632** (TTY **711**), Monday through Friday, 8 a.m. to 8 p.m. (EST) or visit **www.silversneakers.com**. Also, you can simply go to a participating fitness location and show your Senior Advantage membership card to enroll in the program. Tivity Health and SilverSneakers are registered trademarks or trademarks of Tivity Health, Inc. and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2018. All rights reserved.	**No charge**
Health and wellness education programs Health and wellness programs include weight management, quitting tobacco, diabetes management, life care planning, prediabetes, and more. Registered dietitians, health coaches, certified diabetes educators, and other health professionals facilitate our classes. We offer in-person, online, and phone options to fit your learning style. Contact Member Services for more details. You can also view information online at **kp.org**.	**No charge**
Hearing services	

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	$15 Copayment each visit
Hearing aids.	Not Covered
Fitting & Recheck visits	$15 Copayment each visit
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover one screening exam every 12 months. For women who are pregnant, we cover up to three screening exams during a pregnancy.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care† Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include but are not limited to: • Part-time or intermittent skilled nursing and home health aide services. To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week. • Physical therapy, occupational therapy, and speech therapy. • Medical and social services. • Medical equipment and supplies.	**No charge** Note: There is no cost-sharing for home health care services and items provided in accord with Medicare guidelines. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply if the item is covered under a different benefit; for example, durable medical equipment not provided by a home health agency.
Home infusion therapy† We cover home infusion supplies and drugs if all of the following are true: • Your prescription drug is on our Medicare Part D formulary (or you have a formulary exception). • We approved your prescription drug for home infusion therapy. • Your prescription is written by a network provider and filled at a network home-infusion pharmacy.	**No charge**

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief. • Short-term respite care. • Home care. ***For hospice services and services that are covered by Medicare Part A or B and are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. **For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:** If you need nonemergency, non–urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services. • *If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare). **For services that are covered by our plan but are not covered by Medicare Part A or B:** We will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4, "What if you're in Medicare-certified hospice." **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, **not** our plan.

†Your provider must obtain prior authorization from our plan.
***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Hospice care for members without Part A For members without Part A, the hospice benefit described earlier in this section does not apply to members who are not enrolled in Medicare Part A. Our plan, rather than Original Medicare, covers hospice care for members who are not enrolled in Medicare Part A. Members must receive hospice services from network providers.	**No charge**
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine. • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary. • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B. • Other vaccines if you are at risk and they meet Medicare Part B coverage rules. We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.
Inpatient hospital care†	
Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. There is no limit to the number of medically necessary hospital days or services that are generally and customarily provided by acute care general hospitals. Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive care or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical, occupational, and speech language therapy. • Inpatient substance abuse services for medical management of withdrawal symptoms associated with substance abuse (detoxification).	$250 Copayment per admission If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. **Note:** If you are admitted to the hospital in 2017 and are not discharged until sometime in 2018, the 2017 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If we provide transplant services at a location outside the pattern of care for transplants in your community, and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. **Note:** Travel and lodging expenses must be authorized by Medical Group when a network physician refers you to an out-of-network provider outside our service area for transplant services. We will pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. For information specific to your situation, please contact your assigned Transplant Coordinator or call the Transplant Administrative Offices at **1-877-895-2705** (TTY users may call **711**). • Blood - including storage and administration. • Physician services **Note:** To be an "inpatient," your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an "inpatient," or an "outpatient," you should ask the hospital staff. You can also find more information in a Medicare fact sheet called, *"Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!*" This fact sheet is available on the Web at **https://www.medicare.gov/Pubs/pdf/11435.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient substance abuse treatment†	
• Substance abuse inpatient medical detoxification.	$250 Copayment per admission
• Substance abuse inpatient rehabilitation.	$250 Copayment per inpatient admission
Inpatient mental health care†	
Covered services include mental health care services that require a hospital stay.	$250 Copayment per admission

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
• We cover up to 190-days per lifetime for inpatient stays in a Medicare-certified psychiatric hospital. The number of covered lifetime hospitalization days is reduced by the number of inpatient days for mental health treatment previously covered by Medicare in a psychiatric hospital. • The 190-day limit does not apply to mental health stays in a psychiatric unit of a general hospital.	
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay†	
If you have exhausted your inpatient mental health or skilled nursing facility (SNF) benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient or SNF stay. However, in some cases, we will cover certain services you receive while you are in the the hospital or SNF. Covered services include but are not limited to: Covered services include: • Physician services. • Diagnostic tests (like lab tests). • X-ray, radium, and isotope therapy including technician materials and services. • Surgical dressings. • Splints, casts and other devices used to reduce fractures and dislocations. • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes (including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition). • Physical therapy, speech therapy, and occupational therapy.	Medicare Part B medical services, will be covered as described under their respective benefit headings: • Physician services, including doctor office visits. • Outpatient diagnostic tests and therapeutic services and supplies. • Prosthetic devices and related supplies. • Outpatient rehabilitation services. • Physical therapy, speech therapy, and occupational therapy.

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew his or her order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members-eligible for Medicare-covered medical nutrition therapy services. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

†Your provider must obtain prior authorization from our plan.
***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Medicare Part B prescription drugs† These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually are not self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services. • Antigens. • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases.	No Charge
• Clotting factors you give yourself by injection if you have hemophilia. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan. • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa). Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	You pay the same cost-sharing for these Part B drugs when dispensed through a network pharmacy as reflected in the prescription drug section below.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • Laboratory tests. • †Blood -including storage and administration.	**No charge**
• †Surgical supplies, such as dressings. • †Splints, casts, and other devices used to reduce fractures and dislocations.	20% Coinsurance
• †X-rays.	No Charge, per x-ray
• †Other outpatient diagnostic tests — special procedures such as MRI, CT, PET scans and nuclear medicine.	$100 Copayment per procedure
• †Radiation (radium and isotope) therapy, including technician, materials and supplies	$25 Copayment
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called, "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/Pubs/pdf/11435.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	
Outpatient individual therapy (includes visits to monitor outpatient drug therapy). "Partial hospitalization" is a structured program of active psychiatric treatment, provided in a hospital outpatient setting or by a community mental health center that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting.	$15 Copayment each visit $15 Copayment per partial hospitalization day
Outpatient group therapy.	50% of individual therapy Copayment

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs)	$15 Copayment each visit
Outpatient substance abuse services We provide treatment and counseling services to diagnose and treat substance abuse (including individual and group therapy visits).	
Outpatient individual therapy	$15 Copayment each visit $15 Copayment per partial hospitalization day
Outpatient group therapy	50% of individual therapy Copayment
Outpatient surgery†, including services provided at hospital outpatient facilities and ambulatory surgical centers	
Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	$200 Copayment each surgery
Prescription drugs	
Deductible for Outpatient prescription drugs	Not Applicable
Initial Coverage Stage • Outpatient prescription drugs and refills copayments/coinsurance (except as listed below) • Total Drug Costs	$15 Generic/$30 Brand name/$30 Specialty/No Charge injectable Part D vaccines Up to $3,820
Coverage Gap Stage • Outpatient prescription drugs and refills copayments/coinsurance (except as listed below) • Out-of-Pocket Costs	$15 Generic/$30 Brand name/$30 Specialty/No Charge injectable Part D vaccines Up to $5,100
• Prescribed supplies and accessories.	No Charge
Infertility drugs.	Not Covered
Sexual dysfunction drugs.	Not Covered
	Supply Limit
Day supply limit.	30 days
Mail-order supply limit.	90 days @ 2 Copayments
Physician/practitioner services, including doctor's office visits	
"Providers" include, but are not limited to, physicians, physician assistants and nurse practitioners.	

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Covered services include: Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location.	
Primary care visits	$15 Copayment each visit
Specialty care visits (doctor or nurse visit).	$25 Copayment each visit
Second opinion by another network provider prior to surgery.	Your primary care office visit copayment or specialty care office visit copayment, as applicable.
Outpatient surgery services†	$200 Copayment each surgery
Consultations with clinical pharmacists	$15 Copayment each visit
Interactive video visits for professional services when care can be provided in this format as determined by a plan provider. Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a plan provider.	No Charge or No Charge copayment dependent upon provider No Charge or No Charge copayment dependent upon provider
Non-routine dental care† (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	See specialty care office visit and Outpatient surgery cost-sharing above.
Chemotherapy visits.	Your specialty care office visit copayment plus your copayment or coinsurance for office-administered drugs.
Allergy injections.	$15 Copayment each visit Copayment may apply for allergy serum
Allergy evaluation and testing.	$25 Copayment each visit
Group visits—Cooperative Health Care Clinic (CHCC), Drop in Group Medical Appointment (DIGMA) and group mental health and substance abuse treatments.	Your primary care office visit copayment or $10 copayment each visit, whichever is less.
Podiatry services	
Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	See primary care office visit, specialty care office visit, and †Outpatient surgery cost-sharing above.

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Prostate cancer screening exams For men age 50 and older, covered services include the following – once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	There is no coinsurance, copayment or deductible for an annual digital rectal exam or PSA test. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive care you receive during or subsequent to the visit.
Prosthetic devices and related supplies† Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision care" later in this section for more detail.	
Prosthetics	20% Coinsurance
Internally implanted prosthetic devices.	(See Hospital Inpatient Care and Outpatient Care for applicable cost-sharing)
Enteral and parenteral nutrition therapy covered under Medicare.	**No Charge**
Prosthetic arm or leg.	20% Coinsurance
Orthotic devices and related supplies.	20% Coinsurance
Oxygen	20% Coinsurance
Pulmonary rehabilitation services.† Comprehensive programs for pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	$5 Copayment each visit
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. • Eligible members are people aged 55–77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. • For LDCT lung cancer screenings after the initial LDCT screening, the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these covered services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurances, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Services to treat kidney disease and conditions	
Covered services include: Kidney disease education services to teach kidney care and help members make informed decisions about their care.	$15 Copayment each visit or $25 Copayment each visit copayment dependent upon provider
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply). Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section called "Medicare Part B prescription drugs".	No Charge

†Your provider must obtain prior authorization from our plan.
***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Skilled nursing facility (SNF) care† (For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") We cover up to 100 days per benefit period of skilled inpatient services in a skilled nursing facility in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body such as blood clotting factors.) • Blood – including storage and administration. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). A SNF where your spouse is living at the time you leave the hospital.	No Charge Up to 100 days per benefit period A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 calendar days in a row. **Note:** If a benefit period begins in 2018 for you and does not end until sometime in 2019, the 2018 cost-sharing will continue until the benefit period ends.

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) **If you use tobacco, but do not have signs or symptoms of tobacco-related disease:** We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. **If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:** We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30–60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication. • Be conducted in a hospital outpatient setting or a physician's office. • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD. • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques. **Note:** SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time, if deemed medically necessary by a health care provider.	$30 Copayment each visit
Urgently needed services	
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or	$40 Copayment each visit

Services that are covered for you	What you must pay when you get these covered services
by out-of-network providers when network providers are temporarily unavailable or inaccessible. Urgently needed services received in a network urgent care department (or facility) and covered out-of-network urgent care when you are temporarily outside our service area. • **Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstance (for example, major disaster). • **Outside our service area:** You have worldwide urgent care coverage when you travel, if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area.	
Vision care	
Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • For people with diabetes, screening for diabetic retinopathy is covered once per year. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, our plan covers the following exams: Routine eye exams (eye refraction exams) to determine the need for vision correction and to provide a prescription for eyeglass lenses.	
Eye exams performed by an optometrist	$15 Copayment each visit
Eye exams performed by an ophthalmologist.	$25 Copayment each visit
For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older: Glaucoma screening once per year.	**No charge**, unless member receives the screening in conjunction with other services, such as a routine eye exam, then member will be charged the applicable copayment.

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these covered services
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. Following Medicare-covered cataract surgery, the member may use their eyewear benefit (if purchased by your group) as described below to pay for upgrades to the Medicare covered eye wear benefit. The Medicare eyewear benefit following cataract surgery is covered per Medicare guidelines.	**No charge**, unless the cost exceeds the allowed Medicare fee schedule.
• If purchased by your group, lenses, frames, medically necessary contact lenses, or cosmetic contact lenses every two years, purchased at a network optical facility. Any part of the eyewear benefit that is not exhausted at the first point of sale may not be used at a later date. This means that any benefit dollars remaining after the first point of sale are forfeited and cannot be applied to copayments for eye exams or contact lens professional fitting fees. • Eyeglasses and contact lenses must be prescribed by an optometrist or ophthalmologist and purchased at a network optical facility. • See exclusions for eye surgery to correct refractive defects and for cosmetic contact lenses that are not medically necessary later in this section.	$100 Credit every 24 months See Additional Provisions *****
"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. The applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.

†Your provider must obtain prior authorization from our plan.

***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

2019 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. You will find a detailed list of topics at the beginning of each chapter.

CHAPTER 1. Getting started as a member

SECTION 1. Introduction

Section 1.1 You are enrolled in Senior Advantage, which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Kaiser Permanente Senior Advantage.

There are different types of Medicare health plans. Senior Advantage is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization). approved by Medicare and run by a private company.

Section 1.2 What is the Evidence of Coverage booklet about?

This **Evidence of Coverage** booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of our plan.

If you are not certain which plan you are enrolled, please call Member Services or your group's benefit administrator.

This plan is offered by Kaiser Foundation Health Plan of Colorado (Health Plan) and it includes Medicare part D prescription drug coverage. When this **Evidence of Coverage** says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage (Senior Advantage).

The words "coverage" and "covered services" refer to the medical care and services and the prescription drugs available to you as a member of our plan.

It's important for you to learn what our plan's rules are and what services are available to you. We encourage you to set aside some time to look through this **Evidence of Coverage** booklet.

If you are confused or concerned or just have a question, please contact Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the Evidence of Coverage

It's part of our contract with you

This **Evidence of Coverage** is part of our contract with you about how we cover your care. Other parts of this contract include your enrollment form, our **Kaiser Permanente 2019 Comprehensive Formulary**, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

If your group renews on January 1st, the **Evidence of Coverage** is in effect for the months in which you are enrolled in Senior Advantage between January 1, 2019, and December 31, 2019,

unless amended. If your group's agreement renews at a later date in 2019, the term of this **Evidence of Coverage** is during that contract period, unless amended. Your group can tell you the term of this **Evidence of Coverage** and whether this **Evidence of Coverage** is still in effect, and give you a current one if this **Evidence of Coverage** has been amended.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2019. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2019. In addition, your group can make changes to the plans and benefits it offers at any time.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer our plan and Medicare renews its approval of our plan.

SECTION 2. What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (or Medicare Part B) (Section 2.2 below tells you about Medicare Part A and Medicare Part B).
- *-and-* you live in our geographic service area (Section 2.3 below describes our service area).
- *-and-* you are a United States citizen or are lawfully present in the United States.
- *-and-* you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services), skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is our plan service area for Senior Advantage

Although Medicare is a federal program, our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Colorado: **Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson and Park.**

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a special enrollment period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important to notify your group's benefits administrator and that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.4 U.S. citizen or lawful presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify us if you are not eligible to remain a member on this basis. We must disenroll you if you do not meet this requirement.

Section 2.5 Group eligibility requirements

You must meet your group's eligibility requirements that we have approved. Your group is required to inform subscribers of its eligibility requirements, such as dependent eligibility requirements (for example, your spouse).

Please note that your group might not allow enrollment to some persons who meet the requirements described under "Additional eligibility requirements" below.

Additional eligibility requirements

Subscriber. You may be eligible to enroll as a subscriber under this **Evidence of Coverage** if you are entitled to subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

If you are a subscriber under this Evidence of Coverage or a subscriber enrolled in a non-Medicare plan offered by your group, the following persons may be eligible to enroll as your dependents under this Evidence of Coverage if they meet all the other requirements described in this section 2.5:

- Your spouse. (Spouse includes a partner in a valid civil union under state law.)
- Your or your Spouse's children (including adopted children, children placed with you for adoption, and foster children) who are under the dependent limiting age. Check with your group to determine the age limit for dependents.

- Other dependent persons who meet all of the following requirements:
  - they are under the dependent limiting age as determined by your group
  - you or your spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).
- Your or your spouse's unmarried children of any age who are medically certified as disabled and dependent upon you or your spouse are eligible to enroll or continue coverage as your dependents if the following requirements are met:
  - they are dependent on you or your spouse; and
  - you give us proof of the dependent's disability and dependency annually if we request it.
- Subscriber's designated beneficiaries as defined by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

Students on medical leave of absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a medically necessary leave of absence remain eligible for coverage until the earlier of (i) one year after the first day of the medically necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under the non-Medicare plan offered by your group. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is medically necessary.

Note: If you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this Evidence of Coverage, you may be able to enroll them as your dependents under a non-Medicare plan offered by your group. Please contact your group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

If your plan has different eligibility requirements, please see "Additional Provisions."

Section 2.5 When you can enroll and when coverage begins

Your group is required to inform you when you are eligible to enroll and what your effective date of coverage is under this **Evidence of Coverage.** If you are eligible to enroll as described in this section, enrollment is permitted and membership begins at the beginning (12 a.m.) of the effective date of coverage, except that:

- Your group may have additional requirements that we have approved, which allow enrollment in other situations.
- The effective date of your Senior Advantage coverage under this **Evidence of Coverage** must be confirmed by the Centers for Medicare & Medicaid Services, as described under "Effective date of Senior Advantage coverage" in this section.

If you are a subscriber under this **Evidence of Coverage** and you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this **Evidence of Coverage**, you may be able to enroll them as your dependents under a non-

Medicare plan offered by your group. Please contact your group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

If you are eligible to be a dependent under this **Evidence of Coverage** but the subscriber in your family is enrolled under a non-Medicare plan offered by your group, the subscriber must follow the rules applicable to subscribers who are enrolling dependents in this Section 2.5.

Effective date of Senior Advantage coverage

After we receive your completed Senior Advantage enrollment form, we will submit your enrollment request to the Centers for Medicare & Medicaid Services for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this **Evidence of Coverage.**

If CMS confirms your Senior Advantage enrollment and effective date, we will send you a notice that confirms your enrollment and effective date. If CMS tell us that you do not have Medicare Part B coverage, we will notify you that you will be disenrolled from Senior Advantage.

New subscribers

When your group informs you that you are eligible to enroll as a subscriber, you may enroll yourself and any eligible dependent by submitting a Health Plan-approved enrollment application and a Senior Advantage enrollment form for each person to your group within 31 days after you become eligible, or as otherwise specified by your group.

Effective date of Senior Advantage coverage. The effective date of Senior Advantage coverage for new subscribers and their eligible family dependents is determined by your group, subject to confirmation by CMS.

Employees who are not enrolled when newly eligible must wait until the next open enrollment period to become members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your group and Health Plan or (ii) they enroll under the provisions described in "Special Enrollment Due to Loss of Other Coverage" below.

Adding new dependents to an existing account

To enroll a dependent who first becomes eligible to enroll after you became a subscriber (such as a new spouse, a newborn child, or a newly adopted child), you must submit a Health Plan-approved enrollment form and a Senior Advantage enrollment form to your group within 31 days after the dependent first becomes eligible, or as otherwise specified by your group.

Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your group and Health Plan or (ii) they enroll under the provisions described in "Special Enrollment Due to Loss of Other Coverage" below.

Effective date of Senior Advantage coverage. The effective date of coverage for newly acquired dependents is determined by your group, subject to confirmation by the Centers for Medicare & Medicaid Services.

Group open enrollment

You may enroll as a subscriber (along with any eligible dependents), and existing subscribers may add eligible dependents, by submitting a Health Plan-approved enrollment application and a Senior Advantage enrollment form for each person to your group during your group's open enrollment period. Your group will let you know when the open enrollment period begins and ends and the effective date of coverage, which is subject to confirmation by CMS.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless you become eligible as described in this "Special enrollment" section.

Special enrollment events

You may enroll as a subscriber (along with any eligible dependents), and existing subscribers may add eligible dependents, by submitting a Health Plan-approved enrollment application and a Senior Advantage enrollment form for each person to your group within 31 days after the enrolling persons lose other coverage, if:

The enrolling persons had other coverage when you previously declined Health Plan coverage for them (some groups require you to have stated in writing when declining Health Plan coverage that other coverage was the reason); and the loss of the other coverage is due to one of the following: For a comprehensive list of qualifying events for special enrollment see your Group's administrator to obtain a copy of your Group's **Evidence of Coverage.**

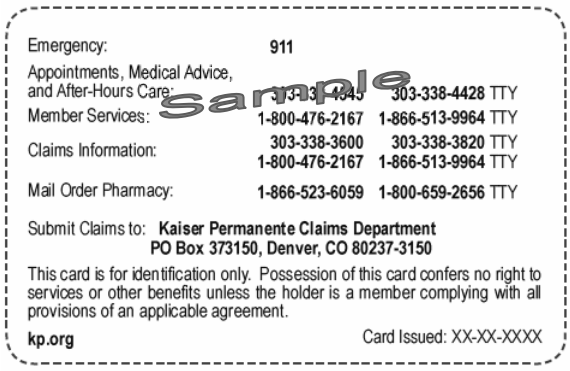
Open enrollment

You may enroll as a subscriber (along with any eligible dependents), and existing subscribers may add eligible dependents, by submitting a Health Plan-approved enrollment application and a Senior Advantage enrollment form for each person to your group during your group's open enrollment period. Your group will let you know when the open enrollment period begins and ends and the membership effective date, which is subject to confirmation by the Centers for Medicare & Medicaid Services.

SECTION 3. What other materials will you get from us?

Section 3.1 Your plan membership card—use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



As long as you are a member of our plan, in most cases, **you must not use your new red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). You may be asked to show your new Medicare card if you need hospital services. Keep your new red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your new red, white, and blue Medicare card instead of using your Senior Advantage membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. Phone numbers for Member Services are printed on the back cover of this booklet.

Section 3.2 The Provider Directory: Your guide to all providers in our network

The **Provider Directory** lists our network providers and durable medical equipment suppliers.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at **kp.org/directory**.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers. See Chapter 3, "Using our plan's coverage for your medical services," for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the **Provider Directory**, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You

can view or download the **Provider Directory** at **kp.org/directory**. Both Member Services and our website can give you the most up-to-date information about our network providers.

Section 3.3 The Pharmacy Directory: Your guide to pharmacies in our network

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the **Pharmacy Directory** to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated **Pharmacy Directory** is located on our website at **kp.org/directory**. You may also call Member Services for updated provider information or to ask us to mail you a **Pharmacy Directory**. Please review the 2019 **Pharmacy Directory** to see which pharmacies are in our network.

If you don't have the **Pharmacy Directory**, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at **kp.org/directory**.

Section 3.4 Our plan's list of covered drugs (formulary)

Our plan has a **Kaiser Permanente 2019 Comprehensive Formulary**. We call it the "Drug List" for short. It tells you which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by our plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved our Drug List. The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of our Drug List. To get the most complete and current information about which drugs are covered, you can visit our website (**kp.org/seniormedrx**) or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 3.5 The Part D Explanation of Benefits (the "Part D *EOB*"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the **Part D Explanation of Benefits** (or the "**Part D EOB**").

The **Part D EOB** tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 ("What you pay for your Part D prescription drugs") gives

you more information
about the **Part D EOB** and how it can help you keep track of your drug coverage.

A **Part D EOB** summary is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet). You can also choose to get your **Part D EOB** online instead of by mail. Please visit **kp.org/goinggreen** and sign on to learn more about choosing to view your **Part D EOB** securely online.

SECTION 4. Your monthly premium for our plan

Section 4.1 How much is your plan premium?

Plan premiums

Your group is responsible for paying premiums. If you are responsible for any contribution to the premiums, your group will tell you the amount and how to pay your group.

SECTION 5. Do you have to pay the Part D “late enrollment penalty”?

Section 5.1 What is the Part D “late enrollment penalty”?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends upon how long you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

If you are required to pay a Part D late enrollment penalty, your group will inform you the amount that you will be required to pay your group.

If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits for failure to pay your plan premium.

Section 5.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2019, this average premium amount is $33.19.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium, and then round it to the nearest 10 cents. In the example here, it would be 14% times $33.19, which equals $4.64. This rounds to $4.60. This amount would be added to the monthly premium for someone with a Part D late enrollment penalty.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, the penalty may change each year because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, you will continue to pay a penalty every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 5.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "creditable drug coverage." **Please note:**
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later. Please

note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.

- The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
- For additional information about creditable coverage, please look in your **Medicare & You** 2019 handbook or call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.

- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 5.4 What can you do if you disagree about your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review within 60 days from the date on the first letter you receive stating you have to pay a late enrollment penalty. If you were paying a penalty before joining our plan, you may not have another change to request a review of that late enrollment penalty. Call Member Services to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 6. Do you have to pay an extra Part D amount because of your income?

Section 6.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, **you must pay an extra amount directly to the government** for your Medicare Part D coverage.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel

Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.

Section 6.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, visit **https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html.**

Section 6.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at **1-800-772-1213** (TTY **1-800-325-0778**).

Section 6.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required by law to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

SECTION 7. More information about your monthly premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 of this chapter, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A and most plan members pay a premium for Medicare Part B. You must continue paying your Medicare premiums to remain a member of our plan.

Some people pay an extra amount for Part D because of their yearly income. This is known as Income Related Monthly Adjustment Amounts, also known as IRMAA. If your income is greater than $85,000 for an individual (or married individuals filing separately) or greater than $170,000 for married couples, you must pay an extra amount directly to the government (not the Medicare plan) for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from our plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan**, will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Section 6 of this chapter. You can also visit **https://www.medicare.gov** on the Web or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or you may call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**.

Your copy of **Medicare & You** 2019 gives you information about Medicare premiums in the section called "2019 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of **Medicare & You** each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of **Medicare & You** 2019 from the Medicare website (**https://www.medicare.gov**) or you can order a printed copy by phone at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

Section 7.1 Paying your plan premium

Your group is responsible for paying premiums. If you are responsible for any contribution to the premiums, your group will tell you the amount and how to pay your group.

Section 7.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for our plan's monthly plan premium during your group's contract year.

However, in some cases, the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 8. Please keep your plan membership record up-to-date

Section 8.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage, including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in our network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up-to-date.

Let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If you receive care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you are participating in a clinical research study.

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 9. We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4, of this booklet.

SECTION 10. How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends upon your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance).
- Liability (including automobile insurance).
- Black lung benefits.
- Workers' compensation.

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2. Important phone numbers and resources

SECTION 1. Kaiser Permanente Senior Advantage contacts
(how to contact us, including how to reach Member Services at our plan)

How to contact our plan's Member Services

For assistance with claims, billing, or membership card questions, please call or write to Senior Advantage Member Services. We will be happy to help you.

Method	Member Services – contact information
CALL	**1-800-476-2167** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	**303-214-6489**
WRITE	Kaiser Foundation Health Plan of Colorado Customer Experience 2500 South Havana Street Aurora, CO 80014-1622
WEBSITE	**kp.org**

How to contact us when you are asking for a coverage decision or making a complaint about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about our plan's coverage or payment, you should look at the section about making an appeal.) For more information about asking for coverage decisions or making complaints about your medical care, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." You may call us if you have questions about our coverage decision or complaint processes.

Method	Coverage decisions or complaints about medical care – contact information
CALL	**1-800-476-2167** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	**1-866-466-4042**
WRITE	Kaiser Foundation Health Plan of Colorado Customer Experience 2500 South Havana Street Aurora, CO 80014-1622
MEDICARE WEBSITE	You can submit a **complaint** about our plan directly to Medicare. To submit an online complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx**.

How to contact us when you are asking for a coverage decision or making a complaint about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about our plan's coverage or payment, you should look at the section below about making an appeal.)

For more information about asking for coverage decisions or making complaints about your Part D prescription drugs, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." You may call us if you have questions about our coverage decision or complaint processes.

Method	Coverage decisions or complaints about Part D prescription drugs – contact information
CALL	**1- 800-476-2167** Calls to this number are free. Monday to Friday, 8:30 a.m. to 5 p.m.

TTY	**711** Calls to this number are free. Monday to Friday, 8:30 a.m. to 5 p.m.
FAX	**1-866-455-1053**
WRITE	Kaiser Foundation Health Plan of Colorado Pharmacy Benefits and Compliance 1975 Research Pkwy, Suite 250 Colorado Springs, CO 80920
WEBSITE	**kp.org**
MEDICARE WEBSITE	You can submit a **complaint** about our plan directly to Medicare. To submit an online complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx**.

How to contact us when you are making an appeal about your medical care or Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information about making an appeal about your medical care or Part D prescription drugs, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."

Method	Appeals for medical care or Part D prescription drugs – contact information
CALL	**1-888-370-9858** Calls to this number are free. Monday through Friday, 8:30 a.m. to 5 p.m.
TTY	**711** Calls to this number are free. Monday through Friday, 8:30 a.m. to 5 p.m.
FAX	**1-866-466-4042**
WEBSITE	**kp.org**
WRITE	Appeals Program Kaiser Foundation Health Plan of Colorado P.O. Box 378066 Denver, CO 80237-8066

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information about situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7, "Asking us to pay our share of a bill you have received for covered medical services or drugs."

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," for more information.

Method	Payment requests – contact information
CALL	**1-800-476-2167** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Foundation Health Plan of Colorado Claims Department P.O. Box 373150 Denver, CO 80237-3150
WEBSITE	**kp.org**

SECTION 2. **Medicare** (how to get help and information directly from the federal Medicare program)

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations, including our plan.

Method	Medicare – contact information
CALL	**1-800-MEDICARE or 1-800-633-4227** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048**

Method	Medicare – contact information
	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	**https://www.medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options, with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about our plan: • **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.)

SECTION 3. State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Colorado, the SHIP is called Colorado State Health Insurance Assistance Program ("Colorado SHIP").

Colorado SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Colorado SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Colorado SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method	Colorado State Health Insurance Assistance Program – contact information
CALL	**1-888-696-7213**
WRITE	SHIP, Colorado Division of Insurance 1560 Broadway St., Ste. 850 Denver, CO 80202
WEBSITE	**https://www.colorado/gov/pacific/dora/senior-healthcare-medicare**

SECTION 4. Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Colorado, the Quality Improvement Organization is called KEPRO.

KEPRO has a group of doctors and other health care professionals who are paid by the federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. KEPRO is an independent organization. It is not connected with our plan.

You should contact KEPRO in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	KEPRO (Colorado's Quality Improvement Organization) – contact information
CALL	**1-844-430-9504** Calls to this number are free. Monday to Friday, 9 a.m. to 5 p.m. Weekends and holidays, 11 a.m. to 3 p.m.
TTY	**1-855-843-4776** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	KEPRO Rock Run Center, Suite 100 5700 Lombardo Center Drive Seven Hills, OH 44131 Attention: Beneficiary Complaints
WEBSITE	https://**www.keproqio.com**

SECTION 5. Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – contact information
CALL	**1-800-772-1213**

Method	Social Security – contact information
	Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday.
WEBSITE	**https://www.ssa.gov**

SECTION 6. **Medicaid** (a joint federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). Some people with QMB are also eligible for full Medicaid benefits (QMB+).
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Health First Colorado (Medicaid).

Method	Health First Colorado (Colorado's Medicaid program) – contact information
CALL	**1-800-221-3943** Calls to this number are free. Monday to Friday, 7:30 a.m. to 5:15 p.m.
TTY	**711**

Method	Health First Colorado (Colorado's Medicaid program) – contact information
WRITE	Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203
WEBSITE	**https://www.healthfirstcolorado.com**

SECTION 7. Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week;
- The Social Security Office at **1-800-772-1213**, between 7 a.m. to 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778** (applications); or
- Your state Medicaid office (applications) (see Section 6 in this chapter for contact information).

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you either to request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

If you aren't sure what evidence to provide us, please contact a network pharmacy or Member Services. The evidence is often a letter from either the state Medicaid or Social Security office that confirms you are qualified for "Extra Help." The evidence may also be state-issued documentation with your eligibility information associated with Home and Community-Based Services.

You or your appointed representative may need to provide the evidence to a network pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate cost-sharing amount until the Centers for Medicare & Medicaid Services (CMS) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to the pharmacy. Please provide your evidence in one of the following ways so we can forward it to CMS for updating:

- Write to Kaiser Permanente at:
  California Service Center
  Attn: Best Available Evidence
  P.O. Box 232407
  San Diego, CA 92193-2407
- Fax it to **1-877-528-8579**.
- Take it to a network pharmacy.

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs to Part D members who have reached the coverage gap and are not receiving "Extra Help." For brand-name drugs, the 70% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 25% of the negotiated price and a portion of the dispensing fee for brand-name drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your **Part D Explanation of Benefits (Part D EOB)** will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them, and move you through the coverage gap. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, we pay 63% of the price for generic drugs and you pay the remaining 37% of the price. For generic drugs, the amount paid by our plan (63%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

The Medicare Coverage Gap Discount Program is available nationwide. Because our plan offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 6, Section 6, for more information about your coverage during the Coverage Gap Stage.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand-name drugs. Also, the plan pays 5% of the costs of brand-name drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?

What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through **Bridging the Gap Colorado**. Note: To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/underinsured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Please call **Bridging the Gap Colorado** at **303-692-2716**.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call **Bridging the Gap Colorado** at **303-692-2716**.

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help," you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand-name drug, you should review your next *Part D Explanation of Benefits* (*Part D EOB*) notice. If the discount doesn't appear on your *Part D EOB*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this chapter)
or by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week.
TTY users should call **1-877-486-2048**.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition or disabilities. Each state has different rules to provide drug coverage to its members.

In Colorado, the name of the State Pharmaceutical Assistance Program is Bridging the Gap Colorado.

Method	Bridging the Gap Colorado - contact information
CALL	**303-692-2716** Monday through Friday, 8 a.m. to 5 p.m.
WRITE	Bridging the Gap Colorado C/O Colorado ADAP A3-3800 4300 Cherry Creek Drive South Denver, Colorado 80246-1530
WEBSITE	**https://www.colorado.gov/pacific/cdphe/colorado-aids-drug-assistance-program-adap**

SECTION 8. How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – contact information
CALL	**1-877-772-5772** Calls to this number are free. Available 9 a.m. to 3:30 p.m., Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.

TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are ***not*** free.
WEBSITE	**https://www.secure.rrb.gov**

SECTION 9. Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. Phone numbers for Member Services are printed on the back cover of this booklet. You may also call **1-800-MEDICARE** (**1-800-633-4227**; TTY: **1-877-486-2048**) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact that group's benefits administrator. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3. Using our plan's coverage for your medical services

SECTION 1. Things to know about getting your medical care covered as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. It gives you definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by our plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the Medical Benefits Chart found at the front of this **EOC**.

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart found at the front of this **EOC**.

Section 1.2 Basic rules for getting your medical care covered by our plan

As a Medicare health plan, our plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

We will generally cover your medical care as long as:

- **The care you receive is included in our plan's Medical Benefits Chart** (found at the front of this **EOC**).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP)** who is providing and overseeing your care. As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
  - In most situations, your network PCP must give you approval in advance before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral" (for more information about this, see Section 2.3 in this chapter).
  - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 in this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. Here are three exceptions:
  - We cover emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider if we authorize the services before you get the care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.3 in this chapter.
  - We cover kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.

SECTION 2. Use providers in our network to get your medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

As a member of our plan, you must choose a network provider to be your primary care provider (PCP). Your PCP is a health care professional who meets state requirements and is trained to give you primary medical care.

Your PCP will provide most of your care and may help you arrange or coordinate the rest of the covered services you get as a member of our plan. This includes your X-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other network providers about your care and how it is going.

There are a few types of covered services you can get on your own without contacting your PCP first (see Section 2.2 in this chapter).

In some cases, your PCP will also need to get prior authorization (prior approval) from us. The services that require prior authorization from us are discussed in Section 2.3 of this chapter.

How do you choose your PCP?

You may choose a primary care provider from any of our available plan physicians who practice in these specialties: internal medicine, family medicine, and pediatrics. When you make a selection, it is effective immediately. To learn how to choose a primary care provider, please call our Personal Physician Selection Services at **1-855-208-7221** (TTY **711**), weekdays 7 a.m. to 5:30 p.m. You can also make your selection at **kp.org**.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our network of providers and you would have to find a new PCP. To change your PCP, call our Personal Physician Selection Team at **1-855-208-7221** or **711** (TTY), weekdays 7 a.m. to 5:30 p.m., or make your selection at **kp.org**.

When you call, be sure to tell our Personal Physician Selection Team if you are seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment). Our Personal Physician Selection Team will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. When you make a new selection, the change is effective immediately.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

You can get the services listed below without getting approval in advance from your PCP:

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations, as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (for example, when you are temporarily outside of our service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.) Phone numbers for Member Services are printed on the back cover of this booklet.
- Consultation (routine office) visits to specialty-care departments within our plan, with the exception of the anesthesia clinical pain department.
- Second opinions from another network provider.
- Mental health care or substance abuse services, as long as you get them from a network provider.

- Preventive care except abdominal aortic aneurysm, prostate specific antigen (PSA) tests, barium enemas, and bone mass measurement, as long as you get them from a network provider.
- Chiropractic services as long as you get them from a network provider.
- Routine eye exams and hearing exams, as long as you get them from a network provider.
- Covered routine care from any Colorado Permanente Medical Group (CPMG) physician at any Kaiser Permanente medical office in our Southern Colorado or Northern Colorado service areas. Note: You cannot get routine care from affiliated network providers in the Southern Colorado or Northern Colorado service areas.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

Referrals from your PCP

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you may get on your own, without getting approval from your PCP first, which are described in Section 2.2 of this chapter.

When your PCP prescribes specialized treatment, he or she will give you a referral to see a plan specialist or certain other network providers. However, for some types of specialty care referrals, your PCP may need to get approval in advance from our plan. If there is a particular plan specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital.

Prior authorization

For the services and items listed below and in Chapter 4, Sections 2.1 and 2.2, your PCP will need to get approval in advance from our plan (this is called getting "prior authorization"). Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

- For **certain specialty care**, your PCP will recommend to our plan that you be referred to a network specialist. The plan will authorize the services if it is determined that the covered services are medically necessary. Referrals to such specialist will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your network physician what services have been authorized. If the specialist wants you to come back for more care, be sure to check if the referral covers more visits to the specialist. If it doesn't, please contact your PCP. You must have an authorized referral for ongoing treatment from a plan specialist except as described in Section 2.2. If you don't have a referral (approval

in advance) before you get certain ongoing services, you may have to pay for these services yourself.

- If your PCP decides that you require **covered services not available from network providers**, he or she will recommend to our plan that you be referred to an out-of-network provider inside or outside our service area. The plan will authorize the services if it is determined that the covered services are medically necessary and are not available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your PCP what services have been authorized. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers more visits to the specialist. If it doesn't, please contact your PCP.
- If your network physician makes a written referral for **bariatric surgery**, the service will be evaluated for medical necessity by our bariatric surgeon and the Metabolic Surgery and Weight Management Department.
- After we are notified that you need **post-stabilization care** from an out-of-network provider following emergency care, we will discuss your condition with the out-of-network provider. If we decide that you require post-stabilization care and that this care would be covered if you received it from a network provider, we will authorize your care from the out-of-network provider only if we cannot arrange to have a network provider (or other designated provider) provide the care. Please see Section 3.1 in this chapter for more information.
- Medically necessary transgender surgery and associated procedures.
- If your specialist makes a written referral for a **transplant**, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the services if it determines that they are medically necessary or covered in accord with Medicare guidelines. In cases where no transplant committee or board exists, the Medical Group will designate a specialist within the group to review and approve your transplant referral. Note: A plan physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us at **1-855-208-7221** (TTY **711**), weekdays, 7 a.m. to 5:30 p.m., so we can assist you in finding a new provider and managing your care.

Section 2.4 How to get care from out-of-network providers

Care you receive from an out-of-network provider will not be covered except in the following situations:

- Emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services mean, see Section 3 in this chapter.
- Our plan authorizes a referral to an out-of-network provider described in Section 2.3 of this chapter.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.
- If you visit the service area of another Kaiser Permanente region, you can receive certain care covered under this **Evidence of Coverage** from designated providers in that service area. Please call Member Services or our away from home travel line at **1-951-268-3900** (24 hours a day, 7 days a week except holidays), TTY **711**, for more information about getting care when visiting another Kaiser Permanente region's service area, including coverage information and facility locations in the District of Columbia and parts of California, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington.

SECTION 3. How to get covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A "medical emergency" is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible**. Call **911** for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency**. We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is listed on the back of your plan membership card.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere inside or outside the United States. We cover ambulance services in situations where getting to the emergency room in any other way could endanger your health. You may get covered emergency medical care (including ambulance) when you need it anywhere in the world (claim forms required). For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. We will cover your follow-up post-stabilization care in accord with Medicare guidelines. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow. It is very important that your provider call us to get authorization for post-stabilization care before you receive the care from the out-of-network provider. In most cases, you will only be held financially liable if you are notified by the out-of-network provider or us about your potential liability.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, we will cover your care as long as you reasonably thought your health was in serious danger.

However, after the doctor has said that it was not an emergency, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- Or the additional care you get is considered "urgently needed services" and you follow the rules for getting these urgently needed services (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in our service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible, and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often answer questions about a minor concern, tell you what to do if a network facility is closed, or advise you about what to do next, including making a same-day urgent care appointment for you if it's medically appropriate. To speak with an advice nurse 24 hours a day, seven days a week, or make an appointment, please call **1-800-218-1059 (**TTY **711).**

What if you are <u>outside</u> our service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, we will cover urgently needed services that you get from any provider. We cover urgently needed services anywhere in the world.

Section 3.3 Getting care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from us.

Please visit the following website**—kp.org—**for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, we will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5, for more information.

SECTION 4. What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay our share of the cost for covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7, "Asking us to pay our share of a bill you have received for covered medical services or drugs," for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

We cover all medical services that are medically necessary, listed in the Medical Benefits Chart (this chart is found at the front of this **EOC**), and obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Any amounts you pay after the benefit has been exhausted will not count toward the out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5. How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study and you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what we will pay.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs:

- We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.
  - Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

- In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following**:

- Generally, Medicare will not pay for the new item or service that the study is testing, unless Medicare would cover the item or service even if you were not in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (**https://www.medicare.gov**). You can also call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTION 6. Rules for getting care covered in a "religious nonmedical health care institution"

Section 6.1 What is a religious nonmedical health care institution?

A religious nonmedical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious nonmedical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (nonmedical health care services). Medicare will only pay for nonmedical health care services provided by religious nonmedical health care institutions.

Section 6.2 What care from a religious nonmedical health care institution is covered by our plan?

To get care from a religious nonmedical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is voluntary and not required by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is not voluntary or is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious nonmedical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to nonreligious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - – and – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Note: Covered services are subject to the same limitations and cost-sharing required for services provided by network providers as described in the Medical Benefits Chart found at the front of the **EOC**, Chapters 4 and 12.

SECTION 7. Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech-generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan, you will not acquire ownership no matter how many copayments you make for the item while a member of our plan.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare before you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in

order to own the item. There are no exceptions to this case when you return to Original Medicare.

CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1. Understanding your out-of-pocket costs for covered services

This chapter and the Medical Benefits Chart found at the front of this **EOC** focuses on your covered services and what you pay for your medical benefits. The Medical Benefits Chart lists your covered services and some limitations and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services. In addition, please see Chapters 3, 11, and 12 for additional coverage information, including limitations (for example, coordination of benefits, durable medical equipment, home health care, skilled nursing facility care, and third party liability).

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A "**copayment**" is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service, unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart found at the front of this **EOC** tells you more about your copayments.)
- "**Coinsurance**" is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service, unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart located found at the front of this **EOC** tells you more about your coinsurance.)
- The "**deductible**" is the amount you must pay for medical services before our plan begins to pay its share for your covered medical services. (**Note**: Not all plans have a deductible.) Until you have paid the deductible amount, you must pay the full cost of your covered services. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance). The deductible does not apply to some services. (The Medical Benefits Chart found at the front of this **EOC** tells you if your plan has a deductible, the deductible amount, and which services are subject to the deductible.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Member Services.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare

Part A and Part B (see the Medical Benefits Chart located at the front of this **EOC**). This limit is called the maximum out-of-pocket amount for medical services.

As a member of our plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2019 is stated in the Medical Benefits Chart found at the front of this **EOC**. The amounts you pay for deductibles (if your plan has a deductible), copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*****) in the Medical Benefits Chart found at the front of this **EOC**.

If you reach the maximum out-of-pocket amount stated in the Medical Benefits Chart found at the front of this **EOC**, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of our plan, an important protection for you is that, after you meet any deductibles (if applicable to your plan), you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends upon which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, we cover services from out-of-network providers only in certain situations, such as when you get a referral.)
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for nonparticipating providers. (Remember, we cover services from out-of-network providers only in certain situations, such as when you get a referral.)

- If you believe a provider has "balance billed" you, call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 2. Use the Medical Benefits Chart at the front of this EOC to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of our plan

The Medical Benefits Chart found at the front of this **EOC** lists the services our plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart found at the front of this **EOC** are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in our plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart found at the front of this **EOC** are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart found at the front of this **EOC** with a footnote (†). In addition, see Section 2.2 in this chapter and Chapter 3, Section 2.3, for more information about prior authorizations, including other services that require prior authorization that are not listed in the Medical Benefits Chart found at the front of this **EOC.**

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others, you pay less. (If you want to know more about the coverage and costs of Original Medicare, look in your **Medicare & You 2019** handbook. View it online at **https://www.medicare.gov** or ask for a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.)

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2019, either Medicare or our plan will cover those services.

 You will see this apple next to the preventive services in the Medical Benefits Chart found at the front of this **EOC**.

SECTION 3. What services are not covered by our plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and, therefore, are not covered by this plan. If a service is "excluded," it means that we don't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception is we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3, in this booklet.)

All exclusions or limitations on services are described in the Medical Benefits Chart at the front of this **EOC** or in the chart below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare		√ This exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.
Experimental medical and surgical procedures, equipment and medications • Experimental procedures and items are those items		√ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community		(See Chapter 3, Section 5 for more information about clinical research studies.)
Private room in a hospital		√ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	√	
Full-time nursing care in your home	√	
Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care • Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	√	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation	√	
Fees charged by your immediate relatives or members of your household	√	
Cosmetic surgery or procedures		√

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings, or dentures		√ Not covered unless your group has purchased coverage. Refer to the Medical Benefits Chart at the front of this **EOC**.
Nonroutine dental care		√ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Routine chiropractic care		√ Manual manipulation of the spine to correct a subluxation is covered. In addition, this exclusion does not apply if your employer purchased coverage for additional chiropractic care. Refer to the Medical Benefits Chart at the front of this **EOC**.
Routine foot care		√ Some limited coverage provided according to Medicare guidelines, for example, if you have diabetes.
Home-delivered meals	√	
Orthopedic shoes		√ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Supportive devices for the feet		√ Orthopedic or therapeutic shoes for people with diabetic foot disease.
Hearing aids		√ This exclusion does not apply if your group has purchased hearing aid coverage. Refer to the Medical Benefits Chart in the front of this **EOC**. **Note**: For all members, this hearing aid exclusion does not apply to cochlear implants and osseointegrated external hearing devices covered by Medicare.
Eyeglasses and contact lenses		√ One pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. No other eyewear is covered unless your employer purchased such coverage for eyewear. Refer to the Medical Benefits Chart at the front of this **EOC**. Eyewear benefits do not cover the following services or items: • Industrial frames. • Lenses and sunglasses without refractive value, except that this exclusion does not apply to any of the following: ♦ A clear balance lens if only one eye needs correction. ♦ Tinted lenses when medically necessary to treat macular degeneration or retinitis pigmentosa. • Replacement of lost, broken, or damaged lenses or frames.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		• Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling. • Eyewear items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits.
Radial keratotomy, LASIK surgery, and other low vision aids	√	
Reversal of sterilization procedures and non-prescription contraceptive supplies.	√	
Acupuncture		√ This exclusion does not apply if your employer has purchased coverage for acupuncture. Refer to the Medical Benefits Chart at the front of the **EOC**.
Naturopath services (uses natural or alternative treatments)	√	
Private duty nursing	√	
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance)		√ Covered if medically necessary and covered under Original Medicare.
Services provided to veterans in Veterans Affairs (VA) facilities		√ When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our plan's cost-sharing amounts.
Reconstructive surgery that offers only a minimal improvement in appearance or is performed to alter or reshape normal structures of the body in order to improve appearance		√ We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defect, developmental abnormalities, accidental injury, trauma, infection, tumors, or disease, if a network physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.
Surgery that, in the judgment of a network physician specializing in reconstructive surgery, offers only a minimal improvement in appearance. Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance	√	
Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, a presbyopia-correcting IOL)		√ You may request and we may provide insertion of a presbyopia-correcting IOL or astigmatism-correcting IOL following cataract surgery in lieu of a conventional IOL. However, you must pay the difference between Plan Charges for a nonconventional IOL and associated services and Plan Charges for insertion of a conventional IOL following cataract surgery.
Directed blood donations	√	
Massage therapy		√

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		Covered when ordered as part of physical therapy program in accord with Medicare guidelines.
Transportation by air, car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a network provider	√	
Licensed ambulance services without transport		√ Covered if the ambulance transports you or if covered by Medicare.
Physical exams and other services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation		√ Covered if a network physician determines that the services are medically appropriate preventive care.
Services related to noncovered services or items		√ When a service or item is not covered, all services related to the noncovered service or item are excluded, (1) except for services or items we would otherwise cover to treat complications of the noncovered service or item, or (2) unless covered in accord with Medicare guidelines.
Services not approved by the federal Food and Drug Administration. Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in		√ This exclusion applies to services provided anywhere, even outside the U.S. It does not apply to Medicare-covered clinical trials or covered emergency care you receive outside the U.S.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
the U.S., but are not approved by the FDA		

CHAPTER 5. Using our plan's coverage for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you.** We sent you a separate document, called the "**Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs**" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this rider, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are printed on the back cover of this booklet.

SECTION 1. Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The Medical Benefits Chart found at the front of this **EOC** and the next chapter tell you what you pay for Part D drugs (Chapter 6, "What you pay for your Part D prescription drugs").

In addition to your coverage for Part D drugs, we also cover some drugs under our plan's medical benefits. Through our coverage of Medicare Part A benefits, we generally cover drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through our coverage of Medicare Part B benefits, we cover drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. The Medical Benefits Chart found at the front of this **EOC** tells you about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. We only cover Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions, and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.4 in this chapter, "What if you're in Medicare-certified hospice." For information on hospice coverage, see the hospice section of the Medical Benefits Chart at the front of this **EOC**.

If your group has purchased enhanced Part D prescription drug coverage, we cover some drugs that are not covered by Medicare Part B and Part D in accord with our formulary for non-Part D

drugs. The Medical Benefits Chart at the front of this **EOC** tells you about your benefits and costs for these drugs.

The following sections discuss coverage of your drugs under our plan's Part D benefit rules. Section 9 in this chapter, "Part D drug coverage in special situations," includes more information about your Part D coverage and Original Medicare.

Section 1.2 Basic rules for our plan's Part D drug coverage

Our plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, "Fill your prescriptions at a network pharmacy or through our mail-order service.")
- Your drug must be on our **Kaiser Permanente 2019 Comprehensive Formulary** (we call it the "Drug List" for short). (See Section 3, "Your drugs need to be on our Drug List.")
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2. Fill your prescription at a network pharmacy or through our mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered only if they are filled at our network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with our plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on our plan's Drug List.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your **Pharmacy Directory**, visit our website (**kp.org/directory**), or call Member Services (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves our plan's network, you will have to find a new pharmacy that is in our network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the **Pharmacy Directory**. You can also find information on our website at **kp.org/directory**.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. I/T/U pharmacies must be within our service area.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use.
  Note: This scenario should happen rarely.

To locate a specialized pharmacy, look in your **Pharmacy Directory** or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using our mail-order services

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, the drugs provided through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our mail-order service are marked as "mail-order" drugs on our Drug List.

Our mail-order service requires you to order at least a 30-day supply of the drug and no more than a 90-day supply.

To get information about filling your prescriptions by mail, call Member Services. You can conveniently order your prescription refills in the following ways:

- Register and order online securely at **kp.org/refill**.
- Call our mail-order service at **303-326-6777** or toll free at **1-866-523-6059 (TTY 711)**, Monday through Friday, 8 a.m. to 6 p.m.
- Call the highlighted number listed on your prescription label and follow the prompts. Be sure to select the mail delivery option when prompted.
- Mail your prescription or refill request on a mail-order form available at any Kaiser Permanente network pharmacy.

When you order refills for home delivery online, by phone, or in writing, you must pay your cost-sharing when you place your order (there are no shipping charges for regular mail-order service). If you prefer, you may designate a network pharmacy where you want to pick up and pay for your prescription. Please contact a network pharmacy if you have a question about whether your prescription can be mailed, or see our *Drug List* for information about the drugs that can be mailed.

Usually a mail-order pharmacy order will get to you in no more than 10 days. If your mail-order prescription is delayed, please call the number listed above or on your prescription bottle's label for assistance. Also, if you cannot wait for your prescription to arrive from our mail-order pharmacy, you can get an urgent supply by calling your local network pharmacy listed in your **Pharmacy Directory** or at **kp.org/directory**. Please be aware that you will pay more if you get a 90-day supply from a network pharmacy instead of from our mail-order pharmacy.

Refills on mail-order prescriptions. For refills, please contact your pharmacy 10 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. When you place your order, please provide your current contact information in case we need to reach you.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost-sharing may be lower. Our plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. Maintenance drugs are drugs that you take on a regular basis for a chronic or long-term medical condition. You may order this supply through mail order (see Section 2.3 in this chapter) or you may go to a retail pharmacy.

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your Pharmacy Directory tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

2. For certain kinds of drugs, you can use our plan's network mail-order services. The drugs available through our mail-order service are marked as "mail-order" drugs on our Drug List. Our mail-order service requires you to order at least a 30-day supply of the drug and no more than a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in our network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are traveling within the United States and its territories but outside the service area and you become ill or run out of your covered Part D prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines.
- If you need a Medicare Part D prescription drug in conjunction with covered out-of-network emergency care or out-of-area urgent care, we will cover up to a 30-day supply from an out-of-network pharmacy. **Note:** Prescription drugs prescribed and provided outside of the United States and its territories as part of covered emergency or urgent care are covered up to a 30-day supply in a 30-day period. These drugs are not covered under Medicare Part D; therefore, payments for these drugs do not count toward reaching the catastrophic coverage stage.
- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a network pharmacy during normal business hours.
- If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible network pharmacy or available through our mail-order pharmacy (including high-cost drugs).
- If you are not able to get your prescriptions from a network pharmacy during a disaster.

In these situations, please check first with Member Services to see if there is a network pharmacy nearby. Phone numbers for Member Services are printed on the back cover of this booklet. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from our plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1, explains how to ask us to pay you back.)

SECTION 3. Your drugs need to be on our "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

Our plan has a **Kaiser Permanente 2019 Comprehensive Formulary**. In this **Evidence of Coverage**, we call it the "Drug List" for short.

The drugs on this list are selected by our plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved our plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on our plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is either:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- Or supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and the USPDI or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

Our Drug List includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Generally, it works just as well as the brand-name drug and usually costs less. There are generic drug substitutes available for many brand-name drugs.

What is not on our Drug List?

Our plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 There are six "cost-sharing" tiers" for drugs on our *Drug List*

Every drug on our plan's Drug List is in one of six cost-sharing tiers. Depending upon the plan your group has selected, cost-sharing may vary from one tier to the next. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Cost-sharing **Tier 1** for preferred generic drugs.
- Cost-sharing **Tier 2** for generic drugs.

- Cost-sharing **Tier 3** for preferred brand-name drugs.
- Cost-sharing **Tier 4** for nonpreferred brand-name drugs.
- Cost-sharing **Tier 5** for specialty-tier drugs.
- Cost-sharing **Tier 6** for injectable Part D vaccines.

To find out which cost-sharing tier your drug is in, look it up on our Drug List. The amount you pay for drugs in each cost-sharing tier is shown in the Medical Benefits Chart found at the front of this **EOC**.

Section 3.3 How can you find out if a specific drug is on our Drug List?

You have three ways to find out:

1. Check the most recent Drug List we provide electronically at **kp.org**.
2. Visit our website (**kp.org/seniormedrx).** Our Drug List (**Kaiser Permanente 2019 Comprehensive Formulary**) on the website is always the most current.
3. Call Member Services to find out if a particular drug is on our plan's Drug List (**Kaiser Permanente 2019 Comprehensive Formulary**) or to ask for a copy of the list. Phone numbers for Member Services are printed on the back cover of this booklet.

SECTION 4. There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when we cover them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2, for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once on our Drug List (**Kaiser Permanente 2019 Comprehensive Formulary**). This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed

by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand-name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand-name drug and usually costs less. In most cases, when a generic version of a brand-name drug is available, our network pharmacies will provide you the generic version. We usually will not cover the brand-name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan before we will agree to cover the drug for you. This is called **"prior authorization."** Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by our plan.

Section 4.3 Do any of these restrictions apply to your drugs?

Our plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services (phone numbers are printed on the back cover of this booklet) or check our website **(kp.org/seniormedrx)**.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2, for information about asking for exceptions.)

SECTION 5. What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by our plan have extra rules to restrict their use. In some cases, you may want us to waive the restriction for you.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be. Our plan puts each covered drug into one of six different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend upon what type of problem you have:

- If your drug is not on our Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on our Drug List or if the drug is restricted in some way?

If your drug is not on our Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask us to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, we can offer a temporary supply of a drug to you when your drug is not on our Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is no longer on our plan's Drug List.
- Or the drug you have been taking is now restricted in some way (Section 4 in this chapter tells you about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in our plan last year:** We will cover a temporary supply of your drug during the first 90 days of your membership in our plan if you are new and during the first 90 days of the calendar year if you were in our plan last year. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in our plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:** We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.
- As a current member of our plan, **if you have a covered inpatient stay in the hospital or in a skilled nursing facility**, the drugs you obtain during your stay will be covered under your medical benefit rather than your Medicare Part D prescription drug coverage. When you are discharged home or to a custodial level of care at a long-term care facility, many outpatient prescription drugs you obtain at a pharmacy will be covered under your Medicare Part D coverage. Since your drug coverage is different depending upon the setting where you obtain the drug, it is possible that a drug you were taking that was covered under your medical benefit might not be covered by Medicare Part D (for example, over-the-counter drugs or cough medicine). If this happens, you will have to pay full price for that drug unless you have other coverage (for example, employer group or union coverage).

To ask for a temporary supply, call Member Services (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by our plan or ask us to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by our plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. Phone numbers for Member Services are printed on the back cover of this booklet.

You can ask for an exception

You and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask us to cover a drug even though it is not on our plan's Drug List. Or you can ask us to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. Phone numbers for Member Services are printed on the back cover of this booklet.

You can ask for an exception

You and your provider can ask us to make an exception to the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our specialty tier (Tier 5) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6. What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, we might make changes to the Drug List. For example, we might:

- Add or remove drugs from the Drug List. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for

an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.

- Move a drug to a higher or lower cost-sharing tier.
- Add or remove a restriction on coverage for a drug (for more information about restrictions to coverage, see Section 4 in this chapter).
- Replace a brand-name drug with a generic drug.

We must follow Medicare requirements before we change our Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- **A new generic drug replaces a brand-name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand-name drug)**
  - We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand-name drug.
  - You and your provider can ask us to make an exception and continue to cover the brand-name drug for you. For information about how to ask for an exception, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.

- **Other changes to drugs on the Drug List.**
  - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand-name drug or change the cost-sharing tier or add new restrictions to the brand-name drug. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' notice or give you a 30-day refill of the drug you are taking at a network pharmacy
  - During this 30-day period, you should be working with your prescriber to switch to a different drug that we cover.
  - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."
- **Changes to drugs on the Drug List that will not affect people currently taking the drug:** For changes to the Drug List that are not described above, if you are currently taking the drug, the following types of changes will not affect you until January 1 of the next year if you stay in our plan:
  - If we move your drug into a higher cost-sharing tier.
  - If we put a new restriction on your use of the drug.
  - If we remove your drug from the Drug List.

If any of these changes happen to a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand-name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the new year's Drug List for any changes to drugs.

SECTION 7. What types of drugs are not covered by our plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section; the only exception is if the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5, in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology; or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Nonprescription drugs (also called over-the-counter drugs).
- Drugs when used to promote fertility.
- Drugs when used for the relief of cough or cold symptoms.
- Drugs when used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs when used for the treatment of sexual or erectile dysfunction.
- Drugs when used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

If you receive "Extra Help" paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8. Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill our plan for our share of your covered prescription drug cost. You will need to pay the pharmacy your share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call our plan to get the necessary information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask us to reimburse you for our share. See Chapter 7, Section 2.1, for information about how to ask us for reimbursement.

SECTION 9. Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by our plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, we will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell you about the rules for getting drug coverage. The Medical Benefits Chart found at the front of this **EOC** gives you more information about drug coverage and what you pay.

Please note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage. (Chapter 10, "Ending your membership in our plan," tells you when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your **Pharmacy Directory** to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of our plan?

If you need a drug that is not on our Drug List or is restricted in some way, we will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of up to a 98-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care (LTC) pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

If you have been a member of our plan for more than 90 days and need a drug that is not on our Drug List or if our plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by our plan that might work just as well for you. Or you and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells you what to do.

Section 9.3 Special note about "creditable coverage"

Each year your employer or retiree group should send you a notice that tells you if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage, from your employer or retiree group plan, you can get a copy from your employer or retiree group's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D. Chapter 6, "What you pay for your Part D prescription drugs," gives more information about drug coverage and what you pay.

SECTION 10. Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition.
- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.
- Prescriptions written for drugs that have ingredients you are allergic to.
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that can help make sure our members safely use their prescription opioid medications, or other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid or benzodiazepine medications, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one pharmacy.
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one doctor.
- Limiting the amount of opioid or benzodiazepine medications we will cover for you.

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies

you prefer to use. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug abuse or the limitation, you and your prescriber have the right to ask us for an appeal. See Chapter 9 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, or you are receiving hospice care or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take.

Our program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back cover of this booklet).

CHAPTER 6. What you pay for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you.** We sent you a separate document, called the "**Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs**" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this rider, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are printed on the back cover of this booklet.

SECTION 1. Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs—some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some excluded drugs may be covered under your group's plan.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- Our **Kaiser Permanente 2019 Comprehensive Formulary**. To keep things simple, we call this the "**Drug List**."
  - This Drug List tells you which drugs are covered for you.
  - It also tells you which of the six "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Member Services (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at **kp.org/seniormedrx**. The Drug List on the website is always the most current.
- **Chapter 5 of this booklet**. Chapter 5 gives you the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells you which types of prescription drugs are not covered by our plan.
- **Our plan's Pharmacy Directory**. In most situations, you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The **Pharmacy Directory** has

a list of pharmacies in our plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month supply).

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost-sharing," and there are three ways you may be asked to pay.

- The "deductible" is the amount you must pay for drugs before our plan begins to pay its share.
- "Copayment" means that you pay a fixed amount each time you fill a prescription.
- "Coinsurance" means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2. What you pay for a drug depends upon which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for Senior Advantage members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under our plan. How much you pay for a drug depends upon which of these stages you are in at the time you get a prescription filled or refilled. Stage 4 applies to everyone, but your group plan may not include a Deductible Stage (Stage 1) or a Coverage Gap Stage (Stage 3). Refer to the Medical Benefits Chart found at the front of this **EOC** to find out which stages apply to you. Keep in mind you are always responsible for our plan’s monthly premium regardless of the drug payment stage.

Stage 1	Stage 2	Stage 3	Stage 4
Yearly Deductible Stage See the Medical Benefits Chart at the front of the **EOC** to find out if this payment stage applies to you. (This stage does not apply to most members.) If your plan has a deductible, during this stage, you pay the full cost of your drugs. You stay in this stage until you have paid your deductible. (Details are in Section 4 of this chapter.)	**Initial Coverage Stage** **If your plan has a deductible, you begin in this stage after you end the Deductible Stage.** **If your plan does not have a deductible, you begin in this stage when you fill your first prescription of the year.** During this stage, we pay our share of the cost of your drugs and you pay your share of the cost. If your plan has a Coverage Gap Stage, you stay in this stage until your year-to-date "**total drug costs**" (your payments plus any Part D plan's payments) total **$3,820**. If your plan does not have a Coverage Gap Stage, you stay in this stage until your year-to-date "**out-of-pocket costs**" (your payments) total **$5,100**. (Details are in Section 5 of this chapter.)	**Coverage Gap Stage** See the Medical Benefits Chart at the front of this **EOC** to find out if this stage applies to you (this stage does not apply to most members). If there is no coverage gap for your plan, this payment stage does not apply to you. If this stage applies to you, coverage during the gap stage varies depending on the plan your group has selected. For **generic drugs, you pay either the copayment** listed in Section 6 of this chapter, depending upon the plan in which you are enrolled, **or 37% of the price**, whichever is lower. For **brand-name drugs, you pay 25% of the price** (plus a portion of the dispensing fee). You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of **$5,100**. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	**Catastrophic Coverage Stage** During this stage, **we will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2019). (Details are in Section 7 of this chapter.)

SECTION 3. We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the **Part D Explanation of Benefits** (it is sometimes called the "**Part D EOB**") when you have had one or more prescriptions filled through our plan during the previous month. It includes:

- **Information for that month.** This report gives you the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2 Help us keep our information about your drug payments up-to-date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up-to-date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask us to pay our share of the cost. For instructions about how to do this, go to Chapter 7, Section 2, of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

- When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Anytime you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a **Part D Explanation of Benefits** (a **Part D EOB**) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also choose to view your **Part D EOB** online instead of by mail. Please visit **kp.org/goinggreen** and sign on to learn more about choosing to view your **Part D EOB** securely online. Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4. During the Deductible Stage, if applicable, you pay the full cost of your drugs

See the Medical Benefits Chart found at the front of this **EOC** to find out if this stage applies to you (this stage does not apply to most members).

Section 4.1 If your plan includes a deductible for your Part D drugs

The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach our plan's deductible amount. Please refer to the Medical Benefits Chart found at the front of this **EOC** for the deductible amount.

- Your "**full cost**" is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The "**deductible**" is the amount you must pay for your Part D prescription drugs before our plan begins to pay its share.

Once you have paid the deductible amount shown in the Medical Benefits Chart found at the front of this **EOC**, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

SECTION 5. During the Initial Coverage Stage, we pay our share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends upon the drug and where you fill your prescription

During the Initial Coverage Stage, we pay our share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending upon the drug and where you fill your prescription.

Our plan has six cost-sharing tiers

Every drug on our plan's Drug List is in one of six cost-sharing tiers. Depending upon the plan your group has selected, cost-sharing may vary from one tier to the next. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-sharing **Tier 1** for preferred generic drugs.
- Cost-sharing **Tier 2** for generic drugs.
- Cost-sharing **Tier 3** for preferred brand-name drugs.
- Cost-sharing **Tier 4** for nonpreferred brand-name drugs.
- Cost-sharing **Tier 5** for specialty-tier drugs.
- Cost-sharing **Tier 6** for injectable Part D vaccines.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends upon whether you get the drug from:

- A retail pharmacy that is in our plan's network.
- A pharmacy that is not in our plan's network.
- Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and our plan's **Pharmacy Directory**.

Section 5.2 Your costs for a one-month supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- "**Copayment**" means that you pay a fixed amount each time you fill a prescription.
- "**Coinsurance**" means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the Medical Benefits Chart found at the front of this **EOC**, the amount of the copayment or coinsurance depends upon which cost-sharing tier your drug is in. **Please note:**

- If your covered drug costs less than the copayment amount listed in the Medical Benefits Chart found at the front of this **EOC**, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5, for information about when we will cover a prescription filled at an out-of-network pharmacy.

Refer to the Medical Benefits Chart found at the front of this **EOC** for your cost-sharing amounts and day supply limit in the Initial Coverage Stage.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month’s supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the amount you pay will be less.
- If you are responsible for a copayment for the drug, your copayment will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.
  - Here's an example: Let's say the copayment for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

Section 5.4 Your costs for a long-term (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

Refer to the Medical Benefits Chart found at the front of this **EOC** for your cost-sharing amounts when you get a long-term (up to a 90-day) supply of a drug.

- **Please note:** If your covered drug costs less than the copayment amount listed in the Medical Benefits Chart found at the front of this **EOC**, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.

Section 5.5 You stay in the Initial Coverage Stage until you reach the next stage

If your group plan does not include a Coverage Gap Stage, you stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$5,100**. When you reach an out-of-pocket limit of **$5,100**, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. Most group plans do not include a Coverage Gap Stage.

If your group plan includes a Coverage Gap Stage, you stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$3,820 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What our plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2019, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The **Part D Explanation of Benefits (Part D EOB)** that we send to you will help you keep track of how much you and our plan, as well as third parties have spent on your behalf during the year. Many people do not reach the **$3,820** limit in a year.

We will let you know if you reach this **$3,820** amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

Refer to the Medical Benefits Chart found at the front of this **EOC** for the amount you will pay for drugs in the Coverage Gap Stage.

SECTION 6. During the Coverage Gap Stage, if applicable, we provide some drug coverage

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $5,100

The benefit coverage you receive during the Coverage Gap Stage will depend on the benefits your group selected. See the Medical Benefits Chart found at the front of this **EOC** to find out if this stage applies to you (this stage does not apply to most members).

Brand-name drugs during the Coverage Gap Stage

When you are in the Coverage Gap Stage, **the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs** (Tiers 3–5)**.** You pay 35% of the negotiated price and a portion of the dispensing fee for brand-name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them, and move you through the coverage gap.

Generic drugs and vaccines during the Coverage Gap Stage

You also receive coverage of generic drugs and injectable Part D vaccines during the Coverage Gap Stage. You pay either the copayments listed in the Medical Benefits Chart found at the front of this **EOC** or 37% of the costs of generic drugs, whichever is lower, until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2019, that amount is **$5,100.**

You continue paying the discounted price for brand-name drugs and no more than 51% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2019, that amount is **$5,100**.

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of **$5,100**, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments <u>are</u> included in your out-of-pocket costs

When you add up your out-of-pocket costs, you can include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:

  - The Deductible Stage (if this stage applies to you).
  - The Initial Coverage Stage.
  - The Coverage Gap Stage (if this stage applies to you).
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments yourself, they are included in your out-of-pocket costs.
- These payments are also included if they are made on your behalf by certain other individuals or organizations. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand-name drugs is included. But the amount we pay for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of **$5,100** in out-of-pocket costs within the calendar year, you will move from either the Initial Coverage Stage (if this stage applies to you) or the Coverage Gap Stage (if this stage applies to you) to the Catastrophic Coverage Stage.

These payments are <u>not</u> included in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **<u>not</u>** allowed to include any of these types of payments for prescription drugs:

- The amount you contribute, if any, toward your group's premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet our plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare prescription drug plan.
- Payments you make toward prescription drugs not normally covered in a Medicare prescription drug plan.
- Payments made by our plan for your brand or generic drugs while in the Coverage Gap, if this stage applies to you.

- Payments for your drugs that are made by group health plans, including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs, such as TRICARE and Veterans Affairs.
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you.** The **Part D Explanation of Benefits (Part D EOB)** report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells you about this report). When you reach a total of **$5,100** in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells you what you can do to help make sure that our records of what you have spent are complete and up-to-date.

SECTION 7. During the Catastrophic Coverage Stage, we pay most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **$5,100** limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this stage, we will pay most of the cost for your drugs.

You will pay **$3.40** for covered generic drugs (includes drugs treated like generics). You will pay **$8.50** for covered brand-name and specialty-tier drugs, and **$0** for covered injectable Part D vaccines. We will pay the rest.

SECTION 8. What you pay for vaccinations covered by Part D depends upon how and where you get them

Section 8.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

We provide coverage for a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart found at the front of this **EOC**.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of the vaccine medication itself. The vaccine is a prescription medication.
- The second part of coverage is for the cost of giving you the vaccine. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends upon three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to the Medical Benefits Chart found at the front of this **EOC**.
   - Other vaccines are considered Part D drugs. You can find these vaccines listed in our **Kaiser Permanente 2019 Comprehensive Formulary.**
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccine.**

What you pay at the time you get the Part D vaccination can vary depending upon the circumstances. For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask us to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine.

If your plan has a Deductible Stage, remember you are responsible for all of the costs associated with Part D vaccines (including their administration) during the Deductible Stage of your benefit.

Situation 1:

- You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends upon where you live. Some states do not allow pharmacies to administer a vaccination.)
  - You will have to pay the pharmacy the amount of your copayment for the vaccine and the cost of giving you the vaccine.
  - Our plan will pay the remainder of the costs.

Situation 2:

- You get the Part D vaccination at your doctor's office.
  - When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
  - You can then ask us to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet ("Asking us to pay our share of a bill you have received for covered medical services or drugs").
  - You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration).

Situation 3:

- You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccine.
  - You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
  - When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask us to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
  - You will be reimbursed the amount charged by the doctor for administering the vaccine.

IMPORTANT NOTE: Generally, when you receive a covered injectable Part D vaccine at a Kaiser Permanente network medical office or injection clinic, **there is no charge for the injectable vaccine.** We may send you a bill for the vaccine administration or office visit copayment, if applicable.

Section 8.2 You may want to call Member Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you first call Member Services whenever you are planning to get a vaccination. Phone numbers for Member Services are printed on the back cover of this booklet.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.

- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

CHAPTER 7. Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1. Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Section 1.1 If you pay our share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of our plan. In either case, you can ask us to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask us to pay you back or to pay a bill you have received:

When you've received emergency or urgently needed medical care from a provider who is not in our network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill our plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

When a network provider sends you a bill you think you should not pay

Network providers should always bill us directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service, and even if there is a dispute and we

don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.3.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

If you are retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. ("Retroactive" means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. Phone numbers for Member Services are printed on the back cover of this booklet.

When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5, to learn more.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call us or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on our **Kaiser Permanente 2019 Comprehensive Formulary**; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has information about how to make an appeal.

SECTION 2. How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (**kp.org**) or call Member Services and ask for the form. Phone numbers for Member Services are printed on the back cover of this booklet.

Mail your request for payment together with any bills or receipts to us at this address:

Kaiser Foundation Health Plan of Colorado
Claims Department
P.O. Box 373150
Denver, CO 80237-3150

You must submit your claim to us within 365 days of the date you received the service, item, or drug.

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3. We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is not covered, or you did not follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details about how to make this appeal, go to Chapter 9 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives you definitions of terms such as "appeal." Then, after you have read Section 4, you can go to the section in Chapter 9 that tells you what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.

SECTION 4. Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the Deductible Stage or Coverage Gap Stage (if your plan has one or both—refer to the Medical Benefits Chart found at the front of this **EOC***)*, you can buy your drug at a network pharmacy for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Deductible or Coverage Gap Stage, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside our plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through our plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 8. Your rights and responsibilities

SECTION 1. We must honor your rights as a member of our plan

Section 1.1 We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or CD)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English-speaking members. This booklet is available in Spanish by calling Member Services (phone numbers are on the back cover of this booklet). We can also give you information in Braille, large print, or CD at no cost if you need it. We are required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet) or contact our Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling **1-800-MEDICARE (1-800-633-4227**) or directly with the Office for Civil Rights. Contact information is included in this **Evidence of Coverage** or with this mailing, or you may contact Member Services for additional information.

Sección 1.1 Debemos proporcionar la información de un modo adecuado para usted (en idiomas distintos al inglés, en Braille, en letra grande o en CD)

Para obtener información de una forma que se adapte a sus necesidades, por favor llame a Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto).

Nuestro plan cuenta con personas y servicios de interpretación disponibles sin costo para responder las preguntas de los miembros discapacitados y que no hablan inglés. Este folleto está disponible en español o chino; llame a Servicio a los Miembros (los números de teléfono están en la contraportada de este folleto). Si la necesita, también podemos darle, sin costo, información en Braille, letra grande o CD. Tenemos la obligación de darle información acerca de los beneficios de nuestro plan en un formato que sea accesible y adecuado para usted. Para obtener nuestra información de una forma que se adapte a sus necesidades, por favor llame a Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto) o comuníquese con nuestro Coordinador de Derechos Civiles.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y adecuado para usted, por favor llame para presentar una queja a Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto). También puede presentar una queja en Medicare llamando al **1-800-MEDICARE (1-800-633-4227**) o directamente en la Oficina de Derechos Civiles. En esta Evidence of Coverage (**Evidencia de**

Cobertura) o en esta carta se incluye la información de contacto, o bien puede comunicarse con Servicio a los Miembros para obtener información adicional.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019 (TTY 1-800-537-7697)** or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 1.3 We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in our network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist), a mental health services provider, and a provider for routine eye exams without a referral, as well as other providers described in Chapter 3, Section 2.2.

As a plan member, you have the right to get appointments and covered services from our network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10, of this booklet tells you what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4, tells you what you can do.)

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in our plan as well as your medical records and other medical and health information.

- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practices," that tells you about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- Your health information is shared with your Group only with your authorization or as otherwise permitted by law.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.5 We must give you information about our plan, our network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in Spanish and in Braille, large print or CD.

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about our plan's financial condition. It also includes information about the number of appeals made by members and our plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers, including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in our network, see the **Provider Directory**.
  - For a list of the pharmacies in our network, see the **Pharmacy Directory**.
  - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at **kp.org/directory**.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details about your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus our plan's Drug List. These chapters, together with the Drug List, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells you about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask us to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking a medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells you how to ask us for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form**. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are printed on the back cover of this booklet).
- **Fill it out and sign it**. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people**. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Colorado Department of Public Health and Environment.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells you what you can do. It gives you the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends upon the situation. You might need to ask us to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019** or TTY **1-800-537-7697**, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or you can call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can call the SHIP. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare:
  - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at **https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**.).)
  - Or you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 1.10 Information about new technology assessments

Rapidly changing technology affects health care and medicine as much as any other industry. To determine whether a new drug or other medical development has long-term benefits, our plan carefully monitors and evaluates new technologies for inclusion as covered benefits. These technologies include medical procedures, medical devices, and new drugs.

Section 1.11 You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this chapter. Please call Member Services with any suggestions (phone numbers are printed on the back cover of this booklet).

SECTION 2. You have some responsibilities as a member of our plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of our plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this **Evidence of Coverage** booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us**. Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from us with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **Tell your doctor and other health care providers that you are enrolled in our plan**. Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care**.
  - To help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure you understand your health problems and participate in developing mutually agreed upon treatment goals with your providers whenever possible.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.

- If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- **Be considerate**. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
  - You must pay your plan premiums to continue being a member of our plan (see Chapter 1, Section 4.1).
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B (or Medicare Part B). Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). The Medical Benefits Chart found at the front of this **EOC** tells you what you must pay for your medical services. The Medical Benefits Chart found at the front of this **EOC** tells you what you must pay for your Part D prescription drugs.
  - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of our plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
  - If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells you about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a special enrollment period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - If you move within our service area, we still need to know so we can keep your membership record up-to-date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.

- For more information about how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 9. What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)

Making complaints 162

Background

SECTION 1. Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the process for coverage decisions and appeals.
- For other types of problems, you need to use the process for making complaints.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by you and us.

Which one do you use?

That depends upon the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" or "coverage determination," or “at-risk determination,” and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful, and sometimes quite important, for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2. You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations, you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3, of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- You can visit the Medicare website (**https://www.medicare.gov**).

SECTION 3. To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help you with your specific problem or concern, *START HERE:*

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

- **Yes, my problem is about benefits or coverage:**

  Go to the next section in this chapter, Section 4: "A guide to the basics of coverage decisions and appeals."

- **No, my problem is not about benefits or coverage:**

  Skip ahead to Section 10 at the end of this chapter: "How to make a complaint about quality of care, waiting times, customer service, or other concerns."

Coverage decisions and appeals

SECTION 4. A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals—*The big picture*

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not, and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision, if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say ***no*** to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call Member Services** (phone numbers are printed on the back cover of this booklet).
- To get free help from an independent organization that is not connected with our plan, **contact your State Health Insurance Assistance Program** (see Section 2 in this chapter).
- **Your doctor can make a request for you.**
  - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under state law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at **https://www.cms. gov/Medicare/CMS-Forms/CMS-**

Forms/downloads/cms1696.pdf or on our website at **kp.org**.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** in this chapter: "Your medical care: How to ask for a coverage decision or make an appeal."
- **Section 6** in this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal."
- **Section 7** in this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
- **Section 8** in this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (applies to these services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services).

If you're not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your SHIP (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5. Your medical care: How to ask for a coverage decision or make an appeal

? Have you read Section 4 in this chapter ("A guide to the basics of coverage decisions and appeals")? If not, you may want to read it before you start this section.

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in the Medical Benefits Chart found at the front of this **EOC**. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

This section tells you what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. We will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by our plan.
3. You have received medical care or services that you believe should be covered by our plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by our plan, and you want to ask us to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:

- **Chapter 9, Section 7:** "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
- **Chapter 9, Section 8:** "How to ask us to keep covering certain medical services if you think your coverage is ending too soon." This section is about three services only: home health care, skilled nursing facility care, and (CORF) services.

For all other situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section in this chapter, **Section 5.2**.
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** in this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to **Section 5.5** in this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask us to authorize or provide the medical care coverage you want)

Legal Terms
When a coverage decision involves your medical care, it is called an "**organization determination**."

Step 1: **You ask us to make a coverage decision on the medical care you are requesting.** If your health requires a quick response, you should ask us to make a "fast coverage decision."

Legal Terms
A "fast coverage decision" is called an "**expedited determination**."

How to request coverage for the medical care you want

- Start by calling, writing, or faxing us to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making a complaint about your medical care."

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days after we receive your request.**

- However, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **A fast coverage decision means we will answer within 72 hours.**
  - However, we can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor tells us that your health requires a "fast coverage decision,"** we will automatically agree to give you a fast coverage decision.
- **If you ask for a fast coverage decision on your own, without your doctor's support,** we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more

information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)

Step 2: **We consider your request for medical care coverage and give you our answer.**

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
  - As explained above, **we can take up to 14 more calendar days** under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells you how to make an appeal.
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- If our answer is ***no*** to part or all of what you requested, we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision, we will give you our answer **within 14 calendar days of receiving your request.**
  - We can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
  - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells you how to make an appeal.
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 14 calendar days after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.

- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no.

Step 3: **If we say *no* to your request for coverage for medical care, you decide if you want to make an appeal.**

- If we say ***no***, you have the right to ask us to reconsider, and perhaps change this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal
(how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms
An appeal to our plan about a medical care coverage decision is called a plan "**reconsideration**."

Step 1: **You contact us and make your appeal. If your health requires a quick response, you must ask for a "fast appeal."**

What to do:

- **To start an appeal, you, your doctor, or your representative must contact us.** For details about how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**
  - If you have someone appealing our decision for you other than your doctor, your appeal must include an "Appointment of Representative" form authorizing this person to represent you. To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at **https://www.cmsgov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1, "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms
A "fast appeal" is also called an "**expedited reconsideration**."

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: **We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said ***no*** to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours** after we receive your appeal**.** We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.

- If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- If our answer is ***no*** to part or all of what you requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
  - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent, outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal.
- If our answer is ***no*** to part or all of what you requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: **If our plan says *no* to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.**

- To make sure we were following all the rules when we said ***no*** to your appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1: **The Independent Review Organization reviews your appeal.**

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a "fast" appeal at Level 1, you will also have a "fast" appeal at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours of when it receives your appeal**.
- However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days.

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 30 calendar days of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days.

Step 2: **The Independent Review Organization gives you their answer.**

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- If the review organization says ***yes*** to part or all of what you requested, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date we receive the decision from the review organization for expedited requests.
- If this organization says ***no*** to part or all of your appeal, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - If the Independent Review Organization "upholds the decision," you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: **If your case meets the requirements, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge or attorney adjudicator. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells you how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 in this

chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service; see the Medical Benefits Chart found at the front of this **EOC**. We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: "Using our plan's coverage for your medical services").

We will say *yes* or *no* to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying ***yes*** to your request for a coverage decision.)
- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying ***no*** to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is ***yes*** at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6. Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

? Have you read Section 4 in this chapter ("A guide to the basics of coverage decisions and appeals")? If not, you may want to read it before you start this

section.

Section 6.1 This section tells what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our **Kaiser Permanente 2019 Comprehensive Formulary**. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3, for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the **Kaiser Permanente 2019 Comprehensive Formulary**, rules and restrictions on coverage, and cost information, see Chapter 5 ("Using our plan's coverage for your Part D prescription drugs") and Chapter 6 ("What you pay for your Part D prescription drugs") or the Medical Benefits Chart found at the front of this **EOC**.

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms
An initial coverage decision about your Part D drugs is called a "**coverage determination**."

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on our **Kaiser Permanente 2019 Comprehensive Formulary**.
  - Asking us to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get).
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier.
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. For example, when your drug is on our **Kaiser Permanente 2019 Comprehensive Formulary**, but we require you to get approval from us before we will cover it for you.
  - **Please note:** If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you have already received and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) **Start with Section 6.2 in this chapter.**	You can ask us for a coverage decision. **Skip ahead to Section 6.4 in this chapter.**	You can ask us to pay you back. (This is a type of coverage decision.) **Skip ahead to Section 6.4 in this chapter.**	You can make an appeal. (This means you are asking us to reconsider.) **Skip ahead to Section 6.5 in this chapter.**

Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "**exception**." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Kaiser Permanente 2019 Comprehensive Formulary.** (We call it the "Drug List" for short.)

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a "**formulary exception**."

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 (nonpreferred brand-name drugs). You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. Removing a restriction on our coverage for a covered drug. There are extra rules or restrictions that apply to certain drugs on our **Kaiser Permanente 2019 Comprehensive Formulary** (for more information, go to Chapter 5 and look for Section 4).

Legal Terms
Asking for removal of a restriction on coverage for a drug is sometimes called asking for a "**formulary exception**."

- The extra rules and restrictions on coverage for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand-name drug.
  - Getting **plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms
Asking to pay a lower price for a covered nonpreferred drug is sometimes called asking for a "**tiering exception**."

- If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
  - If the drug you're taking is a brand-name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand-name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (specialty-tier drugs).
- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "**alternative**" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception. If you ask us for a tiering exception, we will generally not approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you.

We can say *yes* or *no* to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say ***no*** to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: **You ask us to make a coverage decision about the drug(s) or payment you need.** If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do:

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making a complaint about your Part D prescription drugs." Or if you are asking us to pay you back for a drug, go to the section called "Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received."
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 in this chapter tells you how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

- **If you want to ask us to pay you back for a drug,** start by reading Chapter 7 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells you how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

Legal Terms
A "fast coverage decision" is called an "**expedited coverage determination**."

If your health requires it, ask us to give you a "fast coverage decision"

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer **within 72 hours after we receive your doctor's statement**. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision,"** we will automatically agree to give you a fast coverage decision.
- **If you ask for a fast coverage decision on your own** (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell you how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells

you how to file a "fast complaint," which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 in this chapter.)

Step 2: **We consider your request and we give you our answer.**

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent, outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- If our answer is ***yes*** to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- If our answer is ***yes*** to part or all of what you requested:
  - If we approve your request for coverage, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request.
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- If our answer is ***yes*** to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive your request.
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: **If we say *no* to your coverage request, you decide if you want to make an appeal.**

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider—and possibly change—the decision we made.

Section 6.5 Step-by-step: How to make a Level 1 Appeal
(how to ask for a review of a coverage decision made by our plan)

Legal Terms
An appeal to our plan about a Part D drug coverage decision is called a plan "**redetermination**."

Step 1: **You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a "fast appeal."**

What to do:

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details about how to reach us by phone, fax, or mail, or on our website for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1,** "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

Legal Terms
A "fast appeal" is also called an "**expedited redetermination**."

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

Step 2: **We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said ***no*** to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- If our **answer is *yes*** to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- If our **answer is *no*** to part or all of what you requested, we will send you a written statement that explains why we said ***no*** and how to appeal our decision.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days after we receive your appeal for a drug you have not received yet**. We will give you our

decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast appeal".

- If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this review organization and explain what happens at Level 2 of the appeals process.
- If our answer is ***yes*** to part or all of what you requested:
  - If we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request.
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said ***no*** and how to appeal our decision.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- If our answer is ***yes*** to part or all of what you requested, we are also required to make payment to you within 30 calendar days after we receive your request.
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: **If we say *no* to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.**

- If we say ***no*** to your appeal, you then choose whether to accept this decision or continue by making another appeal.

If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6 Step-by-step: How to make a Level 2 Appeal

If we say ***no*** to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review**

Organization reviews the decision we made when we said ***no*** to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1: **To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.**

- If we say ***no*** to your Level 1 Appeal, the written notice we send you will include instructions about how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell you who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: **The Independent Review Organization does a review of your appeal and gives you an answer.**

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

*Deadlines for **"**fast appeal**"** at Level 2*

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal **within 72 hours after it receives your appeal request**.
- If the Independent Review Organization says ***yes*** to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days after it receives your appeal** if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal within 14 calendar days after it receives your request.
- If the Independent Review Organization says ***yes*** to part or all of what you requested:
  - If the Independent Review Organization approves a request for coverage, we must provide the drug coverage that was approved by the review organization within 72 hours after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization.

What if the review organization says *no* to your appeal?

If this organization says ***no*** to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision," you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: **If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details about how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge or attorney adjudicator. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 7. How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see the Medical Benefits Chart found at the front of this **EOC**.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called **An Important Message from Medicare about Your Rights**. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- Read this notice carefully and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:
  - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
  - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
  - Where to report any concerns you have about quality of your hospital care.
  - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms
The written notice from Medicare tells you how you can "**request an immediate review**." Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)

- **You must sign the written notice** to show that you received it and understand your rights.
  - You or someone who is acting on your behalf must sign the notice. (Section 4 in this chapter tells you how you can give written permission to someone else to act as your representative.)
  - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date.
- **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
  - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
  - To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE** (**1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. You can also see it online at **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html**.

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: **Contact the Quality Improvement Organization for your state and ask for a "fast review" of your hospital discharge. You must act quickly.**

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (**An Important Message from Medicare About Your Rights**) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - **If you meet this deadline,** you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - **If you do not meet this deadline,** and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a "fast review" of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A "fast review" is also called an "**immediate review**" or an "**expedited review**."

Step 2: **The Quality Improvement Organization conducts an independent review of your case.**

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives you your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms
This written explanation is called the "**Detailed Notice of Discharge**." You can get a sample of this notice by calling Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) Or you can see a sample notice online at **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html**.

Step 3: **Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.**

*What happens if the answer is **yes**?*

- If the review organization says ***yes*** to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See the Medical Benefits Chart found at the front of this **EOC**.)

*What happens if the answer is **no**?*

- If the review organization says ***no*** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your **inpatient hospital services will end** at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says ***no*** to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost of hospital care** you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: **If the answer to your Level 1 Appeal is *no*, you decide if you want to make another appeal.**

- If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeals process:

Step 1: **You contact the Quality Improvement Organization again and ask for another review.**

- **You must ask for this review within 60 calendar days** after the day the Quality Improvement Organization said ***no*** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: **The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: **Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.**

*If the review organization says **yes**:*

- We must reimburse you for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

*If the review organization says **no**:*

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called "upholding the decision."

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an administrative law judge or attorney adjudicator.

Step 4: **If the answer is *no*, you will need to decide whether you want to take your appeal further by going on to Level 3.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

Step 1: Contact us and ask for a "fast review."

- For details about how to contact us, **go to Chapter 2**, Section 1, and look for the section called "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say *yes* to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say *no* to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
- **If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you received after the planned discharge date.**

Step 4: If we say no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said ***no*** to your fast appeal**,** we are required to send your appeal to the Independent Review Organization. When we do this, it means that you are **automatically** going on to Level 2 of the appeals process.

Step-by-step: Level 2 Alternate Appeal Process

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said ***no*** to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying ***no*** to your first appeal.

(If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 10 in this chapter tells you how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- If this **organization says *yes*** to your appeal, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an administrative law judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say ***no*** to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 8. How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is **only** about the following types of care:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, "Definitions of important words.")
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, "Definitions of important words.")

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information about your covered services, including your share of the cost and any limitations to coverage that may apply, see the Medical Benefits Chart found at the front of this **EOC**.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying our share of the cost for your care.**

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Section 8.2 We will tell you in advance when your coverage will be ending

- **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
  - The written notice tells you the date when we will stop covering the care for you.
  - The written notice also tells you what you can do if you want to ask us to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling how you can request a "**fast-track appeal.**" Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 8.3 below tells you how you can request a fast-track appeal.)

The written notice is called the "**Notice of Medicare Non-Coverage**." To get a sample copy, call Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048.**) Or see a copy online at **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html**.

- You must sign the written notice to show that you received it.
  - You or someone who is acting on your behalf must sign the notice. (Section 4 tells you how you can give written permission to someone else to act as your representative.)
  - Signing the notice shows **only** that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with us that it's time to stop getting the care.

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 in this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

If you ask for a Level 1 Appeal on time, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: **Make your Level 1 Appeal: Contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.**

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5 in this chapter.

Step 2: **The Quality Improvement Organization conducts an independent review of your case.**

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice of explanation is called the "**Detailed Explanation of Non-Coverage**."

Step 3: **Within one full day after they have all the information they need, the reviewers will tell you their decision.**

*What happens if the reviewers say **yes** to your appeal?*

- If the reviewers say ***yes*** to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see the Medical Benefits Chart found at the front of this **EOC**).

*What happens if the reviewers say **no** to your appeal?*

- If the reviewers say ***no*** to your appeal, then **your coverage will end** on the date we have told you. We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, **then you will have to pay the full cost of this care yourself**.

Step 4: **If the answer to your Level 1 Appeal is *no*, you decide if you want to make another appeal.**

- This first appeal you make is "Level 1" of the appeals process. If reviewers say ***no*** to your Level 1 Appeal, and you choose to continue getting care after your coverage for the care has ended, then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

Here are the steps for Level 2 of the appeals process:

Step 1: **You contact the Quality Improvement Organization again and ask for another review.**

- **You must ask for this review within 60 days** after the day when the Quality Improvement Organization said ***no*** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: **The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: **Within 14 days of receipt of your appeal request reviewers will decide on your appeal and tell you their decision.**

*What happens if the review organization says **yes** to your appeal?*

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

*What happens if the review organization says **no**?*

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an administrative law judge or attorney adjudicator.

Step 4: **If the answer is *no*, you will need to decide whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

Step 1: Contact us and ask for a "fast review."

- For details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending our plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say *yes* to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say *no* to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, **then you will have to pay the full cost of this care yourself**.

*Step 4: If we say **no** to your fast appeal, your case will automatically go on to the next level of the appeals process.*

- To make sure we were following all the rules when we said ***no*** to your fast appeal, **we are required to send your appeal to the Independent Review Organization**. When we do this, it means that you are automatically going on to Level 2 of the appeals process.

Step-by-step: Level 2 Alternate Appeal Process

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said ***no*** to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying ***no*** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 10 in this chapter tells you how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- The **Independent Review Organization** is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes*** to your appeal, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say ***no*** to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 9. Taking your appeal to Level 3 and beyond

Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge (called an administrative law judge) or attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the administrative law judge or attorney adjudicator says *yes* to your appeal, the appeals process may or may *not* be over.** We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the administrative law judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the administrative law judge or attorney adjudicator says *no* to your appeal, the appeals process may or may *not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge or attorney adjudicator says ***no*** to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is *yes*, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may *not* be over.** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is *no* or if the Council denies the review request, the appeals process may or may *not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says ***no*** to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge (called an administrative law judge or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the answer is *yes*, the appeals process is over**. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the administrative law judge or attorney adjudicator within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.
- **If the answer is *no*, the appeals process may or may *not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge or attorney adjudicator says ***no*** to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is *yes*, the appeals process is over**. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.
- **If the answer is *no*, the appeals process may or may *not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says ***no*** to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Making complaints

SECTION 10. How to make a complaint about quality of care, waiting times, customer service, or other concerns

? If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 in this chapter.

Section 10.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is **only** used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint":

- **Quality of your medical care**
  - Are you unhappy with the quality of care you have received (including care in the hospital)?
- **Respecting your privacy**
  - Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- **Disrespect, poor customer service, or other negative behaviors**
  - Has someone been rude or disrespectful to you?
  - Are you unhappy with how our Member Services has treated you?
  - Do you feel you are being encouraged to leave our plan?
- **Waiting times**
  - Are you having trouble getting an appointment, or waiting too long to get it?
  - Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Member Services or other staff at our plan?
  - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
- **Cleanliness**
  - Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
- **Information you get from our plan**
  - Do you believe we have not given you a notice that we are required to give?
  - Do you think written information we have given you is hard to understand?

Timeliness (these types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)

The process of asking for a coverage decision and making appeals is explained in Sections 4–9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms
• What this section calls a "complaint" is also called a "grievance." • Another term for "making a complaint" is "filing a grievance." • Another way to say "using the process for complaints" is "using the process for filing a grievance."

Section 10.3 Step-by-step: Making a complaint

Step 1: **Contact us promptly—either by phone or in writing.**

- **Usually calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Call toll-free **1-800-476-2167 (TTY 711)**, 7 days a week, 8 a.m. to 8 p.m.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to you in writing. We will also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care.

- **If you have a complaint, we will try to resolve your complaint over the phone**. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see Chapter 2 for whom you should contact if you have a complaint.
  - You must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint.
    We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest.
  - You can file a fast grievance about our decision not to expedite a coverage decision or appeal, or if we extend the time we need to make a decision about a coverage decision or appeal. We must respond to your fast grievance within 24 hours.
- **Whether you call or write, you should contact Member Services right away.**
  The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision"**
  or a "fast appeal**,**" we will automatically give you a "fast complaint."
  If you have a "fast complaint," it means we will give you an answer **within 24 hours**.

Legal Terms
What this section calls a "**fast complaint**" is also called an "**expedited grievance**."

Step 2: **We look into your complaint and give you our answer.**

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx.** Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users can call **1-877-486-2048**.

CHAPTER 10. Ending your membership in our plan

SECTION 1. Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in our plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- **You might leave our plan because you have decided that you want to leave.**
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in our plan. Section 2 tells you when you can end your membership in our plan.
  - The process for voluntarily ending your membership varies depending upon what type of new coverage you are choosing. Section 3 tells you how to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2. When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave our plan during your group's open enrollment period. In certain situations, you may also be eligible to leave our plan at other times of the year. Before you request disenrollment, please check with your group to determine if you are able to continue your group membership.

If you request disenrollment during your group's open enrollment, your disenrollment effective date is determined by the date your written request is received by us and the date your group coverage ends. The effective date will not be earlier than the first day of the following month after we receive your written request, and no later than three months after we receive your request.

If you request disenrollment at a time other than your group's open enrollment, your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

Section 2.1 Where can you get more information about when you can end your group membership?

If you have any questions or would like more information about when you can end your group membership:

- Contact your group's benefits administrator.
- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the **Medicare & You 2019** handbook.
  - Everyone with Medicare receives a copy of **Medicare & You** each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (**https://www.medicare.gov**). Or you can order a printed copy by calling Medicare at the number below.

You can contact **Medicare** at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTION 3. How do you end your membership in our plan?

Section 3.1 There are several ways to end your Senior Advantage membership

You may request disenrollment by:

- Requesting disenrollment with your group's benefits administrator. You should always consult them before taking any action because it can affect your eligibility for group benefits.
- Calling toll-free **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048,** or
- Sending written notice to the following address:

  Kaiser Foundation Health Plan, Inc.
  California Service Center
  P.O. Box 232407
  San Diego, CA 92193-2400

SECTION 4. Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information about when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our mail-order pharmacy services.
- If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

SECTION 5. We must end your membership in our plan in certain situations

Section 5.1 When must we end your membership in our plan?

We must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and/or Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. Phone numbers for Member Services are printed on the back cover of this booklet.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.

- If you let someone else use your membership card to get medical care. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information about when we can end your membership:

- You can call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

We are not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can look in Chapter 9, Section 10, for information about how to make a complaint.

Section 5.4 What happens if you are no longer eligible for group coverage?

After your group notifies us to terminate your group membership, we will send a termination letter to the subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan member.

- If you are no longer eligible for group membership, you can request enrollment in our Senior Advantage Individual Plan if you still meet the eligibility requirements for Senior Advantage. The premiums and coverage under our individual plan will differ from those under this **Evidence of Coverage** and will include Medicare Part D prescription drug coverage.
- You may not be eligible to enroll in our Senior Advantage individual plan if your membership ends for the reasons stated under Section 5.1. For more information or

information about other individual plans, call Member Services. Phone numbers are printed on the back cover of this booklet.

CHAPTER 11. Legal notices

SECTION 1. Notice about governing law

Many laws apply to this **Evidence of Coverage** and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2. Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

SECTION 3. Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Kaiser Permanente Senior Advantage, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Administration of this Evidence of Coverage

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this **Evidence of Coverage**.

SECTION 5. Amendment of this Agreement

Your group's Agreement with us will change periodically. If these changes affect this **Evidence of Coverage**, your group is required to inform you in accord with applicable law and your group's Agreement.

SECTION 6. Applications and statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this **Evidence of Coverage**.

SECTION 7. Assignment

You may not assign this **Evidence of Coverage** or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

SECTION 8. Attorney and advocate fees and expenses

In any dispute between a member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

SECTION 9. Coordination of benefits

As described in Chapter 1 (Section 10) "How other insurance works with our plan," if you have other insurance, you are required to use your other coverage in combination with your coverage as a Senior Advantage member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For more information about primary payments in third party liability situations, see Section 18, and for primary payments in workers' compensation cases, see Section 20.

You must tell us if you have other health care coverage, and let us know whenever there are any changes in your additional coverage.

SECTION 10. Employer responsibility

For any services that the law requires an employer to provide, we will not pay the employer, and when we cover any such services, we may recover the value of the services from the employer.

SECTION 11. Evidence of Coverage binding on members

By electing coverage or accepting benefits under this **Evidence of Coverage**, all members legally capable of contracting, and the legal representatives of all members incapable of contracting, agree to all provisions of this **Evidence of Coverage**.

SECTION 12. Government agency responsibility

For any services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such services we may recover the value of the services from the government agency.

SECTION 13. Member nonliability

Our contracts with network providers provide that you are not liable for any amounts we owe. However, you are liable for the cost of noncovered services you obtain from network providers or out-of-network providers.

SECTION 14. No waiver

Our failure to enforce any provision of this **Evidence of Coverage** will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

SECTION 15. Notices

Our notices to you will be sent to the most recent address we have. You are responsible for notifying us of any change in your address. If you move, please call Member Services (phone numbers are printed on the back of this booklet) and Social Security at **1-800-772-1213 (TTY 1-800-325-0778)** as soon as possible to report your address change.

Note: When we tell your group about changes to this **Evidence of Coverage** or provide your group other information that affects you, your group is required to notify the subscriber within 30 calendar days (or five days if we terminate your group's Agreement) after receiving the information from us.

SECTION 16. Overpayment recovery

We may recover any overpayment we make for services from anyone who receives such an overpayment or from any person or organization obligated to pay for the services.

SECTION 17. Surrogacy

In situations where a member receives monetary compensation to act as a surrogate, our plan will seek reimbursement of all Plan Charges for covered services the member receives that are associated with conception, pregnancy and/or delivery of the child. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

SECTION 18. Third party liability

As stated in Chapter 1, Section 10, third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must ensure we receive reimbursement for those services. Note: This Section 18 does not affect your obligation to pay cost-sharing for these services.

To the extent permitted or required by law, we shall be subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, worker's compensation, personal injury, medical payments and all other first party types. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are not required to pay attorney fees or costs to any attorney hired by you to pursue your damage claim.

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

Patient Business Services
Kaiser Foundation Health Plan of Colorado
2500 South Havana Street
Aurora, CO 80014-1622

Please contact our Patient Business Services Department at **303-743-5900,** or TTY users may call **711**.

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

SECTION 19. U.S. Department of Veterans Affairs

For any services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such services we may recover the value of the services from the Department of Veterans Affairs.

SECTION 20. Workers' compensation or employer's liability benefits

As stated in Chapter 1, Section 10, workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due.

From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

CHAPTER 12. Definitions of important words

Allowance – A specified credit amount that you can use toward the cost of an item. If the cost of the item(s) you select exceeds the allowance, you will pay the amount in excess of the allowance, which does not apply to the annual out-of-pocket maximum.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measure your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit when you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent **$5,100** in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs after you pay any deductibles, if applicable. Coinsurance is usually a percentage (for example, 20%) of Plan Charges.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of

care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Coordination of Benefits (COB) – Coordination of Benefits is a provision used to establish the order in which claims are paid when you have other insurance. If you have Medicare and other health insurance or coverage, each type of coverage is called a "payer." When there is more than one payer, there are "coordination of benefits" rules that decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay. If payment owed to us is sent directly to you, you are required under Medicare law to give the payment to us. In some cases, there may also be a third payer. See Chapter 1 (Section 10) and Chapter 11 (Section 9) for more information.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to our plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. Note: In some cases, you may not pay all applicable cost-sharing at the time you receive the services, and we will send you a bill later for the cost-sharing. For example, if you receive nonpreventive care during a scheduled preventive care visit, we may bill you later for the cost-sharing applicable to the nonpreventive care.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you are required to pay for the prescription. In general, if you take your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The general term we use to mean all of the health care services and items that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily Cost-Sharing Rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Dependent–A member who meets the eligibility requirements as a dependent (for dependent eligibility requirements, see Chapter 1, Section 2).

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are (1) rendered by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Emergency Medical Condition – Either: (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to

your health or body functions or organs, or (2) active labor when there isn't enough time for safe transfer to a plan hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a nonpreferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if we limit the quantity or dosage of the drug you are requesting (a formulary exception).

Excluded Drug – A drug that is not a "covered Part D drug," as defined under 42 U.S.C. Section 1395w-102(e).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Family – A subscriber and all of his or her dependents.

Formulary – A list of Medicare Part D drugs covered by our plan.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a "generic" drug works the same as a brand-name drug and usually costs less.

Grievance – A type of complaint you make about us, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Group – The entity with which we have entered into the *Agreement* that includes this **Evidence of Coverage**.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (for example, bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart found at the front of this **EOC**. We cover home health care in accord with Medicare guidelines. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services do not include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A member who has six months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Income Related Monthly Adjustment Amount (IRMAA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5 % of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage after you have met your deductible, if applicable, and before your total drug expenses have reached **$3,820**, including amounts you've paid and what our plan has paid on your behalf.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the seven month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

Inpatient Hospital Care – Health care that you get during an inpatient stay in an acute care general hospital.

Kaiser Foundation Health Plan of Colorado (Health Plan) – Kaiser Foundation Health Plan of Colorado is a Colorado nonprofit corporation and a Medicare Advantage organization. This **Evidence of Coverage** sometimes refers to Health Plan as "we" or "us."

Kaiser Permanente – Kaiser Foundation Health Plan of Colorado and the Medical Group.

Kaiser Permanente 2019 Comprehensive Formulary (Formulary or "Drug List") – A list of prescription drugs covered by our plan. The drugs on this list are selected by us with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Kaiser Permanente Region – A Kaiser Foundation Health Plan organization that conducts a direct-service health care program. When you are outside our service area, you can get medically necessary health care and ongoing care for chronic conditions from designated providers in another Kaiser Permanente region's service area. For more information, please refer to Chapter 3, Section 2.2.

Late Enrollment Penalty – An amount added to the plan premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

Long-Term Care Hospital – A Medicare-certified acute-care hospital that typically provide Medicare covered services such as comprehensive rehabilitation, respiratory therapy, head

trauma treatment, and pain management. They are not long-term care facilities such as convalescent or assisted living facilities.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for any contributions toward your group's monthly premium, your Medicare Part A and Part B premiums, and Part D prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2, for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6, for information about how to contact Medicaid in your state.

Medical Care or Services – Health care services or items. Some examples of health care items include durable medical equipment, eyeglasses, and drugs covered by Medicare Part A or Part B, but not drugs covered under Medicare Part D.

Medical Group – It is the network of plan providers that our plan contracts with to provide covered services to you. The name of our medical group is Colorado Permanente Medical Group, P.C., a for-profit professional corporation.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3, for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, PACE plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, a PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand-name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the

federal government and certain drug manufacturers. For this reason, most, but not all, brand-name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-Inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services and **Customer Experience** – Departments within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services and Customer Experience.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Physician – Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide services to our members (but not including physicians who contract only to provide referral services).

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, (including but not limited to, physician assistants, nurse practitioners, and nurses), hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases, to coordinate as well as provide covered services to members of our plan. We play network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-Service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this **Evidence of Coverage***, most drugs you get from out-of-network pharmacies are not covered b*y our plan unless certain conditions apply (see Chapter 5, Section 2.5, for more information).

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "Cost-Sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) for as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – See **"Medicare Advantage (MA) Plan."**

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

Plan Charges – Plan Charges means the following:

- For services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for services provided to members.

- For services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a member for the item if a member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs; the direct and indirect costs of providing Kaiser Permanente pharmacy services to members; and the pharmacy program's contribution to the net revenue requirements of Health Plan).
- For all other services, the payments that Kaiser Permanente makes for the services or, if Kaiser Permanente subtracts cost-sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract cost-sharing.

Post-Stabilization Care – Medically necessary services related to your emergency medical condition that you receive after your treating physician determines that this condition is clinically stable. You are considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (nonpreferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1, for information about Primary Care Providers.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart found at the front of this **EOC** and described in Chapter 3, Section 2.3. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial

limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4, for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (nonemergency) services. Our plan may disenroll you if you permanently move out of our plan's service area.

Services – Health care services or items.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Specialty-Tier Drugs – Very high-cost drugs approved by the FDA that are on our formulary.

Spouse – Your legal husband or wife.

Subscriber – A member who is eligible for membership on his or her own behalf and not by virtue of dependent status (for subscriber eligibility requirements, see Chapter 1, Section 2).

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-800-476-2167** (TTY **711**),8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 2500 South Havana, Aurora, CO 80014 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

KAISER PERMANENTE®

Multi-language Interpreter Services

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-476-2167** (TTY: **711**).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-476-2167** (TTY: **711**).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-476-2167**（TTY：**711**）。

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-476-2167** (TTY: **711**).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-476-2167** (TTY: **711**).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-476-2167 (TTY: **711**)번으로 전화해 주십시오.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-476-2167** (телетайп: **711**).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-476-2167**（TTY:**711**）まで、お電話にてご連絡ください。

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-476-2167** (መስማት ለተሳናቸው: **711**).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-476-2167** (TTY: **711**).

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French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-476-2167** (ATS : **711**).

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-476-2167** (TTY: **711**) تماس بگیرید.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-674-7612** (رقم هاتف الصم والبكم: -**117**).

Yoruba

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-476-2167** (TTY: **711**).

Cushite-Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-476-2167** (TTY: **711**).

Nepali

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् **1-800-476-2167** (टिटिवाइ: **711**)।

KAISER PERMANENTE®

Kaiser Permanente Senior Advantage Member Services

METHOD	Member Services - contact information
CALL	**1-800-476-2167** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	**303-214-6489**
WRITE	Kaiser Foundation Health Plan of Colorado Customer Experience 2500 South Havana Street Aurora, CO 80014-1622
WEBSITE	**kp.org**

Colorado State Health Insurance Assistance Program

Colorado State Health Insurance Assistance Program is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

METHOD	Contact information
CALL	**1-888-696-7213**
WRITE	SHIP, Colorado Division of Insurance 1650 Broadway Street, Suite 850 Denver, CO 80202
WEBSITE	**http://www.dora.state.co.us/insurance/senior/senior.htm**

ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by contracted providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to contracted providers.

   Note: The following are covered, but not under this section: X-ray and laboratory tests, see "X-ray, Laboratory, and X-ray Special Procedures".

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for Chiropractic Care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

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OPTICAL BENEFIT

A credit, as shown in the "Vision Services and Optical" section of the "Schedule of Benefits (Who Pays What)," applies toward the purchase of one pair of: (i) regular lenses; (ii) frames; or (iii) contact lenses, including cosmetic lenses, when obtained at a Plan Medical Office and prescribed by a physician or an optometrist. This includes: a $60 replacement credit for single vision and contact lenses; and $90 replacement credit for multifocal lenses if a Member's prescription changes .50 diopter or more within 12 months of the initial exam.

Covered Services include:

1. The frame;
2. Mounting of lenses in the frames; and
3. The original fitting and subsequent adjustment of the frame.

The credit must be used at the initial point of sale.

Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional charge, when obtained at Plan Medical Offices.

EXCLUSION: Replacement of lost or broken lenses or frames.

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Kaiser Permanente Senior Advantage Member Services

METHOD	Member Services – contact information
CALL	**1-800-476-2167** Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.
FAX	**303-338-3220**
WRITE	Kaiser Foundation Health Plan of Colorado Customer Experience 2500 South Havana Street Aurora, CO 80014-1622
WEBSITE	**kp.org**

Colorado State Health Insurance Assistance Program

Colorado State Health Insurance Assistance Program is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

METHOD	Contact information
CALL	**1-888-696-7213**
WRITE	SHIP, Colorado Division of Insurance 1650 Broadway Street, Suite 850 Denver, CO 80202
WEBSITE	**http://www.dora.state.co.us/insurance/senior/senior.htm**

Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622
Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

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Important plan information

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MECMPL--COIN--CRCS07DEDNADENNADIAL0MDMEB41DMES78DPP--DUMY01EMPH4DEPO--EXAB--FAM11GRPM1GYN8CHC02HCSS45HH0MHOOP--HOS208HRA--INFT6MLAB56MHBI02MHBO01MHIP48
OPMM2OVC22MOXYG31PNMT0MPP01REHB13REOPM5SGOP3GSNFMSNKRSSSTU--TABS17TRAN0MTRGN33TRVL--VADD--WLCH50XPRO27XRAY7MOVCUIRX02BBAPO45GLISGMGREX01GRFD07OAD6
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Kaiser Foundation Health Plan of Colorado

A Colorado Nonprofit Corporation

2019

LARGE GROUP

GROUP AGREEMENT

GROUP AGREEMENT

INTRODUCTION

This Group Agreement (*"Agreement"*), including the Rate Sheet(s), the Evidence of Coverage *("EOC")* brochure(s) and the Group Application form, all of which are incorporated into this *Agreement* by reference, and any amendments to any of them, constitute the entire contract between the group named on the Rate Sheet ("Group") and Kaiser Foundation Health Plan of Colorado ("Health Plan"). In this *Agreement*, some capitalized terms have special meaning; please see the "Definitions" section in the *Evidence of Coverage* document for terms you should know. Pursuant to this *Agreement,* Health Plan will provide covered Services to Members in accordance with the *Evidence of Coverage*.

TERM OF *AGREEMENT* and RENEWAL

Term of Agreement

This *Agreement* is effective for the term shown on the Rate Sheet, unless terminated as set forth in the "Termination of Agreement" section.

Renewal

This *Agreement* does not automatically renew. If Group complies with all of the terms of this *Agreement,* Health Plan will offer to renew this *Agreement* either by sending Group a new Group Agreement to become effective immediately after termination of this *Agreement*, or by extending the term of this *Agreement* pursuant to "Amendments Effective on an Anniversary Date" in the "Amendment of *Agreement*" section. The new or extended Agreement will include a new term of Agreement and other changes. If Group does not renew this *Agreement*, Group must give Health Plan written notice as described under "Termination on Notice" or "Termination Due to Non-Acceptance of Amendments" in the "Termination of *Agreement*" section.

AMENDMENT OF *AGREEMENT*

Amendments Effective on an Anniversary Date

Upon 60 days' prior written notice to Group with respect to benefit or contract changes, or upon 30 days' prior written notice to Group with respect to rate changes, or as otherwise agreed to by Health Plan and Group, Health Plan may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective on any year's Anniversary Date (the Anniversary Date is shown on the Rate Sheet)..

Amendments Related to Government Approval

If Health Plan notified Group that Health Plan had not received all necessary government approvals related to this *Agreement*, Health Plan may amend this *Agreement* by giving written notice to Group after receiving all necessary government approvals. Any such government-approved provisions go into effect on the Anniversary Date that next followed Health Plan's original notice to Group of the provisions for which it had sought government approval (unless the government requires a later effective date).

Amendment Due to Tax or Other Charges

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan or Plan Providers (or any of their activities), then beginning on the effective date of that tax or charge, Health Plan may increase Group's Dues to include Group's share of the new or increased tax or charge. Group's share will be determined by dividing the

number of Members enrolled through Group by the total number of members enrolled in the Health Plan.

Amendment Due to Medicare Changes

Health Plan contracts on a calendar-year basis with the Centers for Medicare & Medicaid Services (CMS) to offer Kaiser Permanente Senior Advantage. Health Plan may amend this Agreement to change any Senior Advantage EOCs and Premiums effective January 1, 2019 (unless the federal government requires or allows a different effective date). The amendment may include an increase or decrease in Premiums and benefits including Member Cost Sharing and the Medicare Part D initial and catastrophic coverage levels. Health Plan will give Group written notice of any such amendment.

Other Amendments

Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to (a) address any law or regulatory requirement, which may include increasing Dues to reflect an increase in costs to Health Plan or Plan Providers, or (b) reduce or expand the Health Plan Service Area, or (c) increase any benefits of any Medicare product approved by the Centers for Medicare and Medicaid Services (CMS), if applicable to this *Agreement*.

Group Acceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of non-acceptance at least 30 days before the effective date of the amendment to the benefits or contract language, or at least 15 days before the effective date of the amendment to rates, in which case this *Agreement* will terminate pursuant to "Termination Due to Non-Acceptance of Amendments" in the "Termination of *Agreement*" section.

TERMINATION OF *AGREEMENT*

This *Agreement* will terminate under any of the conditions listed below. All rights to benefits under this *Agreement* end on 11:59 p.m. on the termination date, except as expressly provided in the *Evidence of Coverage.*

Health Plan will give Group written notice if this *Agreement* terminates. Within five business days of receipt, Group will mail to each Subscriber a legible copy of the notice and will give Health Plan proof of that mailing and of the date thereof.

Termination on Notice

If Group has Kaiser Permanente Senior Advantage Members

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective the anniversary date, if the anniversary date is the first of the month or the first of the month following the anniversary date if the anniversary date is not the first of the month, by giving at least 30 days' prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Dues, for the period prior to the termination date.

If Group does not have Kaiser Permanente Senior Advantage Members

If Group does not have Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective the anniversary date, if the anniversary date is the first of the month or the first of the month following the anniversary date if the anniversary date is not the first of

the month, by giving at least 60 days' prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Dues, for the period prior to the termination date.

Termination Due to Non-Acceptance of Amendments

All amendments are deemed accepted by Group unless Health Plan receives Group's written notice of non-acceptance at least 30 days before the effective date of the amendment, in which case this *Agreement* will terminate on the following date, as applicable:

- In the case of amendments described in the "Amendment of *Agreement*" section under "Amendments Related to Government Approval" and "Amendments Due to Medicare Changes," and amendments described under "Other Amendments" that do not require 60 days notice by Health Plan, if Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice of non-acceptance, the termination date will be first of the month following 30 days after Health Plan receives notice of non-acceptance.
- In all other cases, the termination date will be the day before the effective date of the amendment.

Termination for Nonpayment

When Group fails to pay Dues on or before the Due Date, Group shall have a period of at least thirty-one (31) days to pay all Dues owed ("Grace Period"). The Grace Period shall begin the day after the Due Date and shall apply to all payments except the first payment. This *Agreement* will remain in full force and effect throughout the Grace Period and Group will remain responsible for payment of Dues during the Grace Period (and any additional period prior to termination, if that occurs). If Health Plan receives full of payment of Dues on or before the last day of the Grace Period, this *Agreement* will remain in effect according to its term and conditions.

If Group fails to pay all Dues owed (including those owed for the Grace Period), then Health Plan may, at its option and in lieu of any other remedy, terminate this *Agreement* without further extension or consideration. Health Plan will notify Group of the past-due amount and the effective date of termination. Such notice shall be sent at least thirty (30) days prior to the effective date of termination. If Dues are paid after the Grace Period ends, Health Plan may charge interest on the overdue Dues. Interest shall not accrue during the Grace Period, and the (simple) interest rate shall be six (6) percent per year or the maximum amount permitted by applicable law, whichever is less. If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members in order to comply with CMS termination notice requirements.

Termination for Fraud or for Intentionally Furnishing Incorrect or Incomplete Information

If Group commits fraud or intentionally furnishes incorrect or incomplete material information to Health Plan, Health Plan may terminate this *Agreement* by giving advance notice to Group, and Group is liable for all unpaid Dues up to the termination date.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

Termination for Violation of Contribution or Participation Requirements
If Group fails to comply with Health Plan's contribution or participation requirements, (including those discussed in the "Contribution and Participation Requirements" section), Health Plan may terminate this *Agreement* by giving advance written notice to Group, and Group is liable for all unpaid Dues up to the termination date.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

Termination for Movement Outside the Service Area
Health Plan may terminate this *Agreement* upon 30 days' prior written notice to Group if no eligible person lives, resides, or works in Health Plan's Service Area as described in the *Evidence of Coverage.*

Termination for Discontinuance of a Product or all Products within a Market
Health Plan may terminate a particular product or all products offered in the group market as permitted by law. If Health Plan discontinues offering a particular product in the group market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days' prior written notice to Group. Health Plan will offer Group another product that it makes available in the group market. If Health Plan discontinues offering all products in the group market, Health Plan may terminate this *Agreement* upon 180 days' written notice to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct evidence of coverage.

DUES

Group will pay to Health Plan, for each Member, the amount(s) specified on the Rate Sheet for each month on or before the date on the monthly invoice or, if Group is self-pay, then the date indicated on the Rate Sheet to which Health Plan and Group agree in writing, but in no event later than the last day of the month preceding the month of coverage (the "Due Date"). Only Members for whom Health Plan has received the appropriate Dues payment listed on the Rate Sheet are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan has received appropriate payment.

When this *Agreement* terminates, if Group does not have another agreement with Health Plan, then the due date for all Dues amounts will be the earlier of: (1) the last Due Date, or (2) the termination date of this *Agreement*. If group does not prepay Full Dues by the last day of the month preceding the coverage month, the Dues may include an additional administrative charge upon renewal. "Full Dues" means 100 percent of monthly Dues for each enrolled Member, as set forth in this "Dues" section.

Dues Rebates

If state or federal law requires Health Plan to rebate dues from this or any earlier contract year and Health Plan rebates dues to Group, Group represents that Group will use that rebate for the benefit of Members, in a manner consistent with the requirements of the Public Health Service Act, the Affordable Care Act, and the obligations of a fiduciary under the Employee Retirement Income Security Act (ERISA).

New Members
Dues are payable for the entire month for new Members unless otherwise agreed to by Health Plan.

Membership Termination
Pursuant to C.R.S. 10-16-103.5, dues are payable for each Member:

- Through the date that Health Plan receives written notice from Group that a Member is no longer eligible or covered; or
- Through the date that Health Plan receives written notice from Group that it no longer intends to maintain coverage for its Members through Health Plan.

Involuntary Kaiser Permanente Senior Advantage Membership Terminations

Group must give Health Plan 30 days' prior written notice of Senior Advantage involuntary membership terminations. An involuntary membership termination is a termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or want Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if health Plan receives a termination notice on March 5, for a Senior Advantage Member, the earliest termination date is May 1 and Group is required to pay applicable Dues for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Termination

If Health Plan receives a disenrollment notice from CMS or a membership termination request from the Member, the membership termination date will be in accordance with CMS requirements.

SUBSCRIBER CONTRIBUTIONS FOR MEDICARE PART C AND PART D COVERAGE

Medicare Part C Coverage

This "Subscriber Contributions for Medicare Part C Coverage" section applies to Group's Kaiser Permanente Senior Advantage coverage. Group's Senior Advantage Premiums include the Medicare Part C premium for coverage of items and services covered under Parts A and B of Medicare, and supplemental benefits. Group may determine how much it will require Subscribers to contribute toward the Medicare Part C premium for each Senior Advantage Member in the Subscriber's Family, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part C premium, then Group agrees to the following:
  - any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category
  - Group will not require different Subscriber contributions toward the Medicare Part C premium for Members within the same class
- Group will not require Subscribers to pay a contribution for Medicare Part C coverage for a Senior Advantage Member that exceeds the Medicare Part C Premium for items and services covered under Parts A and B of Medicare, and supplemental benefits. Health Plan will pass through monthly payments received from CMS (the monthly payments described in 42 C.F.R. 422.304(a)) to reduce the amount the Member contributes toward the Medicare Part C premium.

Medicare Part D Coverage

This "Subscriber Contributions for Medicare Part D Coverage" section, applies only to Group's Kaiser Permanente Senior Advantage coverage that includes Medicare Part D coverage. Group's Senior Advantage Dues include the Medicare Part D premium. Group may determine how much it will require

Subscribers to contribute toward the Medicare Part D premium for each Senior Advantage Member in the Subscriber's Family Unit, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part D premium, then Group agrees to the following:
    - any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category, and are not based on eligibility for the Part D Low Income Subsidy (a subsidy described in 42 C.F.R. Section 423 Subpart P, which is offered by the Medicare program to certain low-income Medicare beneficiaries enrolled in Medicare Part D, and which reduces the Medicare beneficiaries' Medicare Part D premiums or Medicare Part D cost-sharing amounts)
    - Group will not require different Subscriber contributions toward the Medicare Part D premium for Members within the same class.
- Group will not require Subscribers to pay a contribution for prescription drug coverage for a Senior Advantage Member who exceeds the Dues for prescription drug coverage (including the Medicare Part D premium). The Group will pass through direct subsidy payments received from CMS to reduce the amount the Member contributes toward the Medicare Part D premiums.
- Health Plan will credit Group with any Low Income Subsidy amounts that Health Plan receives from CMS for Group's Members and Health Plan will identify those Members for Group as required by CMS. For those Members, Group will first credit the Low Income Subsidy amount toward the Subscriber's contribution for that Member's Senior Advantage premium for the same month, and will then apply any remaining portion of the Member's Low Income Subsidy toward the portion of the Senior Advantage premium that Group pays on behalf of that Member for that month. If Group is unable to reduce the Subscriber's contribution before the Subscriber makes the contribution, Group shall, consistent with CMS guidance, refund the Low Income Subsidy amount to the Subscriber (up to the amount of the Subscriber Premium contribution for the Member for that month) within 45 days after the date Health Plan receives the Low Income Subsidy amount from CMS. Health Plan reserves the right to periodically require Group to certify that Group is either reducing Subscribers' monthly Premium contributions or refunding the Low Income Subsidy amounts to Subscribers in accordance with CMS guidance.
- For any Members who are eligible for the Low Income Subsidy, if the amount of that Low Income Subsidy is less than the Member's contribution for the Medicare Part D premium, then Group should inform the Member of the financial consequences of the Member's enrolling in the Member's current coverage, as compared to enrolling in another Medicare Part D plan with a monthly premium equal to or less than the Low Income Subsidy amount.

Late Enrollment Penalty

If any Members are subject to the Medicare Part D late enrollment penalty, Premiums for those Members will increase to include the amount of that penalty.

CONTRIBUTION AND PARTICIPATION REQUIREMENTS

No change in Group's contribution or participation requirements is effective for purposes of this *Agreement* unless Health Plan consents in writing. In addition, Group must:

- Contribute to all health care plans available through Group on a basis that does not financially discriminate against Health Plan or against people who choose to enroll in Health Plan. In no case

will Group's contribution be less than one-half the rate required for a single Subscriber for the plan in which the Subscriber is enrolled.

- Ensure that:
  - All eligible employees enrolled in Health Plan work at least 20 hours per week.
  - All eligible employees enrolled in Health Plan are covered by Workers' Compensation, unless not required by law to be covered.
  - No less than the percentage of eligible employees, as set forth in the Underwriting Assumptions and Requirements document, are covered by one of the company-sponsored health plans.
  - All Health Plan Subscribers live inside Health Plan's Service Area when they enroll.
  - The number of active, eligible employee Subscribers enrolled under this Agreement does not fall below 10 and the ratio between the number of Subscribers and the total number of people who are eligible to enroll as Subscribers will not drop by 20 percent or more. For the purpose of computing this percentage requirement, Group may include subscribers and those eligible to enroll as subscribers under all other agreements between Group and Health Plan and all other Kaiser Foundation Health Plans and Group Health Cooperative.
  - There is a bona fide employer/employee relationship to those offered our plan, except eligible Taft-Hartley trusts and partnerships.
- Hold an annual open enrollment period during which all eligible people may enroll in Health Plan or in any other health care plan available through Group.
- Meet all applicable legal and contractual requirements, such as:
  - Group must adhere to all requirements set forth in the applicable *Evidence of Coverage*.
  - Group must determine its Member eligibility requirements and obtain Health Plan's prior written approval of any Group eligibility or participation or contribution requirements that are not stated in the applicable *Evidence of Coverage*.
  - Group must use Member enrollment application forms that are provided or approved by Health Plan.
  - Comply with Centers for Medicare & Medicaid Services (CMS) requirements governing enrollment in, and disenrollment from, Kaiser Permanente Senior Advantage (KPSA).
- Meet all Health Plan requirements set forth in the "Underwriting Assumptions and Requirements" document.
- Offer enrollment in Health Plan to all eligible people on conditions no less favorable than those for any other health care plan available through Group.
- Permit Health Plan to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*.

Self-Verification of Member Eligibility

Group agrees to assume responsibility for self-verifying the eligibility of its enrolled Members. Such self-verification includes obtaining and verifying the accuracy of any and all supporting documentation received from Groups employees and eligible Dependents. In addition, Group will provide eligibility data to Health Plan that includes coverage effective dates for Group's employees and eligible Dependents to

prove that eligibility complies with all applicable federal and state laws and regulations. Upon request, Group will make all verification data and documentation available to Health Plan. Health Plan reserves the right to inspect the verification data and documentation for any reason, at any time during the term of the *Agreement* and up to five (5) years thereafter.

Group further agrees to provide Health Plan with timely notification of enrollment and cancellation of enrolled Dependents, as specified in the "Eligibility and Enrollment" and "Termination of Membership" sections of the *Evidence of Coverage*.

MISCELLANEOUS PROVISIONS

Acceptance of *Agreement*

Group acknowledges acceptance of this *Agreement* by signing and returning the signature page of this document to Health Plan. If Group does not return the executed signature page to Health Plan, Group will be deemed as having accepted this *Agreement* if Group pays Health Plan any amount toward Dues.

Note: Group may not change this *Agreement* by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement*, Group must contact its Health Plan account manager. Health Plan will issue a new agreement or amendment if Health Plan and Group agree on any changes.

Assignment

Health Plan may assign this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Health Plan's prior written consent. This *Agreement* shall be binding on the successors and permitted assignees of Health Plan and Group.

Attorney Fees and Costs

If Health Plan or Group institutes legal action against the other to collect any sums owed under this *Agreement*, the party that substantially prevails will be reimbursed for its reasonable litigation expenses, including attorneys' fees, by the other party.

Certificates of Creditable Coverage

This "HIPAA Certificates of Creditable Coverage" section does not apply if Group has a written agreement with Health Plan that Group will mail certificates of creditable coverage.

If Group has a waiting period or affiliation period, when Group reports an enrollment of a new hire and any eligible Dependents who enroll at the same time (other than a Kaiser Permanente Senior Advantage enrollment) with a membership effective date that occurs during the term of this *Agreement*, Group must provide the following information in a format Health Plan approves:

- Enrollment reason. (If Group does not provide an enrollment reason, Health Plan will assume that the Subscriber is not a new hire, and certificates for the Subscriber and any Dependents who enrolled at the same time will indicate that there was no waiting period or affiliation period)
- Hire date of the Subscriber. (If the enrollment reason is "new hire" and Group does not provide a hire date, Health Plan will assume that the hire date is the effective date of coverage for the Subscriber and any Dependents who enrolled at the same time, and certificate for those Members will indicate that there was no waiting period of affiliation period).
- Effective date of coverage.

Group has a waiting period or affiliation period if the membership effective date for a new hire and any eligible Dependents who enroll at the same time is not the hire date (for example, if the membership effective date is the first of the month following the hire date).

Upon Health Plan request (whether or not Group has a waiting period or affiliation period), Group must provide any other information that Health Plan needs in order to complete certificates of creditable coverage.

When Health Plan mails a certificate of creditable coverage, the number of months of creditable coverage that Health Plan reports will be based on the information Health Plan has at the time the certificate is mailed.

Commissions
Group's broker may be paid commissions or other incentives by Health Plan.

Delegation of Claims Review Authority
Group delegates to Health Plan the discretion to determine whether a Member is entitled to benefits under this *Agreement*. In making these determinations, Health Plan has authority to review claims in accordance with the procedures contained in this *Agreement* and to construe this *Agreement* to determine whether the Member is entitled to benefits. For health benefit plans that are subject to the Employee Retirement Income Security Act (ERISA), Health Plan is a "named claims fiduciary" with respect to review of claims under this *Agreement*.

Governing Law
Except as preempted by federal law, this *Agreement* will be governed in accordance with the laws of the State of Colorado. Any provision required to be in this *Agreement* by state or federal law shall bind Group and Health Plan whether or not set forth herein.

Member Information
Group will inform Subscribers of eligibility requirements for Members and when coverage becomes effective and terminates.

When Health Plan notifies Group about changes to this *Agreement* or provides Group other information that affects Members, Group will disseminate the information to Subscribers by the next regular communication to them, but in no event later than 30 days after Group receives the information.

Group will provide electronic or paper summaries of benefits and coverage (SBCs) to participants and beneficiaries to the extent required by law, except that Health Plan will provide SBCs to Members who make a request to Health Plan.

No Waiver
Health Plan's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision, or impair Health Plan's right thereafter to require Group's strict performance of any provision.

Notices
Notices must be delivered in writing to the address listed below, except that

- Health Plan and Group may each change its notice address by giving written notice to the other
- Health Plan may send notices and all other documents to Group's broker instead of sending them directly to Group if Health Plan has a Broker of Record statement from Group
- Health Plan may send notices and all other documents to Group's consultant instead of sending them directly to Group if Group has given Health Plan written notice that Group is represented by a consultant

Notices are deemed given when delivered in person or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Health Plan to Group:

To the most current address on record with Health Plan.

Notices from Group to Health Plan:

Kaiser Foundation Health Plan of Colorado
2500 South Havana Street
Aurora, Colorado 80014-1622

Representation Regarding Waiting Periods

By entering into this Agreement, Group hereby represents that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective, in accordance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to Health Plan will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

Social Security and Tax Identification Numbers

Within 30-60 days after Health Plan sends Group a written request, Group will send Health Plan a list of all Members covered under this Group Agreement, along with the following:

- The Member's Social Security number
- The tax identification number of the employer of the Subscriber in the Member's Family Unit
- Any other information that Health Plan is required by law to collect

Time Limit on Reporting Membership Changes

Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes and in accordance with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. The time limit for retroactive membership **additions** is the calendar month when Health Plan receives Group's notification of the change plus the previous two months, unless Health Plan agrees otherwise in writing.

Involuntary Kaiser Permanente Senior Advantage Membership Termination
Group must give Health Plan 30 days prior written notice of Senior Advantage Medicare Plus involuntary membership terminations. An involuntary membership termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or wants Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan receives a Senior Advantage Medicare Plus membership termination notice unless Group specifies a later termination date. For example, if Health Plan receives a termination notice on March 5 for a Senior Advantage Medicare Plus Member, the earliest termination date is May 1 and Group is required to pay applicable Premiums for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Termination
If Health Plan receives a disenrollment notice from CMS or membership termination request from the Member, the membership termination date will be in accordance with CMS requirements.

The administration of COBRA and State Continuation of Coverage participants will be in accordance with applicable Federal and State laws.

The parties have caused this *Agreement* to be executed by their duly authorized officers.

EXECUTED IN DENVER, COLORADO TO TAKE EFFECT AS OF: 1/1/2019

GROUP

BY: COUNTY OF ADAMS 385
Authorized Group Officer Signature

_____
Please Print Your Name and Title

_____
Date Signed

APPROVED AS TO FORM
COUNTY ATTORNEY

KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NONPROFIT CORPORATION

BY:
Authorized Representative Signature

Ron Vance, Interim President – Colorado Region
Please Print Your Name and Title

1/24/2019
Date Signed

Group Name: COUNTY OF ADAMS Group Number: 385

Contract Period: 01/01/2019 - 12/31/2019

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
001	COUNTY OF ADAMS	Non Medicare	A215	$15 OFFICE VISIT HMO
003	COUNTY OF ADAMS - COBRA	Non Medicare	A215	$15 OFFICE VISIT HMO
005	COUNTY OF ADAMS EDC	Non Medicare	A215	$15 OFFICE VISIT HMO

Steps	Total
Employee Only	$590.01
Spouse Only	$590.01
Child Only	$590.01
Employee & Spouse	$1,239.02
Employee & Child	$1,239.02
Spouse & Child	$1,239.02
Children Only (CK)	$1,239.02
Employee, Spouse & Child/Children	$1,781.89
Employee & Children (ECK+)	$1,781.89
Spouse & Children (SCK+)	$1,781.89
Children Only (CKK+)	$1,781.89

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: COUNTY OF ADAMS Group Number: 385

Contract Period: 01/01/2019 - 12/31/2019

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
001	COUNTY OF ADAMS	Medicare	A215	$15 OFFICE VISIT HMO
003	COUNTY OF ADAMS - COBRA	Medicare	A215	$15 OFFICE VISIT HMO
005	COUNTY OF ADAMS EDC	Medicare	A215	$15 OFFICE VISIT HMO

Plan /ENTL	Total
Medicare Risk AB	$250.76
Medicare Risk B	$618.49
Medicare Risk BD	$618.49
Medicare Risk CD	$250.76

Group Name: COUNTY OF ADAMS Group Number: 385

Contract Period: 01/01/2019 - 12/31/2019

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
002	COUNTY OF ADAMS RETIREES	Non Medicare	A215	$15 OFFICE VISIT HMO
004	CO OF ADAMS EARLY RETIREES COB	Non Medicare	A215	$15 OFFICE VISIT HMO

Steps	Total
Employee Only	$635.42
Spouse Only	$635.42
Child Only	$635.42
Employee & Spouse	$1,334.38
Employee & Child	$1,334.38
Spouse & Child	$1,334.38
Children Only (CK)	$1,334.38
Employee, Spouse & Child/Children	$1,918.90
Employee & Children (ECK+)	$1,918.90
Spouse & Children (SCK+)	$1,918.90
Children Only (CKK+)	$1,918.90

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: COUNTY OF ADAMS Group Number: 385

Contract Period: 01/01/2019 - 12/31/2019

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
002	COUNTY OF ADAMS RETIREES	Medicare	A215	$15 OFFICE VISIT HMO
004	CO OF ADAMS EARLY RETIREES COB	Medicare	A215	$15 OFFICE VISIT HMO

Plan /ENTL	Total
Medicare Risk AB	$250.76
Medicare Risk B	$618.49
Medicare Risk BD	$618.49
Medicare Risk CD	$250.76
Medicare Risk Employee & Children (ECK+) 2 AB	$1,136.94
Medicare Risk Employee & Children (ECK+) AB	$1,490.57
Medicare Risk Employee & Spouse AB	$501.52
Medicare Risk Employee & Spouse or Employee	$886.18

KAISER PERMANENTE®

January 1, 2019

County of Adams

Re: Letter of Understanding between County of Adams and Kaiser Foundation Health Plan of Colorado

Dear Group Administrator:

This is a Letter of Understanding between County of Adams (County) and Kaiser Foundation Health Plan of Colorado (Health Plan) regarding County's request to change various time frames in the 2019 Group Agreement as follows:

Amendments Effective on an Anniversary Date
County requested and Health Plan agreed to provide 60 days written notice to County with respect to any rate changes that will become effective on the Anniversary Date as shown on the Rate Sheet.

Other Amendments
County requested and Health Plan agreed to align modification of the County's Service Area with their renewal.

Termination of Agreement
County requested and Health Plan agreed to allow County 30 days to mail each Subscriber a legible copy of the notice to terminate.

Termination for Nonpayment
County requested and Health Plan agreed to allow County to pay dues 14 days after the 31 day grace period for a total of 45 days.

Termination for Movement Outside the Service Area
County requested and Health Plan agreed Health Plan will provide County with 60 days written notice of termination if no eligible person lives, resides, or works in Health Plan's Service Area.

Contribution and Participation Requirements
County request and Health Plan agreed County's contribution will be no less than $50 for a single Subscriber.

Please call **303-306-2686** if you have questions about this Letter of Understanding. Otherwise, please indicate your agreement by signing and dating where indicated below and returning a signed copy to me.

Sincerely,
Benefit, Policy and Contract Administration
2350 South Parker Road – Third Floor
Aurora, CO 80014

AGREED TO:
County of Adams

By: _____
Signature of Authorized Group Representative

_____
Title

Date: _____

APPROVED AS TO FORM
COUNTY ATTORNEY

KAISER PERMANENTE®

January 1, 2019

Pauline Hohn
Benefit Administrator
County of Adams Human Resources Department
4430 S. Adams County Parkway, Suite C4000B
Brighton, Colorado 80601

Subject: Late Enrollment Penalty

Dear Ms. Hohn:

The purpose of this letter is to acknowledge that you have requested Kaiser Foundation Health Plan of Colorado ("Health Plan") to collect any Late Enrollment Penalties that may be assessed by the Centers for Medicare & Medicaid Services (CMS) for your retirees and their dependents ("Members") who did not sign up for Medicare Part D prescription drug coverage when they were first eligible.

Starting January 1, 2019 and for the duration of your 2019 Plan Year, Health Plan will bill Members directly on a monthly basis if they owe a Late Enrollment Penalty. We will bill only for the amount of their Late Enrollment Penalty each month. An explanation of the Late Enrollment Penalty, along with instructions to contact Health Plan with questions or concerns, will be included with each month's statement. We will continue to bill the Members for the Late Enrollment Penalty during the Plan Year for as long as they remain enrolled in the Kaiser Permanente Senior Advantage coverage that you have purchased.

Please note that pursuant to federal guidelines, we may disenroll individuals for nonpayment of the Late Enrollment Penalty, consistent with our disenrollment policies for nonpayment of premium.

Your agreement with Health Plan indicates that we will increase your Premiums by the amount of the Late Enrollment Penalty owed by your Members. However, due to your request that we bill your Members directly, this acknowledgement letter hereby supersedes that provision. Accordingly, by this letter you acknowledge that the Group Agreement between Health Plan and County of Adams for the Plan Year January 1, 2019, is hereby amended as follows:

The following provision in the Section "Late Enrollment Penalty" is hereby deleted in its entirety:

> *If any Members are subject to the Medicare Part D late enrollment penalty, Premiums for those Members will increase to include the amount of the penalty.*

To confirm your acceptance of the terms of this letter, please sign and date a copy of this letter.

Please contact your Health Plan Account Manager if you have questions about the Late Enrollment Penalty or the information in this letter.

Thank you.

Kaiser Permanente
Account Management

THE ABOVE TERMS ARE UNDERSTOOD AND AGREED TO:

County of Adams
By: _____
Name: _____
Title: _____

APPROVED AS TO FORM
COUNTY ATTORNEY

AMENDMENT TO GROUP AGREEMENT

Group Determines Eligibility

This document amends your Group Agreement. The section titled "**Contribution and Participation Requirements**" is hereby amended with the addition of the following language:

Group Determines Eligibility

Group determines its Member eligibility requirements, which must be approved by Health Plan.

Group agrees to assume responsibility for determining the eligibility of its enrolled employees and their dependents. Such self-determination includes obtaining and verifying the accuracy of all supporting documentation received from enrolled employees regarding the following eligibility categories:

- Marriage;
- Common-law marriage;
- Divorce;
- Domestic partner relationships, if applicable;
- Civil Unions;
- Eligible dependent children including natural children, stepchildren and adopted children;
- Student dependents;
- Overage dependents;
- Cancellation of coverage;
- Loss of coverage;
- COBRA eligibility.

Group further agrees to provide Health Plan with timely notification of enrollment and cancellation of employees and/or their dependents, as specified in the "**Eligibility and Enrollment**" and "**Termination of Membership**" sections of the **Evidence of Coverage** brochure.

Health Plan retains responsibility for the determination of disabled dependents. Employees must complete Health plan's Disabled Dependent form and submit it for approval.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: 2019 United Healthcare Contracts
FROM: Terri Lautt, Director
AGENCY/DEPARTMENT: People and Culture Services
HEARD AT STUDY SESSION ON: August 28, 2018
AUTHORIZATION TO MOVE FORWARD: ☒ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners approves the 2019 Financial Renewal and Terms Amendment to the Administrative Services Agreement, the Amendment to the Specific Excess Risk Insurance Policy, and the Summary Plan Descriptions with United Healthcare Services, Inc.

BACKGROUND: The Adams County Board of County Commissioners entered into a contract with United HealthCare Services Inc., to provide Third Party Administration and Specific Excess Risk Insurance for the county's self-funded health plan.

The attached Financial Renewal and Terms Amendment to the Administrative Services Agreement between United HealthCare, Services Inc. and County of Adams provides for changes to the Financial Terms as outlined within Exhibit A and changes to the Performance Standards as outlined within Exhibit B, providing consistent performance reimbursement guarantees for 2019.

The attached Amendment to the Specific Excess Loss Insurance Policy provides for changes as outlined in the Schedule of Benefits.

The attached Summary Plan Description for the United HealthCare Exclusive Provider Organization (EPO) Plan provides for changes based on Federal and State law with no other changes to the plan design, as approved through Study Session.

The attached Summary Plan Descriptions for the United HealthCare Choice Plus High Deductible Health Plan (HDHP) with the Health Savings Account (HSA) and the attached Summary Plan Description for the United HealthCare Colorado Doctors Plan (CDP) outline benefit coverages for new plans introduced in 2019, as approved through Study Session.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

People and Culture Services
County Manager's Office
Budget Office
County Attorney's Office

ATTACHED DOCUMENTS:

Financial Renewal and Terms Amendment (Exhibit A and Exhibit B)
Stop Loss Amendment No. 6
Fully Executed Business Associate Agreement as reference in the Financial Renewal and Terms Amendment
UHC Choice EPO Plan Summary Plan Description
UHC Choice Plus HDHP/HSA Plan Summary Plan Description
UHC Colorado Doctors Plan (CDP) Summary Plan Description

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund: 19

Cost Center: 8612, 8613

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:	Various		16,683,455
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			16,683,455

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note: Current Budgeted Operating Expenditure includes both medical plans, United HealthCare and Kaiser Permanente.

RESOLUTION ADOPTING AMENDMENTS TO ADAMS COUNTY'S CONTRACTS WITH UNITED HEALTHCARE SERVICES

WHEREAS, the Adams County Board of County Commissioners previously entered into a contract with United HealthCare Services Inc. to provide Third Party Administration and Specific Excess Risk Insurance for the county's self-funded health plan; and,

WHEREAS, the attached Financial Renewal and Terms Amendment to the Administrative Services Agreement between United HealthCare, Services Inc. and County of Adams ("Financial Renewal and Terms Amendment") provides for changes to the Financial Terms as outlined in the attached Exhibit A and changes to the Performance Standards as outlined in the attached Exhibit B, providing consistent performance reimbursement guarantees; and,

WHEREAS, except as stated in the Financial Renewal and Terms Amendment and the Amended Non-Financial Terms, all terms and conditions of the original Administrative Services Agreement between United HealthCare, Services Inc. and County of Adams shall remain in full force and effect through December 31, 2019; and,

WHEREAS, the Adams County Board of County Commissioners recognizes the importance of obtaining additional excess risk insurance to mitigate the limit of liability for claims associated with the county's self-funded health plan; and,

WHEREAS, the attached Amendment to the Specific Excess Loss Insurance Policy ("Amendment No. 6") provides for changes as outlined in the United HealthCare Schedule of Benefits; and,

WHEREAS, the attached United HealthCare Choice EPO, Choice Plus HDHP/HSA, and Colorado Doctors Plan (CDP) Summary Plan Descriptions outline the Benefits provided under the contract, and are in effect through December 31, 2019; and,

WHEREAS, the following attached documents constitute the Amendments to Adams County's contracts with United HealthCare Services for the 2019 plan year:

1. Financial Renewal and Terms Amendment (Exhibit A and Exhibit B)
2. Stop Loss Amendment No. 6
3. Fully Executed Business Associate Agreement as reference in the Financial Renewal and Terms Amendment
4. UHC Choice EPO Plan Summary Plan Description
5. UHC Choice Plus HDHP/HSA Plan Summary Plan Description
6. UHC Colorado Doctors Plan (CDP) Summary Plan Description

NOW, THEREFORE, BE IT RESOLVED, that the Board of County Commissioners, County of Adams, State of Colorado, hereby adopts the attached Amendments to Adams County's contracts with United Healthcare Services.

BE IT FURTHER RESOLVED, that the Chair is hereby authorized to execute said Amendments.

FINANCIAL RENEWAL AND TERMS AMENDMENT

This Amendment ("Amendment") is made to the Administrative Services Agreement ("Agreement") by and between United HealthCare Services, Inc. ("United") and Adams County Government ("Customer"), Contract No. 701043, and is effective on January 1, 2019 unless otherwise specified.

Any capitalized terms used in this Amendment have the meanings shown in the Agreement. These terms may or may not have been capitalized in prior contractual documents between the parties but will have the same meaning as if capitalized.

The agreements that are being amended include any and all amendments, if any, that are effective prior to the effective date of this Amendment.

Nothing shown in this Amendment alters, varies or affects any of the terms, provisions or conditions of the agreements other than as stated herein.

The parties, by signing below, agree to amend the agreements as contained herein.

Adams County Government

By _____
Authorized Signature

Print Name _____

Print Title _____

Date _____

United HealthCare Services, Inc.

By _____
Authorized Signature

Print Name _____

Print Title _____

Date _____

APPROVED AS TO FORM
COUNTY ATTORNEY

EXHIBIT A

THE AMENDED FINANCIAL TERMS ARE AS FOLLOWS:

This Exhibit A shall not alter, vary, or affect any previously agreed to financial terms that are not amended by this Exhibit A.

Contract Number: 701043
The following financial terms are effective for the period January 1, 2019 through December 31, 2019.

The Standard Medical Service Fees are the sum of the following:

The Standard Medical Service Fees are as stated below. These fees do not include state or Federal surcharges, assessments, or similar Taxes imposed by governmental entities or agencies on the Plan or United, including but not limited to those imposed pursuant to The Patient Protection and Affordable Care Act of 2010, as amended from time to time as these are the responsibility of the Plan. The Standard Medical Fees are based upon an estimated minimum of 789 enrolled Employees.

- $52.47 per Employee per month for the Choice and Choice Plus HSA portions of the Plan.
- $55.47 per Employee per month for the Doctors Plan portion of the Plan.

Average Contract Size: 2.14

Pharmacy AWP Contract Rate
Customer's contract rate for prescription drugs obtained through the home delivery Network Pharmacy for generic drugs is AWP-57% excluding specialty drugs. United uses Medi-Span's national drug data file as the source for average wholesale price (AWP) information. United reserves the right to revise the pricing and adopt a new source or benchmark if there are material industry changes in pricing methodologies.

The optional and non-standard fees are the sum of the following

Service Description	Fee
Fraud and Abuse Management	Fee equal to thirty-two and five-tenths percent (32.5%) of the gross recovery amount
Hospital Audit Program Services	Fee not to exceed thirty-one percent (31%) of the gross recovery amount
Credit Balance Recovery Services	Fee not to exceed ten percent (10%) of the gross recovery amount.
Standardized Summary of Benefits and Coverage (SBC) as established under The Patient Protection and Affordable Care Act of 2010	United will provide, at no additional charge, standard format, electronic copies of the SBC documents (twice per year) for medical benefit plans administered by United. Customer logos can be included on the SBC at no additional charge. Additional fees will apply for other services. United will not create SBCs for medical plans United does not administer.
Third Party Liability Recovery (Subrogation) Services	Fee equal to thirty-three and one-third percent (33.3%) of the gross recovery amount
Shared Savings Program	The savings used to calculate the fee per individual claim for Shared Savings will not exceed $50,000. Accordingly, the fee per individual claim will not exceed 35% of $50,000. "Savings Obtained" means the amount that would have been payable to a health care provider, including amounts payable by both the Participant and the Plan, if no discount were available, minus the amount that is payable to the health care provider, again, including amounts payable by both the Participant and the Plan, after the discount is taken.
Advanced Analytics and Recovery Services	Fee equal to twenty four percent (24%) of the gross recovery amount
HSA	$2.75 PEPM – Waived if average balance is $3,000 or more $2.50 per ATM transaction $20.00 per Outbound transfer or rollover to another HSA Custodian

EXHIBIT B - PERFORMANCE GUARANTEES FOR HEALTH BENEFITS

The Standard Medical Service Fees (excluding Optional and Non-Standard Fees and that portion of the Standard Medical Service Fees attributable to Commission Funds, if applicable, as described in Exhibit B), (hereinafter referred to as "Fees") payable by Customer under this Agreement will be adjusted through a credit to its Service Fees in accordance with the performance guarantees set forth below unless otherwise defined in the guarantee. Unless otherwise specified, these guarantees apply to medical benefits and are effective for the period beginning January 1, 2019 through December 31, 2019 (each twelve month period is a "Guarantee Period"). With respect to the aspects of our performance addressed in this exhibit, these fee adjustments are Customer's exclusive financial remedies.

These guarantees will become effective upon the later of (1) the effective date of the Guarantee Period; or (2) the date this Agreement is signed by both parties. In the event these guarantees become effective later than the effective date of the Guarantee Period: (1) quarterly guarantees will become effective beginning with the next calendar quarter following signature of this Agreement by both parties and (2) annual guarantees will become effective commencing with the Agreement Period during which this Agreement is signed by both parties.

United reserves the right from time to time to replace any report or change the format of any report referenced in these guarantees. In such event, the guarantees will be modified to the degree necessary to carry out the intent of the parties. United shall not be required to meet any of the guarantees provided for in this Agreement or amendments thereto to the extent United's failure is due to Customer's actions or inactions or if United fails to meet these standards due to fire, embargo, strike, war, accident, act of God, acts of terrorism or United's required compliance with any law, regulation, or governmental agency mandate or anything beyond United's reasonable control.

Prior to the end of the Guarantee Period, and provided that this Agreement remains in force, United may specify to Customer in writing new performance guarantees for the subsequent Guarantee Period. If United specifies new performance guarantees, United will also provide Customer with a new Exhibit that will replace this Exhibit for that subsequent Guarantee Period.

Claim is defined as an initial and complete written request for payment of a Plan benefit made by an enrollee, physician, or other healthcare provider on an accepted format. Unless stated otherwise, the claims are limited to medical claims processed through the UNET claims systems. Claims processed and products administered through any other system, including claims for other products such as vision, dental, flexible spending accounts, health reimbursement accounts, health savings accounts, or pharmacy coverage, are not included in the calculation of the performance measurements. Also, services provided under capitated arrangements are not processed as a typical claim; therefore capitated payments are not included in the performance measurements.

Time to Process in 10 Days			
Definition	The percentage of all claims United receives will be processed within the designated number of business days of receipt.		
Measurement	Percentage of claims processed		**94%**
	Time to process, in business days or less after receipt of claim	**business days**	**10**
Criteria	Standard claim operations reports		
Level	Site Level		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars at Risk for this metric		**$6,429**
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		**20%**
Gradients	11 business days 12 business days 13 business days 14 business days 15 business days or more		
Dollar Accuracy (DAR)			
Definition	Dollar accuracy rate of not less than the designated percent in any quarter.		

Measurement	Percentage of claims dollars processed accurately	99%
Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed correctly out of the total claim dollars paid.	
Level	Office Level	
Period	Annually	
Payment Period	Annually	
Fees at Risk	Total Dollars at Risk for this metric	$6,429
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	98.99% - 98.50% 98.49% - 98.00% 97.99% - 97.50% 97.49% - 97.00 Below 97.00%	
	Procedural Accuracy	
Definition	Procedural accuracy rate of not less than the designated percent.	
Measurement	Percentage of claims processed without procedural (i.e. non-financial) errors	97%
Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed without procedural (i.e. non-financial) errors.	
Level	Office Level	
Period	Annually	
Payment Period	Annually	
Fees at Risk	Total Dollars at Risk for this metric	$6,429
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	96.99% - 96.50% 96.49% - 96.00% 95.99% - 95.50% 95.49% - 95.00% Below 95.00%	

Phone service guarantees and standards apply to Participant calls made to the customer care center that primarily services Customer's Participants. If Customer elects a specialized phone service model the results may be blended with more than one call center and/or level. They do not include calls made to care management personnel and/or calls to the senior center for Medicare Participants, nor do they include calls for services/products other than medical, such as mental health/substance abuse, pharmacy (except when United is Customer's pharmacy benefit services administrator), dental, vision, Health Savings Account, etc.

	Average Speed of Answer		
Definition	Calls will sequence through our phone system and be answered by customer service within the parameters set forth.		
Measurement	Percentage of calls answered		100%
	Time answered in seconds, on average	seconds	30
Criteria	Standard tracking reports produced by the phone system for all calls		
Level	Team that services Customer's account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars at Risk for this metric		$6,429
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		20%
Gradients	32 seconds or less 34 seconds or less 36 seconds or less 38 seconds or less Greater than 38 seconds		
	Abandonment Rate		
Definition	The average call abandonment rate will be no greater than the percentage set forth		
Measurement	Percentage of total incoming calls to customer service abandoned, on average		2%
Criteria	Standard tracking reports produced by the phone system for all calls		
Level	Team that services Customer's account		
Period	Annually		
Payment Period	Annually		
Fees at Risk	Total Dollars at Risk for this metric		$6,429

Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	2.01% - 2.50% 2.51% - 3.00% 3.01% - 3.50% 3.51% - 4.00% Greater than 4.00%	
	Call Quality Score	
Definition	Maintain a call quality score of not less than the percent set forth	
Measurement	Call quality score to meet or exceed	93%
Criteria	Random sampling of calls are each assigned a customer service quality score, using our standard internal call quality assurance program.	
Level	Office that services Customer's account	
Period	Annually	
Payment Period	Annually	
Fees at Risk	Total Dollars at Risk for this metric	$6,429
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	92.99% - 91.00% 90.99% - 89.00% 88.99% - 87.00% 86.99% - 85.00% Below 85.00%	
	Employee (Member) Satisfaction	
Definition	The overall satisfaction will be determined by the question that reads "Overall, how satisfied are you with the way we administer your medical health insurance plan?"	
Measurement	Percentage of respondents, on average, indicating a grade of satisfied or higher	80%
Criteria	Operations standard survey, conducted over the course of the year; may be customer specific for an additional charge.	
Level	Office that services Customer's account	
Period	Annually	
Payment Period	Annually	
Fees at Risk	Total Dollars at Risk for this metric	$3,214
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	N/A
Gradients	Not applicable	
	Customer Satisfaction	
Definition	The overall satisfaction will be determined by the question that reads "How satisfied are you overall with UnitedHealthcare?"	
Measurement	Minimum score on a 10 point scale	score 5
Criteria	Standard Customer Scorecard Survey	
Level	Customer specific	
Period	Annually	
Payment Period	Annually	
Fees at Risk	Total Dollars at Risk for this metric	$3,214
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	N/A
Gradients	Not applicable	

THE AMENDED NON-FINANCIAL TERMS ARE AS FOLLOWS:

The Administrative Services Agreement is amended on January 1, 2014 as noted below.

The Agreement is amended by the addition of the following Section:

Section 4.22 Advanced Analytics and Recovery Services. United or its affiliate will use a combination of large scale analytics, information and analysis to identify post-adjudication claims for additional overpayment opportunities.

The Administrative Services Agreement is amended on January 1, 2015 as noted below.

Section Section 4.3 Managed Care Network Services. of the Agreement is amended by the addition of the following subsection:

Value Based Contracting Program.

United's contracts with some Network Providers may include withholds, incentives, and/or additional payments that may be earned, conditioned on meeting standards relating to utilization, quality of care, efficiency measures, compliance with United's other policies or initiatives, or other clinical integration or practice transformation standards. Customer shall fund these payments due the Network Providers as soon as United makes the determination the Network Provider is entitled to receive the payment under the Network Provider's contract, either upfront or after the standard has been met. For upfront funding, if United makes the determination that the Network Provider failed to meet a standard, United will return to Customer the applicable amount. United shall provide Customer reports describing the amount of payments made on behalf of Customer's Plan.

Only the initial claims based reimbursement to Network Providers will be subject to the Participant's copayment, coinsurance or deductible requirements. Customer will pay the Network Provider the full amount earned or attributable to its Participants, without a reduction for copayments or deductibles and agree that there will be no impact from these payments on the calculation of the Participant's satisfaction of their annual deductible amount.

The Administrative Services Agreement is amended on September 1, 2016 to replace the Business Associate Agreement with the attached updated Business Associate Agreement.

The Administrative Services Agreement is amended on January 1, 2019 as noted below.

Section 1 is amended to add the following definition:

HSA or Health Savings Account: A tax-advantaged account established by Customer's Employees principally to fund certain qualified medical expenses. This account is maintained in accordance with applicable provisions of the IRC and associated guidance issued by the IRS/Treasury Department, as well as under various agreements and documents maintained between an enrolling Employee and the HSA trustee or custodian.

Section 4 is amended to add the following:

4.23 Health Savings Account (HSA). United will provide Customer with an HSA. The HSA is not subject to ERISA, and accordingly, any provisions of this Agreement which reference ERISA or which establish upon United an obligation to provide reporting or other services standardly associated with an ERISA plan shall not apply to the HSA and any services relating thereto.

Customer acknowledges that HSAs are subject to contribution limits and other requirements imposed by the IRC and associated guidance issued by the IRS/Treasury Department. Customer acknowledges and agrees that United shall have no obligation to ensure compliance with any requirements or limitations pertaining to HSAs, their establishment and/or use. To the extent that Customer has established contribution amounts and other HSA program requirements

applicable to Customer Enrolling Employees, Customer will advise United of such requirements. United will not verify that distributions from Customer's Enrolling Employees' HSAs are for qualified medical expenses.

Section 12.1 is amended to add the following:

and/or (iv) Customer's operation of the HSA as an ERISA plan; failure to act in accordance with applicable provisions of the IRC and associated guidance issued by the IRS/Treasury Department with respect to Customer's HSA; and/or claims against United relating to an HSA utilized by Customer's enrolling Employees

Section 5.1 Benefit Determinations and Appeals is amended by the addition of the following:

Catastrophic Events. During such time as a government agency declares a state of emergency or otherwise invokes emergency procedures with respect to Participants who may be affected by severe weather or other catastrophic events (a "Catastrophic Event Timeframe"), Customer directs United to implement certain changes in its claim procedures for affected Participants, including, for example: (a) exemption from the application of prior authorization requirements and/or penalties; (b) waiver of out-of-network restrictions (e.g., out-of-network providers paid at the Network Provider level); (c) extension of time frames for timely claims filing and/or appeals; (d) early replacement of lost or damaged durable medical equipment; and (e) other protocols reasonably required to provide Participants with access to health plan and pharmacy benefits, as applicable. Such protocols are applicable to Participants whose place of residency falls within impacted areas of the Catastrophic Event, and for dates of service that fall within the Catastrophic Event Timeframe.

UnitedHealthcare Insurance Company

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-860-702-5000

AMENDMENT NO. 6

Amendment to be attached to and made a part of Group Policy No. GA-701043AL, issued by UnitedHealthcare Insurance Company (herein called "Company") to Adams County Government (herein called "Policyholder").

It is agreed by and between the Company and the Policyholder that

1. The page entitled "Schedule Of Benefits" as contained in the Policy is hereby replaced with the attached page entitled "Schedule Of Benefits".
2. This Amendment will hereby be effective as of January 1, 2019.

UnitedHealthcare Insurance Company

William J Golden, President

Thomas J. McGuire, Secretary

ACCEPTED BY: _____

Title: _____

Date: _____

APPROVED AS TO FORM
COUNTY ATTORNEY

UHIC AMEND (07/06)

UnitedHealthcare Insurance Company

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-860-702-5000

SCHEDULE OF BENEFITS

This Schedule of Benefits is only applicable to Excess Loss Insurance provided by the Company during the Policy Period shown below.

Policyholder: Adams County Government

Policy Number: GA-701043AL

Effective Date: January 1, 2019

Administrator: United HealthCare Services, Inc.

Coverage specified herein is applicable only during the Policy Period from January 1, 2019 through December 31, 2019, and is further subject to all terms and conditions of this Policy.

SPECIFIC EXCESS LOSS INSURANCE

Benefit Period: Covered Expenses Incurred from January 1, 2007 through December 31, 2019 and Paid from January 1, 2019 through December 31, 2019.

Specific Deductible per Covered Person: $250,000

Specific Percentage Reimbursable: 100%

Maximum Specific Benefit per Covered Person: Unlimited

Specific Excess Loss Insurance includes:

- Medical
- Stand Alone Prescription Drug Program

Specific Excess Loss Premium: $64.13 per subscriber per month

EXPERIENCE REFUND ENDORSEMENT

Policyholder: Adams County Government

Effective Date: January 1, 2019

In consideration for the premium shown in the Schedule of Excess Loss, the Excess Loss Insurance Policy (the "Policy") will be revised with the addition of Experience Refund Provision.

EXPERIENCE REFUND

The Company will pay the Policyholder an Experience Refund of 25% of Net Profit if the Company issues the Policyholder a Policy/Amendment that provides insurance for a Subsequent Policy Period and insurance is continuous from the first day of the Policy Period through the entire Subsequent Policy Period.

NET PROFIT

Net Profit is calculated as:

a. 60% of the sum of all premiums paid by the Policyholder for the Specific Excess Loss Insurance for the Policy Period; minus

b. the sum of all Specific Excess Loss Insurance claims for the Policy Period.

CALCULATION OF REFUND

Company will calculate and send to the Policyholder, the Experience Refund, if due, 6 months after the end of the Policy Period. A premium credit in the amount of the Experience Refund will be applied to the next available bill.

If Specific Excess Loss Insurance claims are paid after an Experience Refund has been paid to the Policyholder, and such claims relate to the Policy Period for which the Experience Refund has been paid a new Net Profit will be calculated and the Policyholder shall reimburse Company for any reduction in the Experience Refund within thirty (30) days after written notice by the Company. Company may, at its option be reimbursed for any reduction on a previously paid Experience Refund by subtracting the reduced amount from any future payable claim.

All other provisions of the Excess Loss Insurance Policy remain unaffected by this Endorsement.

William J Golden, President

Thomas J. McGuire, Secretary

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BAA") is made in connection with the Administrative Services Agreement (Agreement) between UnitedHealthcare Insurance Company identified as Contract No. 701043 on behalf of itself and its Affiliates Business Associate and Adams County Government's group health plan (Covered Entity) (each a "Party" and collectively the "Parties") and is effective August 1, 2016 (Effective Date). This BAA replaces the terms of any business associate BAA between the parties

The Parties hereby agree as follows:

RECITALS:

WHEREAS, Covered Entity is subject to federal privacy rules promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended by the American Recovery and Reinvestment Act of 2009/HITECH Act (P.L. 11-005); and

WHEREAS, Business Associate provides services for Covered Entity that may involve access to, use, or disclosure of Protected Health Information ("PHI") ; and

WHEREAS, Covered Entity and Business Associate are committed to complying with the Privacy and Security Regulations and desire to set forth the rights and responsibilities of the parties with respect to Protected Health Information;

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, the sufficiency of which is hereby acknowledged by the parties, the parties agree as follows:

1. DEFINITIONS

1.1 Capitalized terms used but not otherwise defined in this BAA have the meanings established for purposes of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations as amended from time to time (collectively, "HIPAA".

1.3 "ARRA" shall mean the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§ 17921-17954, and any and all references in this BAA to sections of ARRA shall be deemed to include all associated existing and future implementing regulations, when and as each is effective.

1.4 "Breach" shall mean the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI as defined, and subject to the exceptions set forth, in 45 C.F.R. § 164.402.

1.5 "Compliance Date" shall mean, in each case, the date by which compliance is required under the referenced provision of ARRA and/or its implementing regulations, as applicable; provided that, in any case for which that date occurs prior to the Effective Date of this BAA, the Compliance Date shall mean the Effective Date.

1.6 "Electronic Protected Health Information" (ePHI) shall mean PHI as defined in Section 1.7 that is transmitted or maintained in electronic media.

1.7 "Individual" shall have the same meaning as the term "Individual" in 45 § C.F.R. 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R § 164.502(g).

1.8 "PHI" shall mean Protected Health Information, as defined in 45 C.F.R. § 160.103, and is limited to the Protected Health Information received from, or received or created on behalf of, Covered Entity by Business Associate pursuant to the performance of the Services.

1.9 "Privacy Rule" shall mean the federal privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, codified at 45 C.F.R. §§ 160 and 164 (Subparts A & E).

1.10 "Required by Law" shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.103.

1.11 "Secretary" shall mean the Secretary of the Department of Health and Human Services or his or her designee.

1.13 "Security Rule" shall mean the federal security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, codified at 45 C.F.R. §§ 160 and 164 (Subparts A & C).

1.14 "Services" shall mean, to the extent and only to the extent they involve the creation, use or disclosure of PHI, the services provided by Business Associate to Covered Entity under the Agreement, including those set forth in this BAA in Sections 4.3 through 4.7, as amended by written agreement of the Parties from time to time.

2. RESPONSIBILITIES OF BUSINESS ASSOCIATE

With regard to its use and/or disclosure of PHI, Business Associate agrees to:

2.1 Use and/or disclose PHI only as necessary to provide the Services, as permitted or required by this BAA and in compliance with each applicable requirement of 45 C.F.R. 164.504(e) or as otherwise Required by Law; provided that, to the extent Business Associate is to carry out Covered Entity's

obligations under the Privacy Rule, Business Associate will comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of those obligations.

2.2 Develop, implement, maintain and use appropriate administrative, physical and technical safeguards to (i) prevent use or disclosure of PHI other than as permitted or required by this BAA, or as otherwise required by law; (ii) reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity; and (iii) as of the Compliance Date of 42 U.S.C. § 17931, comply with the Security Rule requirements set forth in 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316.

2.3 Without unreasonable delay, report to Covered Entity: (i) any use or disclosure of PHI, of which it becomes aware, that is not provided for by this BAA and/or the Agreement; and/or (ii) any Security Incident of which Business Associate becomes aware in accordance with 45 C.F.R. § 164.314(a)(2)(i)(C).

2.4 With respect to any use or disclosure of Unsecured PHI not permitted by the Privacy Rule that is caused solely by Business Associate's failure to comply with one or more of its obligations under this BAA, Covered Entity hereby delegates to Business Associate the responsibility for determining when any such incident is a Breach. In the event of a Breach, Business Associate shall (i) provide Covered Entity with written notification, and (ii) provide all legally required notifications to Individuals, HHS and/or the media, on behalf of Covered Entity. Business Associate shall provide these notifications in accordance with the data breach notification requirements set forth in 42 U.S.C. § 17932 and 45 C.F.R. §§ 160 & 164 subparts A, D & E as of their respective Compliance Dates, and shall pay for the reasonable and actual costs associated with such notifications. In the event of a Breach, without unreasonable delay, and in any event no later than sixty (60) calendar days after Discovery, Business Associate shall provide Covered Entity with written notification that includes a description of the Breach, a list of Individuals and a copy of the template notification letter to be sent to Individuals.

2.5 Require all of its subcontractors and agents that create, receive, maintain, or transmit PHI on behalf of Business Associate to agree, in writing, to the same restrictions and conditions on the use and/or disclosure of PHI that apply to Business Associate; including but not limited to the extent that Business Associate with respect to that PHI.

2.6 Make available its internal practices, books, and records relating to the use and disclosure of PHI to the Secretary for purposes of determining Covered Entity's compliance with the Privacy Rule.

2.7 After receiving a written request from Covered Entity or an Individual, make available to the Covered Entity, or at the direction of the Covered Entity,

directly to an Individual, an accounting of disclosures of PHI about the Individual, in accordance with 45 C.F.R. § 164.528.

2.8 Notwithstanding Section 2.7, in the event that Business Associate in connection with the Services uses or maintains an Electronic Health Record of PHI of or about an Individual, then Business Associate shall, when and as directed by Covered Entity or when requested by an Individual, make an accounting of disclosures of PHI directly to an Individual within thirty (30) days after receiving a written request, in accordance with the requirements for accounting for disclosures made through an Electronic Health Record in 42 U.S.C. § 17935(c) as of its Compliance Date.

2.9 Provide accessafter receiving a written request from Covered Entity or an Individual, to PHI in a Designated Record Set about an Individual, to the Covered Entity, or at the direction of the Covered Entity, directly to an Individual, in accordance with the requirements of 45 C.F.R. § 164.524.

2.10 Notwithstanding Section 2.9, in the event that Business Associate in connection with the Services uses or maintains an Electronic Health Record of PHI of or about an Individual, then Business Associate shall provide an electronic copy of the PHI, directly to an Individual or a third party designated by the Individual, all in accordance with 42 U.S.C. § 17935(e) as of its Compliance Date.

2.11 To the extent that the PHI in Business Associate's possession constitutes a Designated Record Set, make available, within thirty (30) days after a written request by Covered Entity or an Individual, PHI for amendment and incorporate any amendments to the PHI, as directed by Covered Entity or an Individual, all in accordance with 45 C.F.R. § 164.526.

2.12 Request, use and/or disclose only the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure; provided, that Business Associate shall comply with 42 U.S.C. § 17935(b) as of its Compliance Date.

2.13 Accommodate reasonable requests by Individuals for confidential communications in accordance with 45 C.F.R. 164.522(b) of the Privacy Rule.
2.14 Not directly or indirectly receive remuneration in exchange for any PHI as prohibited by 42 U.S.C. § 17935(d) as of its Compliance Date.

2.15 Not make or cause to be made any communication about a product or service that is prohibited by 42 U.S.C. § 17936(a) as of its Compliance Date.

2.16 Not make or cause to be made any written fundraising communication that is prohibited by 42 U.S.C. § 17936(b) as of its Compliance Date.

2.17 Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of this BAA.

3. RESPONSIBILITIES OF COVERED ENTITY

In addition to any other obligations set forth in th Agreement, including this BAA, Covered Entity:

3.1 Shall provide to Business Associate only the minimum PHI necessary to accomplish the Services

3.2 Shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

3.3 Shall notify Business Associate of any changes in, or revocation of, permission by Individuals to use or disclose Protected Health Information, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

3.4 Shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

3.5 Agrees and understands that the Covered Entity is independently responsible for the security of all PHI in its possession (electronic or otherwise), including all PHI that it receives from outside sources, including the Business Associate.

3.6 In the event Covered Entity takes action as described in this Section, Business Associate shall decide which restrictions or limitations it will administer. In addition, if those limitations or revisions materially increase Business Associate's cost of providing Services under the Agreement, including this BAA, Covered Entity shall reimburse Business Associate for such increase in cost.

4. OTHER PERMITTED USES AND DISCLOSURES OF PHI

Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or required by this BAA or the Agreement, Business Associate may:

4.1 Make any and all uses and disclosures of PHI necessary to provide the Services to Covered Entity.

4.2 Use and disclose to subcontractors and agents the PHI in its possession for its proper management and administration or to carry out the legal responsibilities of Business Associate, provided that any third party to which Business Associates discloses PHI for those purposes provides written assurances in advance that: (i) the information will be held confidentially and used or further disclosed only as Required by Law; (ii) the information will be used only for the purpose for which it was disclosed to the third party; and (iii) the third party promptly will notify

Business Associate of any instances of which it becomes aware in which the confidentiality of the information has been breached.

4.3 De-identify any and all PHI obtained by Business Associate under this BAA, which De-identified information does not constitute PHI, is not subject to this BAA and may be used and disclosed on Business Associate's own behalf, all in accordance with the De-identification requirements of the Privacy Rule.

4.4 Provide Data Aggregation services relating to the Health Care Operations of the Covered Entity, including through subcontractors and agents, in accordance with the Privacy Rule.

4.5 Identify Research projects conducted by Business Associate, its Affiliates or third parties for which PHI may be relevant; obtain on behalf of Covered Entity documentation of individual authorizations or an Institutional Review Board or privacy board waiver that meets the requirements of 45 C.F.R. § 164.512(i)(1) (each an ""Authorization" or "Waiver") related to such projects; provide Covered Entity with copies of such Authorizations or Waivers, subject to confidentiality obligations owed to the sponsor of the study ("Required Documentation"); and disclose PHI for such Research provided that Business Associate does not receive Covered Entity's disapproval in writing within ten (10) days of Covered Entity's receipt of Required Documentation.

4.6 Make PHI available for reviews preparatory to Research and obtain and maintain written representations in accord with 45 C.F.R. 164.512(i)(1)(ii) that the requested PHI is sought solely as necessary to prepare a Research protocol or for similar purposes preparatory to Research, that the PHI is necessary for the Research, and that no PHI will be removed from the location in which it is being held on behalf of the Covered Entity in the course of the review.

4.7 Use the PHI to create a Limited Data Set ("LDS") in compliance with 45 C.F.R. 164.514(e).

4.8 Use and disclose the LDS referenced in Section 4.7 solely for Research, Health Care Operations, or Public Health purposes provided that Business Associate shall: (1) not use or further disclose the information other than as permitted by this Section 4.8 or as otherwise Required by Law; (2) use appropriate safeguards to prevent use or disclosure of the information other than as provided for by this Section 4.8; (3) report to Covered Entity any use or disclosure of the information not provided for by this Section 4.8 of which Business Associate becomes aware; (iv) ensure that any agents or subcontractors to whom Business Associate provides the LDS agree to the same restrictions and conditions that apply to Business Associate with respect to such information; and (v) not identify the information or contact the individuals.

5. TERM, TERMINATION, COOPERATION, AND INDEMNIFICATION

5.1 Term. The Term of this BAA shall be effective as of the Effective Date, and shall terminate upon the final expiration of the contract or business arrangement unless earlier terminated in accordance with Section 5.2 of this BAA.

5.2 Termination. If either Party knows of a pattern of activity or practice of the other Party that constitutes a material breach or violation of this BAA then the non-breaching Party shall provide written notice of the breach or violation to the other Party that specifies the nature of the breach or violation. The breaching Party must cure the breach or end the violation on or before sixty (30) days after receipt of the written notice. In the absence of a cure reasonably satisfactory to the non-breaching Party within the specified time frame, or in the event the breach is reasonably incapable of cure, then the non-breaching Party may do the following:

(1) If feasible, terminate the Agreement, including this BAA; or

(2) If termination of the Agreement is infeasible, report the issue to HHS.

5.3 Effect of Termination or Expiration. Within sixty (60) days after the termination or expiration of the contract and/or this BAA, Business Associate shall return or destroy all PHI, if feasible to do so, including all PHI in possession of Business Associate's agents or subcontractors. If Business Associate determines that return or destruction of the PHI is not feasible, Business Associate may retain the PHI subject to this Section 5.3. Under any circumstances, Business Associate shall extend any and all protections; limitations and restrictions contained in this BAA to Business Associate's use and/or disclosure of any PHI retained after the termination or expiration of this BAA, and shall limit any further uses and/or disclosures solely to the purposes that make return or destruction of the PHI infeasible.

5.4 Cooperation. Each Party shall cooperate in good faith in all respects with the other Party in connection with any request by a federal or state governmental authority for additional information and documents or any governmental investigation, complaint, action or other inquiry.

6. MISCELLANEOUS

6.1 Scope of BAA. This BAA relates only to the use, disclosure and protection of PHI if it is disclosed to, created or received by Business Associate in connection with any relation between Business Associate and Covered Entity, is the sole understanding between the parties relating to such matters, and supersedes all prior BAAs and understandings, whether oral or written.

6.2 Contradictory Terms; Construction of Terms. The terms of this BAA to the extent they are unclear shall be construed to allow for compliance by Covered Entity and Business Associate with HIPAA and ARRA.

6.3 No Third Party Beneficiaries. Nothing in this BAA shall confer upon any person other than the Parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

6.4 Survival. Sections 4.8, 5.3, 5.4, 6.2, 6.3 and 6.4 shall survive the termination for any reason or expiration of this BAA or the BAA.

6.5 Independent Contractor. Business Associate and Covered Entity are and shall remain independent contractors throughout the term. Nothing in this BAA shall be construed to constitute Business Associate and Covered Entity as partners, joint venturers, agents or anything other than independent contractors.

Approved as to form:

County Attorney's Office

The parties, by signing below, agree to this Business Associate Agreement.

Adams County Government

By _____
Authorized Signature

Print Name Terri Lautt

Print Title HR Director

Date 7/5/18

United HealthCare Services, Inc.

By _____
Authorized Signature

Print Name B Renee Feagan

Print Title Regional Contract Manager

Date July 9, 2018

Summary Plan Description

Adams County Government
Choice Plan

Effective: January 1, 2019
Group Number: 701043

UnitedHealthcare®

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Care Coordination℠ and Mental Health/Substance-Related and Addictive Disorder Administrator: 1-800-827-2744.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555.
- Online assistance: **www.myuhc.com**.

This Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- Who is eligible.
- Services that are covered, called Covered Health Services.
- Services that are not covered, called Exclusions and Limitations.
- How Benefits are paid.
- Your rights and responsibilities under the Plan.

This SPD supersedes any previous printed or electronic SPD for this Plan.

The Plan Administrator intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. The Plan Administrator is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Adams County Government Choice Health Benefit Plan works. If you have questions contact your local Human Resources department or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments or request printed copies by contacting Human Resources.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- The Plan Administrator is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time employee or project designated employee of the Plan Sponsor who is scheduled to work at his or her job at least 40 hours per week or a regular part-time employee or project designated employee of the Plan Sponsor who is scheduled to work at least 30 hours per week..

An eligible person also includes designated elected officials who are serving in an active capacity and Economic Development employees working at least 30 hours per week.

An eligible Person also includes a Retired Employee, as defined under (Section 14: Glossary).

Retirees over 65 years of age, actively enrolled in Medicare are not eligible for coverage. Please contact the Plan Administrator for more information regarding your options after Medicare eligibility.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your legal Spouse by marriage or common law (a copy of the marriage certificate or common law affidavit is required).
- Civil Union partners (certificate required).
- Domestic Partner (effective 6/1/2019, certificate required) as defined in Section 14, *Glossary*.
- You and/or your Spouse's, Domestic Partner's or civil union partner's biological children under the age of 26.
    - Children born through a gestational carrier or surrogate are not Dependents under the terms of the Plan unless the surrogate is an eligible Dependent under the terms of the plan and submits legal guardianship of the child to the Plan Administrator.
- A child of any age who is medically certified as disabled and dependent upon you or your Spouse for their total support.
- Children placed for adoption or for whom you have obtained legal guardianship.

- A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled, except under certain circumstances. Contact the Plan Administrator for details.

Cost of Coverage

You and the Company share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions may be deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld—and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of Adams County Government's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and the Company reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll

To enroll, call Human Resources within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month coinciding with, or following the completion of a 45 day waiting period. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- Your marriage, divorce, legal separation or annulment.
- Registering a Domestic Partner.
- The birth, legal adoption, placement for adoption or legal guardianship of a child.
- A change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.
- Your death or the death of a Dependent.
- Your Dependent child no longer qualifying as an eligible Dependent.
- A change in your or your Spouse's position or work schedule that impacts eligibility for health coverage.
- Contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer).

- You or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent.
- Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent.
- Termination of your or your Dependent's *Medicaid* or *Children's Health Insurance Program (CHIP)* coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination).
- You or your Dependent become eligible for a premium assistance subsidy under *Medicaid* or *CHIP* (you must contact Human Resources within 60 days of the date of determination of subsidy eligibility).
- A strike or lockout involving you or your Spouse.
- A court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Adams County Government's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under the Plan Administrator's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Copayment.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Network Physician or health care professional you prefer each time you need to receive Covered Health Services.

You are eligible for Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. You must see a Network Physician in order to obtain Benefits. Except as specifically described within the SPD, Benefits are not available for services provided by a non-Network provider. This Plan does not provide a non-Network level of Benefits.

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Benefits. In general health care terminology, a Primary Physician may also be referred to as a Primary Care Physician or PCP. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Benefits also include Emergency Health Services.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified by UnitedHealthcare as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 5, *Plan Highlights*. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider.

Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider.

Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as Out-of-Network Benefits.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of the Company or UnitedHealthcare. It is your responsibility to select your provider.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition

period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify the Claims Administrator, and if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services.

If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you.

In the event that you do not use the selected Network Physician, Benefits will not be paid.

Designated Provider and Other Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a

Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider,Benefits will not be paid.

Eligible Expenses

The Company has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by UnitedHealthcare, you will be responsible to the non-Network provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For Designated Network Benefits and Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Don't Forget Your ID Card
Remember to show your ID card every time you receive health care services from a Network provider. If you do not show your ID card, a Network provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for some Covered Health Services before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

This Plan includes an Annual Deductible that applies to certain Covered Health Services. Refer to Section 5, *Plan Highlights*, for details about the specific Covered Health Services to which the Annual Deductible applies.

The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear in this section under the heading *Eligible Expenses*.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is calculated as a flat dollar amount and is paid at the time of service or when billed by the provider. When Copayments apply, the amount is listed in Section 5, *Plan Highlights*, next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear in this section under the heading *Eligible Expenses*.

Copays count toward the Out-of-Pocket Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear in this section under the heading *Eligible Expenses*.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following will never apply to the Out-of-Pocket Maximum:

- Charges for Non-Covered Health Services.
- The amount of any reduced benefits if you don't notify the Claims Administrator.
- Charges that exceed eligible expenses.

The following table identifies what does and does not apply toward your Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?
Copays, including those for Covered Health Services available in Section 15, *Outpatient Prescription Drugs*	Yes
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for non-Covered Health Services	No
The amounts of any reductions in Benefits you incur by not notifying Care Coordination℠	No

SECTION 4 - CARE COORDINATION[SM]

What this section includes:

- An overview of the Care Coordination[SM] program.
- Covered Health Services for which you need to contact Care Coordination[SM].

UnitedHealthcare provides a program called Care Coordination[SM] designed to encourage personalized, efficient care for you and your covered Dependents.

Care Coordination[SM] nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Care Coordination[SM] nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

Care Coordination[SM] nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Care CoordinationSM process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Care CoordinationSM program includes:

- Admission counseling - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- Inpatient care management - If you are hospitalized, a Care CoordinationSM nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- Readmission Management - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Care CoordinationSM nurse to confirm that medications, needed equipment, or follow-up services are in place. The Care CoordinationSM nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- Risk Management - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Care CoordinationSM nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Care Coordination[SM] nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Contacting UnitedHealthcare or Care Coordination℠ is easy.
Simply call the number on your ID card.

Network providers are generally responsible for notifying the Claims Administrator before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying the Claims Administrator.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying the Claims Administrator before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator is not notified.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the notification requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to provide notification before receiving Covered Health Services.

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:

- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Designated Network (includes United UnitedHealth Premium®) and Network Amounts
Copays In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.	
■ Emergency Health Services.	$200
■ Physician's Office Services - Primary Physician.	**Designated Network** $30 **Network** $30
■ Physician's Office Services – Specialist Physician.	**Designated Network** $40 **Network** $80
■ Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.	$30
■ Urgent Care Center Services.	$40
■ Virtual Visits.	$30

Plan Features	Designated Network (includes United UnitedHealth Premium®) and Network Amounts
Copays do not apply toward the Annual Deductible. Copays do apply toward the Out-of-Pocket Maximum.	
Annual Deductible ■ Individual. ■ Family (not to exceed the Individual amount for all Covered Persons in a family).	 $500 $1,000
Annual Out-of-Pocket Maximum ■ Individual. ■ Family (not to exceed the Individual amount for all Covered Persons in a family). The Annual Deductible does apply toward the Out-of-Pocket Maximum for any Covered Health Services.	 $4,500 $9,000
Lifetime Maximum Benefit There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act:* Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).	Unlimited

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1]	**Benefit** *(The Amount Payable by the Plan based on Eligible Expenses)*
	Designated Network and Network
Ambulance Services ■ Emergency Ambulance. ■ Non-Emergency Ambulance.	*Ground and/or Air Ambulance* 95% after you meet the Annual Deductible 95% after you meet the Annual Deductible
Cancer Services For Network Benefits, oncology services must be received by a Designated Provider. See *Cancer Resource Services (CRS)* in Section 6, *Additional Coverage Details*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Cellular and Gene Therapy Services must be received at a Designated Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
Congenital Heart Disease (CHD) Surgeries For Network Benefits, CHD surgeries must be received and performed by a Designated Provider. Non-Network Benefits under this section include only the CHD surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	95% after you meet the Annual Deductible
Dental Services - Accident Only	95% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Outpatient Prescription Drugs*.
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits.	95% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	100% after you pay a Copayment of $200 per visit
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section and in Section 15, *Outpatient Prescription Drugs*.
Home Health Care See Section 6, *Additional Coverage Details*, for limits.	95% after you meet the Annual Deductible
Hospice Care See Section 6, *Additional Coverage Details*, for limits.	95% after you meet the Annual Deductible
Hospital - Inpatient Stay	95% after you meet the Annual Deductible
Kidney Services For Network Benefits, kidney services must be received by a Designated Provider. *See Kidney Resource Services (KRS) in Section 6, Additional Coverage Details.*	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
Lab, X-Ray and Diagnostics - Outpatient	
■ Lab testing - Outpatient.	100% at a freestanding lab 95% at a Hospital-based lab after you meet the Annual Deductible 100% after you pay the applicable Copayment per visit at a Physician's office-based lab No copayment applies when no Physician charge is assessed.
■ X-ray and Other Diagnostic Testing - Outpatient.	100% after you pay a Copayment of $150 per date of service at a free-standing center 95% at a Hospital-based lab after you meet the Annual Deductible 100% after you pay the applicable Copayment per visit at a Physician's office-based lab No copayment applies when no Physician charge is assessed.
■ PSA Screenings	100%
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	100% after you pay a Copayment of $150 per date of service at a free-standing center 95% at a Hospital-based lab after you meet the Annual Deductible
Mental Health Services	
■ Inpatient.	95% after you meet the Annual Deductible
■ Outpatient.	100% after you pay a Copayment of $30 per visit
■ Outpatient – Group Visit.	100% after you pay a Copayment of $20 per visit

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
	95% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Neonatal Resource Services (NRS) For Network Benefits, neonatal services must be received by a Designated Provider. See *Neonatal Resource Services (NRS)* in Section 6, *Additional Coverage Details*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient. ■ Outpatient – Group Visit.	95% after you meet the Annual Deductible 100% after you pay a Copayment of $30 per visit 100% after you pay a Copayment of $20 per visit 95% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Nutritional Counseling	100% after you pay a Copayment of $30 per visit
Ostomy Supplies	95% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient ■ Primary Physician. ■ Specialist Physician.	**Designated Network** 100% after you pay a Copayment of $30 per visit **Network** 100% after you pay a Copayment of $30 per visit **Designated Network**

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
	100% after you pay a Copayment of $40 per visit **Network** 100% after you pay a Copayment of $80 per visit
Physician Fees for Surgical and Medical Services	95% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury ■ Primary Physician.	**Designated Network** 100% after you pay a Copayment of $30 per visit **Network** 100% after you pay a Copayment of $30 per visit
■ Specialist Physician.	**Designated Network** 100% after you pay a Copayment of $40 per visit **Network** 100% after you pay a Copayment of $80 per visit
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Service category in this section.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
Preventive Care Services ■ Physician Office Services. ■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps.	100% 100% 100%
Prosthetic Devices See Section 6, *Additional Coverage Details*, for limits.	95% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits.	100% after you pay a Copayment of $30 per visit
Scopic Procedures - Outpatient Diagnostic and Therapeutic	100% after you pay a Copayment of $150 per date of service at a free-standing center 95% at a Hospital-based lab after you meet the Annual Deductible 100% after you pay the applicable Copayment per visit at a Physician's office-based lab
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for limits.	95% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
Substance-Related and Addictive Disorders Services ■ Inpatient. ■ Outpatient. ■ Outpatient – Group Visit.	95% after you meet the Annual Deductible 100% after you pay a Copayment of $30 per visit 100% after you pay a Copayment of $20 per visit 95% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Surgery - Outpatient	95% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	100% after you pay a Copayment of $30 per visit
Transplantation Services	95% after you meet the Annual Deductible
Travel and Lodging Covered Health Services must be received by a Designated Provider.	For patient and companion(s) of patient undergoing transplant procedures
Urgent Care Center Services	100% after you pay a Copayment of $40 per visit
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	100% after you pay a Copayment of $30 per visit
Vision Examinations See Section 6, Additional Coverage Details, for limits.	100% after you pay a Copayment of $30 per visit

[1]Please notify the Claims Administrator before receiving Covered Health Services, as described in Section 6, *Additional Coverage Details*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to notify the Claims Administrator or Care Coordination℠ before you receive them, and any reduction in Benefits that may apply if you do not call the Claims Administrator or Care Coordination℠.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call the Claims Administrator or Care Coordination℠. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions and Limitations*.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance as UnitedHealthcare determines appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to the closest Network Hospital.
- To the closest Network Hospital or facility that provides Covered Health Services that were not available at the original Hospital or facility.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such

as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.

- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must notify the Claims Administrator as soon as possible prior to the transport.

If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by a Designated Provider participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or Care Coordination℠.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Pre-Service Notification Requirement
For Benefits you must provide pre-service notification as soon as the possibility of a Cellular or Gene Therapy arises. If you fail to provide pre-service notification as required, No Benefits will be paid.

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:

    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*

- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember that you must notify the Claims Administrator or Care Coordination℠ as soon as the possibility of participation in a Clinical Trial arises. If the Claims Administrator or Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Benefits are available for the following CHD services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about

CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Please remember, for Covered Health Services required to be received by a Designated Provider, you must notify the Claims Administrator as soon as the possibility of a CHD surgery arises. If you do not notify the Claims Administrator and if, as a result, the CHD surgeries are not performed by a Designated Provider, Benefits will not be paid.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- Dental services related to medical transplant procedures.
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system).
- Direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for treatment of accidental Injury only for:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described is Section 15, *Outpatient Prescription Drugs*.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen.
- Equipment to assist mobility, such as a standard wheelchair.
- Hospital beds.
- Delivery pumps for tube feedings.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.
- Orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Note: DME is different from prosthetic devices - see *Prosthetic Devices* in this section.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within two business days of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network will not be provided. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 3, *How the Plan Works*.

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under *Mental Health Services* in this section.
- Cross-sex hormone therapy:

- Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided under *Pharmaceutical Products – Outpatient* in the section.
- Cross-sex hormone therapy dispensed from a pharmacy is provided under Section 15, *Outpatient Prescription Drugs*.

■ Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.

■ Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.

■ Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

Male to Female:

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)
- Breast Construction

Female to Male:

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

■ A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:

- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.
- Must be 18 years or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
- The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Surgical Treatment: Please remember, you must notify the Claims Administrator as soon as the possibility for any of surgery arises.

Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Non-Surgical Treatment: Depending upon where the Covered Health Service is provided, any applicable notification requirements will be the same as those stated under each Covered Health Service category in this section.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 14, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are limited to 60 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Benefits are limited to 275 days during the entire period of time you are covered under this Plan. Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) provided by a Designated Provider participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

You or a covered Dependent may:

- Be referred to KRS by the Claims Administrator or Care Coordination℠.
- Call KRS at 1-866-561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Referral Services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Neonatal Resource Services (NRS)

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by a Designated Provider participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. Designated Provider is defined in Section 14, *Glossary*.

To take part in the NRS program, call a neonatal nurse at 1-866-534-7209. The Plan will only pay Benefits under the NRS program if NRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

You or a covered Dependent may also:

- Call the Claims Administrator or Care Coordination[SM].
- Call NRS at 1-888-936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.

- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a *Board Certified Applied Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout (a form of arthritis).
- Renal failure.
- Phenylketonuria (a genetic disorder diagnosed at infancy).
- Hyperlipidemia (excess of fatty substances in the blood).

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician’s office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category

in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Office visit copays are waived for the diagnosis and treatment of asthma and or diabetes when no other services are provided.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

No copay applies to office visits after the first visit, unless non routine maternity health services are provided.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clincal Programs and Resources*, for details.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to **www.myuhc.com** or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits are limited to a single purchase of each type of prosthetic device every three calendar years.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed a mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please remember for Benefits, you must notify the Claims Administrator or Care Coordination℠ five business days before undergoing a Reconstructive Procedure. When you provide notification the Claims Administrator can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage. If the Claims Administrator or Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

Benefits are limited to:

- 20 visits per calendar year for physical therapy.
- 20 visits per calendar year for occupational therapy.
- 20 visits per calendar year for speech therapy.
- 20 visits per calendar year for pulmonary rehabilitation therapy.
- 36 visits per calendar year for cardiac rehabilitation therapy.
- 20 visits per calendar year for cognitive rehabilitation therapy.
- 24 visits per calendar year for Manipulative Treatment.
- 30 visits per calendar year for post-cochlear implant aural therapy.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and diagnostic endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Benefits are limited to 60 days per calendar year.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.

- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- Referral Services.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received by a Designated Provider.

Benefits are also available for cornea transplants. You are not required to notify the Claims Administrator or Care Coordination℠ of a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received by a Designated Provider.

Please remember you must notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If the Claims Administrator is not notified, as required, Benefits will be reduced to 50% of Eligible Expenses.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Travel and Lodging

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding Travel and Lodging, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offers a lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

  The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*.

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and

video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Vision Examinations

The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a Network provider in the provider's office every other calendar year. Benefits are limited to children up to age 18 only.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

SECTION 7 – CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools.
- Disease and Condition Management Services.
- Wellness Programs.

The Company believes in giving you tools to help you be an educated health care consumer. To that end, United Healthcare has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. UnitedHealthcare and the Company are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

Consumer Solutions and Self-Service Tools

Health Survey

You and your enrolled dependents are invited to learn more about health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page.

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information to help you make more informed health care decisions. When you call, a registered nurse may refer you to any additional resources that are available that may help

you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- A recent diagnosis.
- A minor Sickness or Injury.
- Men's, women's, and children's wellness.
- How to take Prescription Drug Products safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

NurseLine℠ gives you another way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no additional cost. To use this service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine℠ any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

With NurseLine℠, you also have access to nurses online. To use this service, log onto **www.myuhc.com** where you may access the link to initiate an online chat with a registered nurse who can help answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® program including how to locate a UnitedHealth Premium Physician, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and self-service tools.

With **www.myuhc.com** you can:

- Receive personalized messages that are posted to your own website.
- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Access all of the content and wellness topics from NurseLine[SM] including Live Nurse Chat 24 hours a day, seven days a week.
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered on **www.myuhc.com**, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information, including Copays and Annual Deductibles.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes℠. HealtheNotes℠ provides you and your Physician with information regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes℠ report may include health tips and other wellness information.

UnitedHealthcare provides this information through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified who may benefit from this information using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes℠ report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the information UnitedHealthcare provides. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the number on your ID card. This program offers:

- Pregnancy consultation to identify special needs.
- Written and on-line educational materials and resources.
- 24-hour access to experienced maternity nurses.
- A phone call from a care coordinator during your Pregnancy, to see how things are going.
- A phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure and acupuncture.

. Aromatherapy.

. Hypnotism.

. Massage therapy.

5. Rolfing.

6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Extractions (including wisdom teeth), restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

3. Dental implants, bone grafts, and other implant-related procedures.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some type of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. Cranial banding.

4. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

5. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.

6. The replacement of lost or stolen prosthetic devices.

7. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.

8. Oral appliances for snoring.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Outpatient Prescription Drugs*, for coverage details and exclusions.

1. Prescription Drug Products for outpatient use that are filled by a prescription order or refill.

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

Foot Care

1. Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

   - Cutting or removal of corns and calluses.
   - Nail trimming or cutting.
   - Debriding (removal of dead skin or underlying tissue).

2. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. Treatment of flat feet.

4. Treatment of subluxation of the foot.

5. Shoe inserts.

6. Arch supports.

7. Shoes (standard or custom), lifts and wedges.

8. Shoe orthotics.

Gender Dysphoria

1. Cosmetic Procedures, including the following:

   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement after initial construction, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal.
   - Hair transplantation.

- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Reversal of genital surgeries.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples:

   - Compression stockings, ace bandages, diabetic strips, and syringes.
   - Urinary catheters.

   This exclusion does not apply to:

   - Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. Tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.

3. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.

4. The replacement of lost or stolen Durable Medical Equipment.

5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services/Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services in Section 6, Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorder.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living Services.

8. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

   - Nutritional education is required for a disease in which patient self-management is a part of treatment.
   - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

3. Food of any kind. Foods that are not covered include:

- Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU), unless they are the only source of nutrition. Infant formula available over the counter is always excluded.
- Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
- Oral vitamins and minerals.
- Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
- Other dietary and electrolyte supplements.

4. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. (This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.)
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Electric scooters.
   - Exercise equipment and treadmills.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Medical alert systems.
   - Motorized beds, non-Hospital beds, comfort beds and mattresses.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Safety equipment.
   - Saunas.
   - Stair lifts and stair glides.
   - Strollers.
   - Treadmills.

- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Wigs and other scalp hair prosthesis regardless of the reason for the hair loss.

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

3. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

4. Speech therapy to treat stuttering, stammering, or other articulation disorders.

5. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*.

6. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.

7. Psychosurgery (lobotomy).

8. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

9. Chelation therapy, except to treat heavy metal poisoning.

10. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

11. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity even if there is a diagnosis of morbid obesity.

12. Medical and surgical treatment of excessive sweating (hyperhidrosis).

13. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

14. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

15. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

16. Congenital Heart Disease surgery that is not received by a Designated Provider.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a freestanding or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a freestanding or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

   This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue).

4. The reversal of voluntary sterilization.

5. Fetal reduction surgery.

6. Health services and associated expenses for elective abortions.

7. Health services associated with the use of non-surgical or drug induced Pregnancy termination, unless medically necessary.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB).*

2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you, except as otherwise provided by law.

3. While on active military duty.

4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants except those described under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available).

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

4. Health services not performed by a Designated Provider.

5. Solid organ Transplant that is performed as a treatment for Cancer.

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 14, *Glossary*.

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice

care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1.. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

4. Eye exercise or vision therapy.

5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That do not meet the definition of a Covered Health Service in Section 14, *Glossary*.
   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion

does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
- That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
- For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
- That exceed Eligible Expenses or any specified limitation in this SPD.

6. Foreign language and sign language services.

7. Long term (more than 30 days) storage of blood, umbilical cord or other material.

8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider as a result of an Emergency, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

You must submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to UnitedHealthcare within 15 months of the date of service, Benefits for that health service will be denied or reduced, at UnitedHealthcare's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
- You pay a Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information

listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Participant.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The *Current Procedural Terminology (CPT)* codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for outpatient Prescription Drug Product Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the provider the charges you incurred.

Payment of Benefits

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider without UnitedHealthcare's consent. When you assign your Benefits under the Plan to a provider with UnitedHealthcare's consent, and the provider submits a claim for payment, you and the provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Participant) for you to reimburse the provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a provider, you remain the sole beneficiary of the payment, and

the provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the provider as well. If payment to a provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments* in Section 10 *Coordination of Benefits*.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary*, for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 15 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot

resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.

- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits. For Urgent requests for benefits, the Company has delegated UnitedHealthcare the exclusive right to interpret and administer the terms of the plan. UnitedHealthcare's decisions are conclusive and binding.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you

request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the Plan Administrator or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

You cannot bring any legal action against the Plan Administrator or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Plan Administrator or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.

- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the custodial parent; then
  - The parent not having custody of the child; then
  - The Spouse of the non-custodial parent.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan - as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare".

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become enrolled in Medicare. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is

the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are enrolled in Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Company also reserves the right to recover any overpayment by legal action.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the

amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Benefits paid by the Plan may also be considered to be Benefits advanced.

- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA), if applicable with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value

of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- Extended coverage.
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, the Plan Administrator will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Your coverage under the Plan will end on the earliest of:

- The last day of the month your employment with the Company ends.
- The date the Plan ends.
- The last day of the month you stop making the required contributions.
- The last day of the month you are no longer eligible.
- The last day of the month UnitedHealthcare receives written notice from the Plan Administrator to end your coverage, or the date requested in the notice, if later.
- The last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- The date your coverage ends.
- The last day of the month you stop making the required contributions.
- The last day of the month UnitedHealthcare receives written notice from The Plan Administrator to end your coverage, or the date requested in the notice, if later.
- The last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not

limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent, improper use of ID, failure to pay, or threatening behavior. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and the Company find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, Adams County Government has the right to demand that you pay back all Benefits Adams County Government paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. Failure to comply with the eligibility requirements as set forth in this SPD may lead to disciplinary action, up to and including, termination of employment.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability.
- The child depends mainly on you for support.
- You provide to the Plan Administrator proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age.
- You provide proof, upon the Plan Administrator's request, that the child continues to meet these conditions.

The proof might include medical examinations at the Plan Administrator's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Extended Coverage for Total Disability

If a Covered Person has a Total Disability on the date their coverage under the Plan ends, their Benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of:

- The Total Disability ends.
- twelve months from the date coverage would have ended.

Continuing Coverage Through COBRA

COBRA continuation coverage is a temporary extension of coverage under the Plan. When you become eligible for COBRA, you may also become eligible for other coverage options

that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for Medicaid, or for a 30-day special enrollment period to enroll in another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Qualified Beneficiaries

A Qualified Beneficiary generally is any individual covered by a group health plan on the day before a Qualifying Event, such as an employee, the employee's spouse, and dependent children. Dependents continuing coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) are not considered to be Qualified Beneficiaries for COBRA purposes.

A child born to, placed for adoption with, or adopted by the covered employee during a period of COBRA coverage will be considered on the same basis as the covered employee.

Qualifying Events

A Qualifying Event is a life event that would cause the Qualified Beneficiary to lose coverage under the Plan including;

- Termination of employment (other than for gross misconduct), reduction in hours of an eligible employee
- Divorce, legal separation, dependent cessation (a child no longer qualifies as an eligible dependent under the Plan)
- Death of the employee
- Extended military leave of the employee

- Medicare entitlement (Part A, Part B or both) of the employee.

The taking of leave under the Family Medical Leave Act does not constitute a Qualifying Event under COBRA.

COBRA continuation coverage begins on the date that Plan coverage would otherwise have been lost. Qualified Beneficiaries electing continuation coverage must pay 102 percent of the cost of that coverage.

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. For a Qualifying Event such as termination of employment, reduction in hours, death of the employee, or extended military leave of the employee, the employer will notify the Plan Administrator within 31 days of the qualifying event. The Plan Administrator will notify you within 14 days of your rights, enrollment deadlines and the premium required for your continued coverage. Each Qualified Beneficiary will have an independent right to elect continuation coverage.

You must notify the Plan Administrator in writing in the event of a divorce or legal separation, Medicare entitlement (Part A, Part B or both), or in the event a child no longer qualifies as a dependent, as soon as possible, but no later than 60 days after the date of the Qualifying Event. The Plan Administrator will notify you within 14 days of your rights, enrollment deadlines and the premium required for your continued coverage.

How long coverage may be continued

- Up to 18 months for the reason of termination of employment (other than for gross misconduct) or reduction in hours of an eligible employee
- Up to 24 months for the reason of continued military leave as defined by USERRA
- Up to 36 months for the reason of death of an employee, a divorce or legal separation, the employee becoming entitled to Medicare benefits (Part A, Part B or both), or a dependent child ceasing to be eligible under the plan
- Up to 36 months for Qualified Beneficiaries, other than the employee, if the Qualifying Event is termination of employment or reduction in hours of the employee, and the employee became entitled to Medicare benefits (Part A, Part B or both) less than 18 months before the Qualifying Event.

Extended Coverage due to Disability

Coverage could be extended up to 11 months, for a total of 29 months of coverage, for all Qualified Beneficiaries if:

- A Qualified Beneficiary is totally disabled according to the Social Security Administration before the 60th day of COBRA continuation coverage, lasting at least until the end of the 18-month period of continuation coverage; and
- The employee or eligible dependent provides the Human Resources Department with a copy of the Social Security Administration (SSA) Determination of Total Disability (notice must be received within the initial 18 months of continued coverage); and

- Timely premium payments are made (premiums are increased to 150 percent of the cost of coverage for the additional 11 months).
- The Plan Administrator must be notified within 31 days if the Qualified Beneficiary is no longer considered disabled by the Social Security Administration.

Employees disabled while continuing coverage under USERRA are not eligible for the 11-month extension rule.

Second Qualifying Events

Coverage for qualified dependents could be extended up to 36 months from the date of the Initial Qualifying Event if:

- The covered employee dies
- A divorce or legal separation from the covered employee occurs
- A covered dependent child no longer qualifies as an eligible dependent
- A covered employee subsequently becomes entitled to Medicare (Part A, Part B or both) during the initial 18-month COBRA period.

These events can be a Second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the Initial Qualifying Event had not occurred. You must notify the Human Resources Department within 60 days after a Second Qualifying Event occurs if you wish to extend coverage.

For Additional Questions

For more information about your rights and obligations under the Plan and federal law you may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of the EBSA Offices are available through the EBSA website at www.dol.gov/ebsa.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- During Open Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Participant's termination of coverage under the Plan.
- The day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with UnitedHealthcare and the Company.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and the Company

In order to make choices about your health care coverage and treatment, Adams County Government believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- The Company and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this SPD.

- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Company and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Company and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. The Company and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between the Company, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not the Company's agents or employees, nor are they agents or employees of UnitedHealthcare. The Company and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

The Company and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the Company and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Company's employees nor are they employees of UnitedHealthcare. The Company and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. The Company and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

The Company is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.

- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- Must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Company is that of employer and employee, Dependent or other classification as defined in the SPD.

Interpretation of Benefits

The Company and UnitedHealthcare have the sole and exclusive discretion to:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Summary of Material Modifications and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

The Company and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Company may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that the Company does so in any particular case shall not in any way be deemed to require the Company to do so in other similar cases.

Information and Records

The Company and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The Company and UnitedHealthcare may request additional information from you to decide your claim for Benefits. The Company and UnitedHealthcare will keep this information confidential. The Company and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Company and UnitedHealthcare with all information or copies of records relating to the services provided to you. The Company and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. The Company and UnitedHealthcare agree that such information and records will be considered confidential.

The Company and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Company is required to do by law or regulation. During and after the term of the Plan, The Company and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements the Company recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, the Company and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination

with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

Rebates and Other Payments

The Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Company and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) is the official plan document that has been adopted by the Company. There is no other document that controls the benefits under the Plan.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) - the amount of Eligible Expenses you must pay for Covered Health Services in a calendar year before you are eligible to begin receiving Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The CRS program provides:

- Specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer.

- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Care Coordination℠ - programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 15, *Outpatient Prescription Drugs*.

Company - Adams County Government.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 15, *Outpatient Prescription Drugs*.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorder Services or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Included in Section 5, Plan Highlights and Section 6, Additional Coverage Details.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not identified in Section 8, *Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "Scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Covered Person - either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that the Claims Administrator has identified as Designated Network providers. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.
- They must be financially interdependent.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by Human Resources upon your request.

The Participant and Domestic Partner must jointly register their domestic partnership with either Denver or Boulder in order to add the Domestic Partner onto Benefits (an affidavit will not be accepted). The following requirements apply for each:

Denver

Committed Partnership Registry

The City and County of Denver allows couples who are not married to recognize their commitment through the Committed Partnership Registry.

The Registry is open to any two partners who:

- Are unmarried, eighteen years of age or older, and competent to enter into a contract;
- Are not prohibited from marrying each other under the law of this state by reason of a blood relationship or other comparable domestic partnership;
- Are sharing a common household; and
- Do not already have different partners under the provisions of the Denver Committed Partnership Ordinance, the Colorado Civil Unions Act or any other comparable domestic partnership provision.

Boulder

Who are Domestic Partners:

Domestic Partners are two people who have signed an affidavit swearing that they are:

- Are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship;
- Are each other's sole domestic partner;
- Are both at least 18 years of age and competent to contract;
- Share a life and home together;
- Are not related by kinship closer than would bar marriage in the State of Colorado; and
- Are not married.

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Employee Retirement Income Security Act of 1974 (ERISA) - the federal legislation that regulates retirement and employee welfare benefit programs maintained by some employers and unions.

Employer - Adams County Government.

EOB - see Explanation of Benefits (EOB).

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the

Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Diagnostic criteria for children:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
  - ♦ A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - ♦ In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - ♦ A strong preference for cross-gender roles in make-believe play or fantasy play.
  - ♦ A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - ♦ A strong preference for playmates of the other gender.
  - ♦ In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - ♦ A strong dislike of ones' sexual anatomy.
  - ♦ A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Gestational Carrier- a Gestational Carrier is a woman who agrees to have a couple's fertilized egg (embryo) implanted in her uterus. The gestational carrier carries the pregnancy for the couple, who usually has to adopt the child. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- ■ It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- ■ It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI).*

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The KRS program provides:

- Specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International*

Classification of Diseases section on Mental and Behavioral Disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator - the organization or individual designated by the Plan Administrator who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Network Benefits and Section 3, *How the Plan Works*, for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Network Benefits - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Non-Network Benefits and Section 3, *How the Plan Works*, for details about how Non-Network Benefits apply.

Open Enrollment - the period of time, determined by the Company, during which eligible Participants may enroll themselves and their Dependents under the Plan. The Company determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

Participant - a Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Pharmaceutical Product(s) – *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The Adams County Government Choice Health Benefit Plan.

Plan Administrator - Adams County Government or its designee.

Plan Sponsor - Adams County Government, references to "we", "us" and "our" refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.

- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.

- Evaluation and diagnosis.
- Counseling.
- Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee - an Employee under the age of 65 who meets the retirement eligibility rules as defined by Adams County policy guidelines. Retirees over 65 years of age actively enrolled in Medicare are not eligible for coverage.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - - a woman who becomes pregnant usually by artificial insemination or surgical implantation of a fertilized egg for the purpose of carrying the fetus to term for another woman.

Total Disability or Totally Disabled - a Participant's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's or retired person's inability to perform the normal activities of a person of like age and gender.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorder Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.

- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care - care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

SECTION 15 - OUTPATIENT PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drug Products.
- How to utilize the retail and mail order service for obtaining Prescription Drug Products.
- Any Benefit limitations and exclusions that exist for Prescription Drug Products.
- Definitions of terms used throughout this section related to the Prescription Drug Product Plan.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments or other payments that vary depending on which of the tiers of the Prescription Drug List (PDL) the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Copayments requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

You are responsible for paying the applicable Copayment described in the *Payment Information - Outpatient Prescription Drugs* table or *Schedule of Benefits - Outpatient Prescription Drugs*.

The amount you pay for any of the following under this section will be included in calculating any Out-of-Pocket Maximum stated in your SPD:

- Copayments for Prescription Drug Products.
- Coinsurance for Prescription Drug Products.
- The Annual Drug Deductible.

The amount you pay for any of the following under this section will not be included in calculating any Out-of-Pocket Maximum stated in your SPD:

- Certain coupons or offers from pharmaceutical manufacturers. You may access information on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Terms and Features - Outpatient Prescription Drugs

Prescription Drug Product Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug Product coverage. It includes Copay amounts that apply when you have a prescription filled at a Network Pharmacy after you meet the Annual Prescription Drug Deductible. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Note: An Annual Prescription Drug Deductible of $100 per Covered Person, not to exceed $300 for all Covered Persons in the family applies to your Network Benefits, which is separate from the Annual Deductible for your medical coverage. Copays do not apply toward the Annual Prescription Drug Deductible.

Coupons: UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment or apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the number on your ID card.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change. As a result, your Copay may change. You will pay the Copay applicable for the tier to which the Prescription Drug Product is assigned.

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare or its designee. The reason for notifying UnitedHealthcare or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 14, *Glossary*.

The Plan may also require you to notify UnitedHealthcare or its designee so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying UnitedHealthcare.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, you can ask UnitedHealthcare to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*.

When you submit a claim on this basis, you may pay more because you did not notify UnitedHealthcare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and any Deductible that applies.

To determine if a Prescription Drug Product requires notification, either visit **www.myuhc.com** or call the number on your ID card. The Prescription Drug Products requiring notification are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after UnitedHealthcare reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require notification for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable notification, participation or activation requirements associated with such programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Schedule of Benefits - Outpatient Prescription Drugs

Benefit Information for Prescription Drug Products at a Network Pharmacy

Benefit[1,2] **Description and Supply Limits**	**Percentage of Prescription Drug Charge Payable by the Plan:** **(Per Prescription Order or Refill):**
Your Copayment is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List (PDL) are assigned to Tier 1, Tier 2 or Tier 3. Please access **www.myuhc.com** through the Internet or call the telephone number on your ID card to determine tier status.	
Retail The following supply limits apply: As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.[2] A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.	100% after you meet the $100 Prescription Drug Deductible per Covered Person, not to exceed $300 for all Covered Persons in the family and pay a:

Benefit[1,2] Description and Supply Limits	Percentage of Prescription Drug Charge Payable by the Plan: (Per Prescription Order or Refill):
When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment that applies will reflect the number of days dispensed.	
■ Tier-1	100% after you pay a $20 Copay
■ Tier-2	100% after you pay a $40 Copay
■ Tier-3	100% after you pay a $80 Copay
Mail Order Network Pharmacy The following supply limits apply: As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.	100% after you meet the $100 Prescription Drug Deductible per Covered Person, not to exceed $300 for all Covered Persons in the family and pay a:
■ Tier-1	100% after you pay a $35 Copay
■ Tier-2	100% after you pay a $90 Copay
■ Tier-3	100% after you pay a $200 Copay

[1]Please notify UnitedHealthcare before receiving Prescription Drug Products, as described in *Payment Terms and Features*, under *Notification Requirements* in this section.

[2]You are not responsible for paying a Copayment for Preventive Care Medications. Benefits for Preventive Care Medications are not subject to payment of the Annual Prescription Drug Products Deductible.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* does not apply to covered Prescription Drug Products as described in this section, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare Part B.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by UnitedHealthcare during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*, under the heading, *If Your Provider Does Not File Your Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment, and any deductible that applies.

Submit your claim to:

Optum Rx
PO Box 29077
Hot Spring, AR 71903

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drug Products.

All Prescription Drug Products covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay after you have met the Annual Prescription Drug Deductible, when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Copay option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Copay option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of:

- The applicable Copay.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug.
- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copay.
- The Prescription Drug Charge for that particular Prescription Drug.

Retail

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy. The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the number on your ID card or by logging onto **www.myuhc.com**.

To obtain your prescription from a Network Pharmacy, simply present your ID card and pay the Copay, after meeting the Annual Prescription Drug Deductible. The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Copay for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay that applies will reflect the number of days dispensed.

If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

Note: Network Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The mail order service may allow you to purchase up to a 90-day supply of a covered Prescription Drug Product through the mail from a Network Pharmacy.

To use the mail order service, all you need to do is complete a patient profile and enclose your Prescription Order or Refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the number on your ID card.

The following supply limits apply: As written by the provider, up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for any Prescription Order or Refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined, in this section, under *Glossary - Prescription Drug Products*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the number on your ID card. Such preventive drugs are covered at 100%.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

You may fill a prescription for Specialty Prescription Drug Products up to two times at any Network Pharmacy. However, after that you will be directed to a Designated Pharmacy.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

Please see *Glossary - Outpatient Prescription Drugs*, for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Please see *Glossary - Outpatient Prescription Drugs*, in this section for definitions of [4]Specialty Prescription Drug Product and Designated Pharmacy.

Want to lower your out-of-pocket Prescription Drug Product costs?
Consider tier-1 Prescription Drug Products, if you and your Physician decide they are appropriate.

Assigning Prescription Drug Products to the Prescription Drug List (PDL)

UnitedHealthcare's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on UnitedHealthcare's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access **www.myuhc.com** through the Internet or call the number on your ID card for the most up-to-date tier status.

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)

The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Benefit.

Prescription Drug Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, UnitedHealthcare may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits that are stated in the table under the heading *Prescription Drug Product Coverage Highlights*. For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing, through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Special Programs

The Company and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement,

reduction or no Benefit through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Rebates and Other Discounts

UnitedHealthcare and Adams County Government may, at times, receive rebates for certain drugs included on the PDL, including those drugs that you purchase prior to meeting any applicable deductible. As determined by UnitedHealthcare, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug* section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 8, *Exclusions and Limitations* also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access **www.myuhc.com** through the Internet or by calling the number on your ID card for information on which Prescription Drug Products are excluded.

1. For any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

2. Any Prescription Drug Product for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Outpatient Prescription Drugs*) portion of the Plan.

This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. Available over-the-counter medications that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician.

   - Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent.
   - Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement.

   Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

5. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product.

6. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.

7. Prescription Drug Products dispensed outside of the United States, except in an Emergency.

8. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *SPD*. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

9. Certain Prescription Drug Products for tobacco cessation.

10. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

11. The amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

12. The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

13. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

14. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee.

15. Prescribed, dispensed or intended for use during an Inpatient Stay.

16. Prescribed, dispensed for appetite suppression, and other weight loss products.

17. Prescribed to treat infertility.

18. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that UnitedHealthcare and the Company determines do not meet the definition of a Covered Health Service.

19. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

20. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

22. Unit dose packaging or repackagers of Prescription Drug Products.

23. Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and the Company have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*.

24. Used for cosmetic purposes

25. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

26. General vitamins, except for the following which require a Prescription Order or Refill:

    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.

27. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury.

28. A Prescription Drug Product that contains marijuana, including medical marijuana.

29. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

30. Diagnostic kits and products.

31. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Glossary - Outpatient Prescription Drugs

Annual Drug Deductible (or Prescription Drug Deductible) - the amount that you are required to pay for covered Tier 1, Tier 2 and Tier 3 Prescription Drug Products in a calendar year before the Plan begins paying for Prescription Drug Products. The Annual Prescription Drug Deductible is shown in the table at the beginning of this section.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that UnitedHealthcare identifies as a Brand-name product, based on available data resources including, but not limited to, medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that UnitedHealthcare identifies as a Generic product based on available data resources including, but not limited to, medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with UnitedHealthcare or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by UnitedHealthcare as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by UnitedHealthcare's Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

Prescription Drug Charge – the rate the Plan has agreed to pay UnitedHealthcare on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration*. This list is subject to UnitedHealthcare's periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting UnitedHealthcare at the number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.

- Ketone-testing strips and tablets.
- Lancets and lancet devices.
- Glucose meters. This does not include continuous glucose monitors. Benefits for continuous glucose monitors are provided as described in your *SPD*.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the number on your ID card.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Insurance Company. The named fiduciary of Plan is Adams County Government, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

This Plan is considered a Non-Grandfathered as defined under the Patient Protection and Affordable Care Act (healthcare reform). Therefore, additional benefits may be available to you and your eligible dependents.

- Coverage for approved clinical trials
- Expanded claims appeal
- Habilitative coverage
- Well woman preventive services; i.e. contraceptives paid 100 percent as outlined under the health care reform law
- All co-pays, including prescription drug co-pays, deductibles and co-insurance apply to your out-of-pocket maximum

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to UnitedHealthcare Service, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130
The toll-free member phone number listed on your health plan ID card, TTY 711

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

Your can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

ATTACHMENT IV – THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA)

This group health plan does not discriminate in premium amounts, contributions charged or eligibility for coverage based on any individual's genetic information. The plan does not use, request or require genetic information about anyone covered by the plan. Genetic information, within the context of GINA, includes the following: an individual's genetic tests; the genetic tests of an individual's family members (up to fourth-degree relatives by birth, marriage or adoption); manifestation of disease or disorder in family members of an individual; an individual's request for or receipt of genetic services; and genetic information of a fetus carried by an individual or his or her family.

Any Health Risk Assessment (HRA) completed by a person covered by this plan is in compliance with regulations under GINA.

ATTACHMENT V – MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) FREE OR LOW COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

Medicaid and the Children's Health Insurance Program (CHIP) Free or Low Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or **dial 1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 1, 2010. You should contact your State for further information on eligibility**.**

GEORGIA – Medicaid	**MONTANA** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	**NEBRASKA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	**NEVADA** – Medicaid and CHIP

Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	**NEW MEXICO –** Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	**NEW YORK –** Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP

Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since September 1, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid.1-877-267-2323, Ext. 61565

ATTACHMENT VI – THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Under the federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to protect the confidentiality of your Protected Health Information (PHI). Protected Health Information is individually identifiable health information related to your condition, services provided to you, or payments made for your care, which is created or received by a health plan, a health care clearinghouse, or a health care provider and identifies you or provides a means by which you could be identified. The Plan and the Plan Sponsor will not use or disclose PHI except for treatment, payment, health plan operations (collectively known as "TPO"), or as permitted or required by other state and federal law, or to Business Associates to help administer the Plan.

Further, the Plan Sponsor will take reasonable steps to ensure that any use or disclosure is the minimum necessary to accomplish the task.

In addition, under the federal security regulations enacted pursuant to HIPAA, your health plans are required to safeguard the confidentiality and ensure the integrity and availability of your Electronic Protected Health Information (ePHI). ePHI is PHI that is maintained or transmitted in electronic form. The Plan and the Plan Sponsor will reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.

The Plan and Plan Sponsor are separate and independent legal entities, which exchange information to coordinate your Plan coverage. In order to receive PHI from the Plan, the Plan Sponsor agrees to, and has certified to the Plan, that it will:

- Restrict the use or further disclosure of PHI except as permitted by HIPAA or as required by law;
- Ensure that any other entity to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan;
- Not use genetic information that is PHI for underwriting purposes;
- Report to the Privacy Officer any use or disclosure of the information that is inconsistent with the permitted uses or disclosures;
- Make PHI available to Plan participants, consider their amendments and, upon request, provide them with an accounting of PHI disclosures as required by law;
- Make internal practices and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request;
- Provide adequate safeguards to protect PHI;

- Provide legally required notices of unauthorized acquisition, access or disclosures of your health information as required by law; and
- If feasible, upon termination of the plan, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible.

In order to receive ePHI from the Plan, the Plan Sponsor agrees that it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that access to, and use and disclosure of ePHI by the employees or classes of employees described in the Plan document is supported by reasonable and appropriate security measures; and
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides this information agrees to implement reasonable and appropriate security measures to protect the information

Only limited members of the workforce of the Group Health Plan may be permitted to use and/or disclose PHI. Under this Plan the following individuals are permitted to have access to, use and/or disclose PHI:

- Employees of the Plan Sponsor who perform administrative services on behalf of the Plan, including payment, health care operations, design and administration. This includes County Administrator, Director of Human Resources, Benefits Manager, Benefits Administrator, Human Resources Specialists.
- Employees of the Plan Sponsor who have access to PHI for purposes of its use by the Employer in performing services for the Plan, including procurement of insurance, financial transactions and accounting. This includes Director of Finance, Administrative Coordinators, Payroll Accountants, Payroll Technicians, General Accounting Managers, Budget Managers and Budget Analysts.
- Service providers to the Plan. This includes County Attorneys, Benefit Consultants, Third Party Administrators, and IT Personnel.

The Plan will limit the use, disclosure or request for PHI to the minimum amount that is reasonably necessary to fulfill a request as set forth in this Agreement. Requests for disclosures other than by legal authority or by the participant will be reviewed by the Privacy Officer or his/her designee.

Where PHI is used or disclosed for the purposes of the Plan's own payment activity, whether through a TPA or Carrier, the employees of the Plan are permitted to use and disclose information to perform these functions using the minimum necessary to accomplish the purpose.

If you believe that your privacy rights have been violated, you may file a complaint with the privacy officer or with the Secretary of the United States Department of Health and Human Services. All complaints must be submitted in writing. You will not be retaliated against in any way for filing a complaint.

You may receive a complete copy of the Plan's Notice of Privacy Practices by contacting the Privacy Officer.

PRIVACY OFFICER

The Plan Administrator has designated a privacy officer who is the contact person for all issues regarding your privacy rights. You may contact the privacy officer at the following address and telephone number.

Director of Human Resources
4430 S. Adams County Parkway, Suite C4000B.
Brighton, CO 80601
phone: 720.523.6070
fax: 720.523.6069

ATTACHMENT VII– HEALTH INSURANCE MARKETPLACE NOTIFICATION

General Information
When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes (pre-tax premiums). Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This Plan provides minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." This Plan does meet the minimum value standard for the benefits it provides**.**

ATTACHMENT VIII– GETTING HELP IN OTHER LANGUAGES OR FORMATS

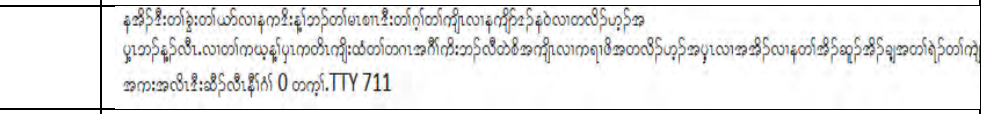
You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ ሚስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հէռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꮻ ᏱᎠ ᎫCZᏋᎫ Ꭻ4ᏯᎫ ᏂAᏪᎳW it, ᏣᏙᎠ VᏯ ᏱR ᎫJAVᎫ ACᏯVᎫ ᏆΘᏲᏯᎫT, ᏤᏐᎾᏯᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, ૦ દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी निःशुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77

Language	Translated Taglines
	bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟੋਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕੋਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711

Language	Translated Taglines
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܠܟ ܙܟܝܘܬܐ ܕܬܫܡܫ ܥܡ ܥܕܪܐ ܘܠܡܐ ܒܠܫܢܟ ܕܝܠܟ ܒܠܐ ܡܨܪܐ. ܠܡܬܚܢܢܐ ܥܠ ܡܬܪܓܡܢܐ، ܩܪܝ ܠܡܢܝܐ ܕܛܠܦܘܢ ܕܚܒܪ ܒܪ ܟܪܛܝܣ ܕܐܝܕ ܐܝ ܕܡܬܐ ܒܬܘܟ ܐܝ ܕܝܠܟ ܘܠܚܘ ܒܬܘ ܠ 0 ܘܐܫܪ ܠ TTY 711.
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు స మాచార పొందడానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta'etotongi ma'ae kau memipa 'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. TTY 711

Language	Translated Taglines
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן קארטל , דרוקט 0. TTY 711 ID
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:
UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.Unitedhealthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important:
You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.Unitedhealthallies.com** or by calling the number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description illustrates the benefits you may be eligible for under the ParentSteps® program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

> *Important*:
> ParentSteps® is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps® will collect the provider payment from you online via the ParentSteps® website and forward the payment to the provider on your behalf. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description Section 5, *Plan Highlights*, when a benefit is available.

What is ParentSteps®?

ParentSteps® is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- Guidance to help you make informed decisions on where to receive care.
- Education and support resources through experienced infertility nurses.
- Access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services.
- Discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *Glossary*.

Registering for ParentSteps®

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at **www.myoptumhealthparentsteps.com** or by calling ParentSteps® toll-free at 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps® facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see

the specific rates negotiated by ParentSteps® with each provider for select types of infertility treatment in order to make an informed decision.

Visiting Your Selected Health Care Professional

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps® member. ParentSteps® will validate your choice and send a validation email to you and the clinic.

Obtaining a Discount

If you and your provider choose a treatment in which ParentSteps® discounts apply, the provider will enter in your proposed course of treatment. ParentSteps® will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps® website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps® will notify your provider with a statement saying that treatments may begin.

Speaking with a Nurse

Once you have successfully registered for the ParentSteps® program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps® nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps® nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

Additional ParentSteps® Information

Additional information on the ParentSteps® program can be obtained online at **www.myoptumhealthparentsteps.com** or by calling 1-877-801-3507 (toll-free).

Summary Plan Description

Adams County Government
Choice Plus Plan with Health Savings Account

Effective: January 1, 2019
Group Number: 701043

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Care Coordination℠ and Mental Health/Substance-Related and Addictive Disorder Administrator: 1-800-827-2744.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555.
- Online assistance: **www.myuhc.com**.

This Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- Who is eligible.
- Services that are covered, called Covered Health Services.
- Services that are not covered, called Exclusions and Limitations.
- How Benefits are paid.
- Your rights and responsibilities under the Plan.

This SPD supersedes any previous printed or electronic SPD for this Plan.

The Plan Administrator intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. The Plan Administrator is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Adams County Government Choice Plus Health Benefit Plan works. If you have questions contact your local Human Resources department or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments or request printed copies by contacting Human Resources.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- The Plan Administrator is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time employee or project designated employee of the Plan Sponsor who is scheduled to work at his or her job at least 40 hours per week or a regular part-time employee or project designated employee of the Plan Sponsor who is scheduled to work at least 30 hours per week.

An eligible person also includes designated elected officials who are serving in an active capacity and Economic Development employees working at least 30 hours per week.

An eligible Person also includes a Retired Employee, as defined under (Section 14: Glossary).

Retirees over 65 years of age, actively enrolled in Medicare are not eligible for coverage. Please contact the Plan Administrator for more information regarding your options after Medicare eligibility.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your legal Spouse by marriage or common law (a copy of the marriage certificate or common law affidavit is required).
- Civil Union partners (certificate required).
- Domestic Partner (effective 6/1/2019, certificate required) as defined in Section 14, *Glossary*.
- You and/or your Spouse's, Domestic Partner's or civil union partner's biological children under the age of 26.
    - Children born through a gestational carrier or surrogate are not Dependents under the terms of the Plan unless the surrogate is an eligible Dependent under the terms of the plan and submits legal guardianship of the child to the Plan Administrator.
- A child of any age who is medically certified as disabled and dependent upon you or your Spouse for their total support.
- Children placed for adoption or for whom you have obtained legal guardianship.

- A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled, except under certain circumstances. Contact the Plan Administrator for details.

Cost of Coverage

You and the Company share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions may be deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld—and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of Adams County Government's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and the Company reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll

To enroll, call Human Resources within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month coinciding with, or following the completion of a 45 days waiting period. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- Your marriage, divorce, legal separation or annulment.
- Registering a Domestic Partner.
- The birth, legal adoption, placement for adoption or legal guardianship of a child.
- A change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.
- Your death or the death of a Dependent.
- Your Dependent child no longer qualifying as an eligible Dependent.
- A change in your or your Spouse's position or work schedule that impacts eligibility for health coverage.
- Contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer).

- You or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent.
- Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent.
- Termination of your or your Dependent's *Medicaid* or *Children's Health Insurance Program (CHIP)* coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination).
- You or your Dependent become eligible for a premium assistance subsidy under *Medicaid* or *CHIP* (you must contact Human Resources within 60 days of the date of determination of subsidy eligibility).
- A strike or lockout involving you or your Spouse.
- A court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Adams County Government's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under the Plan Administrator's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider.

Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as Out-of-Network Benefits.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare will work with you and your Network Physician to coordinate care through a non-Network provider.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of the Company or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Designated Provider and Other Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider, Designated Provider or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event that you do not use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

The Company has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare) you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay..

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
      - 50% of CMS for the same or similar laboratory service.
      - 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.
    - When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
      - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor

that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

- For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reute*rs (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

- When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

UnitedHealthcare updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Don't Forget Your ID Card
Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for some Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums

for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following will never apply to the Out-of-Pocket Maximum:

- Charges for Non-Covered Health Services.
- The amount of any reduced benefits if you don't notify the Claims Administrator.
- Charges that exceed eligible expenses.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying Care Coordination℠	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4 - CARE COORDINATION℠

What this section includes:

- An overview of the Care Coordination℠ program.
- Covered Health Services for which you need to contact Care Coordination℠.

UnitedHealthcare provides a program called Care Coordination℠ designed to encourage personalized, efficient care for you and your covered Dependents.

Care Coordination℠ nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Care Coordination℠ nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

Care Coordination℠ nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Care CoordinationSM process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.As of the publication of this SPD, the Care CoordinationSM program includes:

- Admission counseling - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- Inpatient care management - If you are hospitalized, a Care CoordinationSM nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- Readmission Management - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Care CoordinationSM nurse to confirm that medications, needed equipment, or follow-up services are in place. The Care CoordinationSM nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- Risk Management - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Care CoordinationSM nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Care Coordination℠ nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Contacting UnitedHealthcare or Care Coordination℠ is easy.
Simply call the number on your ID card.

Network providers are generally responsible for notifying the Claims Administrator before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying the Claims Administrator.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying the Claims Administrator before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator is not notified.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the notification requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to provide notification before receiving Covered Health Services.

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:
- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network Amounts	Non-Network Amounts
Annual Deductible		
■ Individual.	$1,350	$2,100
■ Family (not to exceed the Individual amount for all Covered Persons in a family).	$2,700	$4,200
Annual Out-of-Pocket Maximum		
■ Individual.	$6,550	$8,000
■ Family (not to exceed the Individual amount for all Covered Persons in a family).	$7,900	$16,000
The Annual Deductible does apply toward the Out-of-Pocket Maximum for any Covered Health Services.		
Lifetime Maximum Benefit	Unlimited	
There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.		
Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act:*		
Ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products;		

Plan Features	Network Amounts	Non-Network Amounts
rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).		

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Ambulance Services	*Ground and/or Air Ambulance*	*Ground and/or Air Ambulance*
■ Emergency Ambulance.	80% after you meet the Annual Deductible	Same as Network
■ Non-Emergency Ambulance. Ground or air ambulance, as the Claims Administrator determines appropriate.	80% after you meet the Annual Deductible	Same as Network
Cancer Services For Network Benefits, oncology services must be received by a Designated Provider. See *Cancer Resource Services (CRS)* in Section 6, *Additional Coverage Details*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Cellular and Gene Therapy Services must be received at a Designated Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Non-Network Benefits are not available

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries For Network Benefits, CHD surgeries must be received and performed by a Designated Provider . Non-Network Benefits under this section include only the CHD surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this section.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible	Same as Network
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Outpatient Prescription Drugs*.	
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Emergency Health Services - Outpatient	80% after you meet the Annual Deductible	Same as Network
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section and in Section 15, *Outpatient Prescription Drugs*.	
Home Health Care See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Hospice Care See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Kidney Services For Network Benefits, kidney services must be received by a Designated Provider. *See Kidney Resource Services (KRS) in Section 6, Additional Coverage Details.*	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Lab, X-Ray and Diagnostics - Outpatient		

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
■ Lab testing - Outpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ X-ray and Other Diagnostic Testing - Outpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ PSA Screenings	100%	50% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Mental Health Services		
■ Inpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Outpatient.	80% after you meet the Annual Deductible 80% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible	50% after you meet the Annual Deductible 50% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Neonatal Resource Services (NRS) For Network Benefits, neonatal services must be received by a Designated Provider. See *Neonatal Resource Services (NRS)* in Section 6, *Additional Coverage Details*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Neurobiological Disorders - Autism Spectrum Disorder Services		

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
■ Inpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Outpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
	80% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible	50% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Nutritional Counseling	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Service category in this section.	
Preventive Care Services ■ Physician Office Services.	100%	Non-Network

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps.	100% 100%	Benefits are not available
Prosthetic Devices See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services		
■ Inpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Outpatient.	80% after you meet the Annual Deductible 80% for Partial Hospitalization/Intensive Outpatient	50% after you meet the Annual Deductible 50% for Partial Hospitalization/Intensive Outpatient

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
	Treatment after you meet the Annual Deductible	Treatment after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Transplantation Services	80% after you meet the Annual Deductible	Non-Network Benefits are not available
Travel and Lodging Covered Health Services must be received by a Designated Provider.	For patient and companion(s) of patient undergoing transplant procedures	
Urgent Care Center Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible	Non-Network Benefits are not available

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Vision Examinations See Section 6, Additional Coverage Details, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

[1]Please notify the Claims Administrator before receiving Covered Health Services, as described in Section 6, *Additional Coverage Details*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to notify the Claims Administrator or Care Coordination℠ before you receive them, and any reduction in Benefits that may apply if you do not call the Claims Administrator or Care Coordination℠.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call the Claims Administrator or Care Coordination℠. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions and Limitations*.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers non-Emergency transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must notify the Claims Administrator as soon as possible before transport.

If the Claims Administrator or Care Coordination℠, Benefits will be reduced to 50% of Eligible Expenses.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by a Designated Provider participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or Care Coordination℠.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Pre-Service Notification Requirement
For Network Benefits you must provide pre-service notification as soon as the possibility of a Cellular or Gene Therapy arises. If you do not provide pre-service notification and if, as a result, the services are not received from a Designated Provider, Network Benefits will not be paid.

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember that you must notify the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Benefits are available for the following CHD services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.

- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Please remember, for Covered Health Services required to be received by a Designated Provider, you must notify the Claims Administrator as soon as the possibility of a CHD surgery arises. If you do not notify the Claims Administrator and if, as a result, the CHD surgeries are not performed by a Designated Provider, Benefits will not be paid. Non-Network Benefits will apply.

Please remember that for Non-Network Benefits you must notify the Claims Administrator as soon as the possibility of a CHD surgery arises.

For Non-Network Benefits, if the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- Dental services related to medical transplant procedures.
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system).

- Direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for treatment of accidental Injury only for:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Any combination of Network Benefits and Non-Network Benefits is limited to $3,000 per calendar year. Benefits are further limited to a maximum of $900 per tooth.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon the medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described is Section 15, *Outpatient Prescription Drugs*.

Please remember for Non-Network Benefits, you must notify the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the purchase, rental, repair or replacement of DME will cost more than $1,000. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen.
- Equipment to assist mobility, such as a standard wheelchair.
- Hospital beds.
- Delivery pumps for tube feedings.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.
- Orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are also excluded from coverage.

- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Note: DME is different from prosthetic devices - see *Prosthetic Devices* in this section.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Please remember for Non-Network Benefits, you must notify the Claims Administrator if the retail purchase cost or cumulative rental cost of a single item will exceed $1,000. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within two business days of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible

Expenses will be determined as described under *Eligible Expenses* in Section 3, *How the Plan Works*.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services in this section.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided under *Pharmaceutical Products – Outpatient* in the section.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided under Section 15, *Outpatient Prescription Drugs*.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

  Male to Female:

  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)
  - Breast Construction

  Female to Male:

  - Bilateral mastectomy or breast reduction
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of male urethra)
  - Vaginectomy (removal of vagina)
  - Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
- The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Surgical Treatment: Please remember, you must notify the Claims Administrator as soon as the possibility for any of surgery arises.

Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Non-Surgical Treatment: Depending upon where the Covered Health Service is provided, any applicable notification requirements will be the same as those stated under each Covered Health Service category in this section.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.

- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 14, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network Benefits and Non-Network Benefits is limited to 60 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Please remember for Non-Network Benefits, that you must notify the Claims Administrator five business days before receiving services or as soon as reasonably possible. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Benefits are limited to 275 days during the entire period of time you are covered under this Plan.

Please remember for Non-Network Benefits, you must notify the Claims Administator five business days before admission for an Inpatient Stay in a hospice facility. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Please remember for Non-Network Benefits, you [5must][6should] notify the Claims Administrator as follows:

- For scheduled admissions: five business days before admission or as soon as reasonably possible.
- For non-scheduled admissions (including Emergency admissions): as soon as is reasonably possible.

If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) provided by a Designated Provider participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

You or a covered Dependent may:

- Be referred to KRS by the Claims Administrator or Care Coordination℠.
- Call KRS at 1-866-561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.

- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

For Non-Network Benefits for sleep studies, you must notify the Claims Administrator five business days before scheduled services are received. If you fail to notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Referral Services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the Claims Administrator to receive inpatient Benefits. For a scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility) you must provide notification five business days in advance of the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

Please call the number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Neonatal Resource Services (NRS)

The Plan pays Benefits for neonatal intensive care unit (NICU) services provided by a Designated Provider participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions. Designated Provider is defined in Section 14, *Glossary*.

To take part in the NRS program, call a neonatal nurse at 1-866-534-7209. The Plan will only pay Benefits under the NRS program if NRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

You or a covered Dependent may also:

- Call the Claims Administrator or Care Coordination℠.
- Call NRS at 1-888-936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.

- Provided by a *Board Certified Applied Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the Claims Administrator to receive inpatient Benefits. For a scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility) you must provide advance notification five business days prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. Pre-service notification is also required for Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA).

Please call the number that appears on your ID card. Without advance notification, Benefits will be reduced to 50% of Eligible Expenses.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout (a form of arthritis).
- Renal failure.
- Phenylketonuria (a genetic disorder diagnosed at infancy).
- Hyperlipidemia (excess of fatty substances in the blood).

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

Please remember for Non-Network Benefits you must notify the Claims Administrator as soon as is reasonably possible before Genetic Testing – BRCA is performed. If notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Please remember for Non-Network Benefits, you must notify the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clinical Programs and Resources*, for details.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to **www.myuhc.com** or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits are limited to a single purchase of each type of prosthetic device every three calendar years.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

For Non-Network Benefits you must notify the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed a mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. When you provide notification, the Claims Administrator can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage. If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.

- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.

- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

Any combination of Network Benefits and Non-Network Benefits are limited to:

- 20 visits per calendar year for physical therapy.
- 20 visits per calendar year for occupational therapy.
- 20 visits per calendar year for speech therapy.
- 20 visits per calendar year for pulmonary rehabilitation therapy.
- 36 visits per calendar year for cardiac rehabilitation therapy.
- 20 visits per calendar year for cognitive rehabilitation therapy.
- 24 visits per calendar year for Manipulative Treatment.
- 30 visits per calendar year for post-cochlear implant aural therapy.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and diagnostic endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.

- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 60 days per calendar year.

Please remember for Non-Network Benefits, you must notify the Claims Administrator as follows:

- For a scheduled admission: five business days before admission.
- For a non-scheduled admission within two business days or as soon as is reasonably possible.

If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- Referral Services.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.

- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the Claims Administrator to receive inpatient Benefits. For a scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility) you must provide advance notification five business days prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

Please call the number that appears on your ID card. Without advance notification, Benefits will be reduced to 50% of Eligible Expenses.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

For Non-Network Benefits for blepharoplasty uvulopalatopharyngoplasty, vein procedures and sleep apnea surgeries, cochlear implant you must notify the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. If the Claims Administratoris not notified, Benefits will be reduced to 50% of Eligible Expenses.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please remember for Non-Network Benefits, you must notify the Claims Administrator for the following outpatient therapeutics five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as reasonably possible. Services that require notification: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound. If the Claims Administrator is not notified, as required, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received by a Designated Provider.

Benefits are also available for cornea transplants. You are not required to notify the Claims Administrator or Care Coordination℠ of a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received by a Designated Provider.

Please remember for Network Benefits you must notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If the Claims Administrator is not notified and if, as a result, the services are not performed by a Designated Provider, Network Benefits will not be paid.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Travel and Lodging

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care by a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding Travel and Lodging, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.

- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offers a lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

  The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*.

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Vision Examinations

The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a Network provider in the provider's office every other calendar year. Benefits are limited to children up to age 18 only.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

SECTION 7 – CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools.
- Disease and Condition Management Services.
- Wellness Programs.

The Company believes in giving you tools to help you be an educated health care consumer. To that end, United Healthcare has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. UnitedHealthcare and the Company are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

Consumer Solutions and Self-Service Tools

Health Survey

You and your enrolled dependents are invited to learn more about health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page.

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information to help you make more informed health care decisions. When you call, a registered nurse may refer you to any additional resources that are available that may help

you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- A recent diagnosis.
- A minor Sickness or Injury.
- Men's, women's, and children's wellness.
- How to take Prescription Drug Products safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

NurseLine℠ gives you another way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no additional cost. To use this service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine℠ any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

With NurseLine℠, you also have access to nurses online. To use this service, log onto **www.myuhc.com** where you may access the link to initiate an online chat with a registered nurse who can help answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® program including how to locate a UnitedHealth Premium Physician, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and self-service tools.

With **www.myuhc.com** you can:

- Receive personalized messages that are posted to your own website.
- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Access all of the content and wellness topics from NurseLine℠ including Live Nurse Chat 24 hours a day, seven days a week.
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered on **www.myuhc.com**, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information, including Annual Deductibles.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes℠. HealtheNotes℠ provides you and your Physician with information regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes℠ report may include health tips and other wellness information.

UnitedHealthcare provides this information through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified who may benefit from this information using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes℠ report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the information UnitedHealthcare provides. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the number on your ID card. This program offers:

- Pregnancy consultation to identify special needs.
- Written and on-line educational materials and resources.
- 24-hour access to experienced maternity nurses.
- A phone call from a care coordinator during your Pregnancy, to see how things are going.
- A phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure and acupuncture.

. Aromatherapy.

. Hypnotism.

. Massage therapy.

5. Rolfing.

6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Extractions (including wisdom teeth), restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

3. Dental implants, bone grafts, and other implant-related procedures.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some type of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. Cranial banding.

4. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

5. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.

6. The replacement of lost or stolen prosthetic devices.

7. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.

8. Oral appliances for snoring.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Outpatient Prescription Drugs*, for coverage details and exclusions.

1. Prescription Drug Products for outpatient use that are filled by a prescription order or refill.

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

Foot Care

1. Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

   - Cutting or removal of corns and calluses.
   - Nail trimming or cutting.
   - Debriding (removal of dead skin or underlying tissue).

2. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. Treatment of flat feet.

4. Treatment of subluxation of the foot.

5. Shoe inserts.

6. Arch supports.

7. Shoes (standard or custom), lifts and wedges.

8. Shoe orthotics.

Gender Dysphoria

1. Cosmetic Procedures, including the following:

   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement after initial construction, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal.
   - Hair transplantation.

- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Reversal of genital surgeries.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples:

   - Compression stockings, ace bandages, diabetic strips, and syringes.
   - Urinary catheters.

   This exclusion does not apply to:

   - Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. Tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.

3. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.

4. The replacement of lost or stolen Durable Medical Equipment.

5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services/Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services in Section 6, Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorder.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living Services.

8. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

   - Nutritional education is required for a disease in which patient self-management is a part of treatment.
   - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

3. Food of any kind. Foods that are not covered include:

    - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU), unless they are the only source of nutrition. Infant formula available over the counter is always excluded.
    - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
    - Oral vitamins and minerals.
    - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
    - Other dietary and electrolyte supplements.

4. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

    - Air conditioners, air purifiers and filters and dehumidifiers.
    - Batteries and battery chargers.
    - Breast pumps. (This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.)
    - Car seats.
    - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
    - Electric scooters.
    - Exercise equipment and treadmills.
    - Hot tubs.
    - Humidifiers.
    - Jacuzzis.
    - Medical alert systems.
    - Motorized beds, non-Hospital beds, comfort beds and mattresses.
    - Music devices.
    - Personal computers.
    - Pillows.
    - Power-operated vehicles.
    - Radios.
    - Safety equipment.
    - Saunas.
    - Stair lifts and stair glides.

- Strollers.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Wigs and other scalp hair prosthesis regardless of the reason for the hair loss.

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

3. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

4. Speech therapy to treat stuttering, stammering, or other articulation disorders.

5. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*.

6. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.

7. Psychosurgery (lobotomy).

8. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

9. Chelation therapy, except to treat heavy metal poisoning.

10. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

11. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity even if there is a diagnosis of morbid obesity.

12. Medical and surgical treatment of excessive sweating (hyperhidrosis).

13. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

14. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

15. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

16. Congenital Heart Disease surgery that is not received by a Designated Provider.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a freestanding or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a freestanding or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

   This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue).

4. The reversal of voluntary sterilization.

5. Fetal reduction surgery.

6. Health services and associated expenses for elective abortions.

7. Health services associated with the use of non-surgical or drug induced Pregnancy termination, unless medically necessary.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB).*

2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you, except as otherwise provided by law.

3. While on active military duty.

4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants except those described under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available).

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

4. Health services not performed by a Designated Provider.

5. Solid organ Transplant that is performed as a treatment for Cancer.

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 14, *Glossary*.

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

4. Eye exercise or vision therapy.

5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.

- Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That do not meet the definition of a Covered Health Service in Section 14, *Glossary*.
   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
   - That exceed Eligible Expenses or any specified limitation in this SPD.
   - For which a non-Network provider waives the Annual Deductible or Coinsurance amounts.

6. Foreign language and sign language services.

7. Long term (more than 30 days) storage of blood, umbilical cord or other material.

8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

You must submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to UnitedHealthcare within 15 months of the date of service, Benefits for that health service will be denied or reduced, at UnitedHealthcare's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
- You pay a Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information

listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Participant.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The *Current Procedural Terminology (CPT)* codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for outpatient Prescription Drug Product Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Adams County Government reserves the right to offset Benefits

to be paid to the provider by any amounts that the provider owes Adams County Government (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary*, for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 15 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain

maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
- Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits. For Urgent requests for benefits, the Company has delegated UnitedHealthcare the exclusive right to interpret and administer the terms of the plan. UnitedHealthcare's decisions are conclusive and binding.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the Plan Administrator or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

You cannot bring any legal action against the Plan Administrator or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Plan Administrator or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.

- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the custodial parent; then
  - The parent not having custody of the child; then
  - The Spouse of the non-custodial .
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan - as long as this amount is not more than the Plan would have paid had it been the only plan involved.
- If, based on the allowable expense, the Plan would have paid more if it were the only plan involved, the difference between the amount it would have paid and the amount it actually paid is recorded as a benefit reserve for the Covered Person. This reserve can be used to pay any future allowable expenses not otherwise paid by the Plan during the calendar year.
- At the end of the calendar year, the benefit reserve returns to zero. A new benefit reserve is created for each calendar year.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare".

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become enrolled in Medicare. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).

- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are enrolled in Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Company also reserves the right to recover any overpayment by legal action.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the

overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Benefits paid by the Plan may also be considered to be Benefits advanced.

- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA),if applicable with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value

of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- Extended coverage.
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, the Plan Administrator will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Your coverage under the Plan will end on the earliest of:

- The last day of the month your employment with the Company ends.
- The date the Plan ends.
- The last day of the month you stop making the required contributions.
- The last day of the month you are no longer eligible.
- The last day of the month UnitedHealthcare receives written notice from the Plan Administrator to end your coverage, or the date requested in the notice, if later.
- The last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- The date your coverage ends.
- The last day of the month you stop making the required contributions.
- The last day of the month UnitedHealthcare receives written notice from the Plan Administrator to end your coverage, or the date requested in the notice, if later.
- The last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not

limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent, improper use of ID, failure to pay, or threatening behavior. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and the Company find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, Adams County Government has the right to demand that you pay back all Benefits Adams County Government paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. Failure to comply with the eligibility requirements as set forth in this SPD may lead to disciplinary action, up to and including, termination of employment.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability.
- The child depends mainly on you for support.
- You provide to the Plan Administrator proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age.
- You provide proof, upon the Plan Administrator's request, that the child continues to meet these conditions.

The proof might include medical examinations at the Plan Administrator's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Extended Coverage for Total Disability

If a Covered Person has a Total Disability on the date their coverage under the Plan ends, their Benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of:

- The Total Disability ends.
- twelve months from the date coverage would have ended.

Continuing Coverage Through COBRA

COBRA continuation coverage is a temporary extension of coverage under the Plan. When you become eligible for COBRA, you may also become eligible for other coverage options

that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for Medicaid, or for a 30-day special enrollment period to enroll in another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Qualified Beneficiaries

A Qualified Beneficiary generally is any individual covered by a group health plan on the day before a Qualifying Event, such as an employee, the employee's spouse, and dependent children. Dependents continuing coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) are not considered to be Qualified Beneficiaries for COBRA purposes.

A child born to, placed for adoption with, or adopted by the covered employee during a period of COBRA coverage will be considered on the same basis as the covered employee.

Qualifying Events

A Qualifying Event is a life event that would cause the Qualified Beneficiary to lose coverage under the Plan including;

- Termination of employment (other than for gross misconduct), reduction in hours of an eligible employee
- Divorce, legal separation, dependent cessation (a child no longer qualifies as an eligible dependent under the Plan)
- Death of the employee
- Extended military leave of the employee

- Medicare entitlement (Part A, Part B or both) of the employee.

The taking of leave under the Family Medical Leave Act does not constitute a Qualifying Event under COBRA.

COBRA continuation coverage begins on the date that Plan coverage would otherwise have been lost. Qualified Beneficiaries electing continuation coverage must pay 102 percent of the cost of that coverage.

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. For a Qualifying Event such as termination of employment, reduction in hours, death of the employee, or extended military leave of the employee, the employer will notify the Plan Administrator within 31 days of the qualifying event. The Plan Administrator will notify you within 14 days of your rights, enrollment deadlines and the premium required for your continued coverage. Each Qualified Beneficiary will have an independent right to elect continuation coverage.

You must notify the Plan Administrator in writing in the event of a divorce or legal separation, Medicare entitlement (Part A, Part B or both), or in the event a child no longer qualifies as a dependent, as soon as possible, but no later than 60 days after the date of the Qualifying Event. The Plan Administrator will notify you within 14 days of your rights, enrollment deadlines and the premium required for your continued coverage.

How long coverage may be continued

- Up to 18 months for the reason of termination of employment (other than for gross misconduct) or reduction in hours of an eligible employee
- Up to 24 months for the reason of continued military leave as defined by USERRA
- Up to 36 months for the reason of death of an employee, a divorce or legal separation, the employee becoming entitled to Medicare benefits (Part A, Part B or both), or a dependent child ceasing to be eligible under the plan
- Up to 36 months for Qualified Beneficiaries, other than the employee, if the Qualifying Event is termination of employment or reduction in hours of the employee, and the employee became entitled to Medicare benefits (Part A, Part B or both) less than 18 months before the Qualifying Event.

Extended Coverage due to Disability

Coverage could be extended up to 11 months, for a total of 29 months of coverage, for all Qualified Beneficiaries if:

- A Qualified Beneficiary is totally disabled according to the Social Security Administration before the 60th day of COBRA continuation coverage, lasting at least until the end of the 18-month period of continuation coverage; and
- The employee or eligible dependent provides the Human Resources Department with a copy of the Social Security Administration (SSA) Determination of Total Disability (notice must be received within the initial 18 months of continued coverage); and

- Timely premium payments are made (premiums are increased to 150 percent of the cost of coverage for the additional 11 months).
- The Plan Administrator must be notified within 31 days if the Qualified Beneficiary is no longer considered disabled by the Social Security Administration.

Employees disabled while continuing coverage under USERRA are not eligible for the 11-month extension rule.

Second Qualifying Events

Coverage for qualified dependents could be extended up to 36 months from the date of the Initial Qualifying Event if:

- The covered employee dies
- A divorce or legal separation from the covered employee occurs
- A covered dependent child no longer qualifies as an eligible dependent
- A covered employee subsequently becomes entitled to Medicare (Part A, Part B or both) during the initial 18-month COBRA period.

These events can be a Second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the Initial Qualifying Event had not occurred. You must notify the Human Resources Department within 60 days after a Second Qualifying Event occurs if you wish to extend coverage.

For Additional Questions

For more information about your rights and obligations under the Plan and federal law you may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of the EBSA Offices are available through the EBSA website at www.dol.gov/ebsa.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- During Open Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Participant's termination of coverage under the Plan.
- The day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with UnitedHealthcare and the Company.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and the Company

In order to make choices about your health care coverage and treatment, Adams County Government believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- The Company and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this SPD.

- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Company and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Company and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. The Company and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between the Company, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not the Company's agents or employees, nor are they agents or employees of UnitedHealthcare. The Company and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

The Company and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the Company and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Company's employees nor are they employees of UnitedHealthcare. The Company and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. The Company and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

The Company is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.

- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- Must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Company is that of employer and employee, Dependent or other classification as defined in the SPD.

Interpretation of Benefits

The Company and UnitedHealthcare have the sole and exclusive discretion to:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Summary of Material Modifications and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

The Company and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Company may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that the Company does so in any particular case shall not in any way be deemed to require the Company to do so in other similar cases.

Information and Records

The Company and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The Company and UnitedHealthcare may request additional information from you to decide your claim for Benefits. The Company and UnitedHealthcare will keep this information confidential. The Company and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Company and UnitedHealthcare with all information or copies of records relating to the services provided to you. The Company and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. The Company and UnitedHealthcare agree that such information and records will be considered confidential.

The Company and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Company is required to do by law or regulation. During and after the term of the Plan, the Company and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements the Company recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, the Company and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is

yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

Rebates and Other Payments

The Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Company and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) is the official plan document that has been adopted by the Company. There is no other document that controls the benefits under the Plan.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The CRS program provides:

- Specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer.

- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Care Coordination℠ - programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 15, *Outpatient Prescription Drugs*.

Company - Adams County Government.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorder Services or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Included in Section 5, Plan Highlights and Section 6, Additional Coverage Details.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not identified in Section 8, *Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "Scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Covered Person - either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.

- They must be financially interdependent.

The Participant and Domestic Partner must jointly register their domestic partnership with either Denver or Boulder in order to add the Domestic Partner onto Benefits (an affidavit will not be accepted). The following requirements apply for each:

Denver

Committed Partnership Registry

The City and County of Denver allows couples who are not married to recognize their commitment through the Committed Partnership Registry.

The Registry is open to any two partners who:

- Are unmarried, eighteen years of age or older, and competent to enter into a contract;
- Are not prohibited from marrying each other under the law of this state by reason of a blood relationship or other comparable domestic partnership;
- Are sharing a common household; and
- Do not already have different partners under the provisions of the Denver Committed Partnership Ordinance, the Colorado Civil Unions Act or any other comparable domestic partnership provision.

Boulder

Who are Domestic Partners:

Domestic Partners are two people who have signed an affidavit swearing that they are:

- Are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship;
- Are each other's sole domestic partner;
- Are both at least 18 years of age and competent to contract;
- Share a life and home together;
- Are not related by kinship closer than would bar marriage in the State of Colorado; and
- Are not married.

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Employee Retirement Income Security Act of 1974 (ERISA) - the federal legislation that regulates retirement and employee welfare benefit programs maintained by some employers and unions.

Employer - Adams County Government.

EOB - see Explanation of Benefits (EOB).

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the

Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Diagnostic criteria for children:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
  - ♦ A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - ♦ In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - ♦ A strong preference for cross-gender roles in make-believe play or fantasy play.
  - ♦ A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - ♦ A strong preference for playmates of the other gender.
  - ♦ In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - ♦ A strong dislike of ones' sexual anatomy.
  - ♦ A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Gestational Carrier- a Gestational Carrier is a woman who agrees to have a couple's fertilized egg (embryo) implanted in her uterus. The gestational carrier carries the pregnancy for the couple, who usually has to adopt the child. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- ■ It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- ■ It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI).*

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The KRS program provides:

- Specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International*

Classification of Diseases section on Mental and Behavioral Disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator - the organization or individual designated by the Plan Administrator who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Network Benefits and Section 3, *How the Plan Works*, for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Network Benefits - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Non-Network Benefits and Section 3, *How the Plan Works*, for details about how Non-Network Benefits apply.

Open Enrollment - the period of time, determined by the Company, during which eligible Participants may enroll themselves and their Dependents under the Plan. The Company determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

Participant - a Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Pharmaceutical Product(s) – *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The Adams County Government Choice Plus Health Benefit Plan.

Plan Administrator - Adams County Government or its designee.

Plan Sponsor - Adams County Government, references to "we", "us" and "our" refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.

- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.

- Evaluation and diagnosis.
- Counseling.
- Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee - an Employee under the age of 65 who meets the retirement eligibility rules as defined by Adams County policy guidelines. Retirees over 65 years of age actively enrolled in Medicare are not eligible for coverage.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - - a woman who becomes pregnant usually by artificial insemination or surgical implantation of a fertilized egg for the purpose of carrying the fetus to term for another woman.

Total Disability or Totally Disabled - a Participant's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's or retired person's inability to perform the normal activities of a person of like age and gender.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorder Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.

- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care - care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

SECTION 15 - OUTPATIENT PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drug Products.
- How to utilize the retail and mail order service for obtaining Prescription Drug Products.
- Any Benefit limitations and exclusions that exist for Prescription Drug Products.
- Definitions of terms used throughout this section related to the Prescription Drug Product Plan.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List (PDL) the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

What You Must Pay

You are responsible for paying the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Coinsurance described in the *Payment Information - Outpatient Prescription Drugs* table or *Schedule of Benefits - Outpatient Prescription Drugs*.

Payment Terms and Features - Outpatient Prescription Drugs

Prescription Drug Product Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug Product coverage. It includes Coinsurance amounts that apply when you have a prescription filled at a Network or non-Network Pharmacy after you meet the Annual Prescription Drug Deductible. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Note: An Annual Prescription Drug Deductible of $100 per Covered Person, not to exceed $300 for all Covered Persons in the family applies to your Network Benefits, which is separate from the Annual Deductible for your medical coverage.

Coupons: UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Coinsurance or apply to your Annual Drug Deductible. You

may access information on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the number on your ID card.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change. As a result, your Coinsurance may change. You will pay the Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare or its designee. The reason for notifying UnitedHealthcare or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 14, *Glossary*.

The Plan may also require you to notify UnitedHealthcare or its designee so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying UnitedHealthcare.

Non-Network Pharmacy Notification

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician, are responsible for notifying UnitedHealthcare as required.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Drug Product order or refill. You will be required to pay for the Prescription Drug Product at the time of purchase. The Prescription Drug Products requiring notification are subject to UnitedHealthcare's periodic review and modification. You may determine whether a particular Prescription Drug Product requires notification through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, you can ask UnitedHealthcare to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. UnitedHealthcare contracted pharmacy reimbursement rates (UnitedHealthcare's Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*.

When you submit a claim on this basis, you may pay more because you did not notify UnitedHealthcare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Coinsurance and any deductible that applies.

To determine if a Prescription Drug Product requires notification, either visit **www.myuhc.com** or call the number on your ID card. The Prescription Drug Products requiring notification are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after UnitedHealthcare reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require notification for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable notification, participation or activation requirements associated with such programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Schedule of Benefits - Outpatient Prescription Drugs

Benefit Information for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy

Covered Health Services[1,2,3]	**Percentage of Prescription Drug Charge Payable by the Plan:**	**Percentage of Out-of-Network Reimbursement Rate Payable by the Plan:**
	Network	**Non-Network**
Retail - up to a 31-day supply		
■ Tier-1	80% after you meet the Prescription Drug Deductible	50% after you meet Prescription Drug Deductible
■ Tier-2	80% after you meet the Prescription Drug Deductible	50% after you meet Prescription Drug Deductible
■ Tier-3	80% after you meet the Prescription Drug	50% after you meet Prescription Drug Deductible

Covered Health Services[1,2,3]	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Out-of-Network Reimbursement Rate Payable by the Plan:
	Network	Non-Network
	Deductible	
Specialty Prescription Drug Products - As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.		
■ Tier-1	80% after you meet the Prescription Drug Deductible	Not Covered
■ Tier-2	80% after you meet the Prescription Drug Deductible	Not Covered
■ Tier-3	80% after you meet the Prescription Drug Deductible	Not Covered
Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a non-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.		

Covered Health Services[1,2,3]	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Out-of-Network Reimbursement Rate Payable by the Plan:
	Network	Non-Network
Mail order - up to a 90-day supply		
■ Tier-1	80% after you meet the Prescription Drug Deductible	Not Covered
■ Tier-2	80% after you meet the Prescription Drug Deductible	Not Covered
■ Tier-3	80% after you meet the Prescription Drug Deductible	Not Covered

[1]Please notify UnitedHealthcare before receiving Prescription Drug Products, as described in *Payment Terms and Features*, under *Prior Authorization Requirements* in this section.

[2]The Plan pays Benefits for Specialty Prescription Drug Products as described in this table.

[3]You are not responsible for paying a Coinsurance for Preventive Care Medications. Benefits for Preventive Care Medications are not subject to payment of the Annual Prescription Drug Products Deductible.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* does not apply to covered Prescription Drug Products as described in this section, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare Parts B and D.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by UnitedHealthcare during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*, under the heading, *If Your Provider Does Not File Your Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Coinsurance, and any deductible that applies.

Submit your claim to:

Optum Rx
PO Box 29077
Hot Spring, AR 71903

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drug Products.

All Prescription Drug Products covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the number on your ID card for the most current information.

Each tier is assigned a Coinsurance, which is the amount you pay after you have met the Annual Prescription Drug Deductible, when you visit the pharmacy or order your medications through mail order. Your Coinsurance will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Coinsurance option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Coinsurance option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Coinsurance option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

Coinsurance for a Prescription Drug at a Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug at a non-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of:

- The applicable Coinsurance.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug.
- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- The applicable Coinsurance.
- The Prescription Drug Charge for that particular Prescription Drug.

Retail

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy. The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the number on your ID card or by logging onto **www.myuhc.com**.

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy. If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with UnitedHealthcare, as described in your SPD, *Section 9*, *Claims Procedures*. The Plan will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. The Plan will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Coinsurance, after meeting the Annual Prescription Drug Deductible. The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Coinsurance for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Coinsurance that applies will reflect the number of days dispensed.

If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The mail order service may allow you to purchase up to a 90-day supply of a covered Prescription Drug Product through the mail.

To use the mail order service, all you need to do is complete a patient profile and enclose your Prescription Order or Refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the number on your ID card.

The following supply limits apply: As written by the provider, up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged the mail order Coinsurance for any Prescription Order or Refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined, in this section, under *Glossary - Prescription Drug Products*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the number on your ID card.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product.

Specialty Prescription Drug Products]

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom UnitedHealthcare has an arrangement to provide those Specialty Prescription Drug Products. You may fill a prescription for Specialty Prescription Drug Products up to two times at any Pharmacy. However, after that you will be directed to a Designated Pharmacy.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.

Please see *Glossary - Outpatient Prescription Drugs*, for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Please see *Glossary - Outpatient Prescription Drugs*, in this section for definitions of Specialty Prescription Drug Product and Designated Pharmacy.

Want to lower your out-of-pocket Prescription Drug Product costs?
Consider tier-1 Prescription Drug Products, if you and your Physician decide they are appropriate.

Assigning Prescription Drug Products to the Prescription Drug List (PDL)

UnitedHealthcare's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on UnitedHealthcare's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual

Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access **www.myuhc.com** through the Internet or call the number on your ID card for the most up-to-date tier status.

Prescription Drug Product, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)
The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Benefit.

Prescription Drug Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, UnitedHealthcare may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits that are stated in the table under the heading *Prescription Drug Product Coverage Highlights*. For a single Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing, through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Special Programs

Adams County Government and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Rebates and Other Discounts

UnitedHealthcare and Adams County Government may, at times, receive rebates for certain drugs included on the PDL, including those drugs that you purchase prior to meeting any applicable deductible. As determined by UnitedHealthcare, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Coinsurance.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug* section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 8, *Exclusions and Limitations* also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access **www.myuhc.com** through the Internet or by calling the number on your ID card for information on which Prescription Drug Products are excluded.

1. For any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

2. Any Prescription Drug Product for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Outpatient Prescription Drugs*) portion of the Plan.

   This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. Available over-the-counter medications that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

5. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product.

6. Prescription Drug Products dispensed outside of the United States, except in an Emergency.

7. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *SPD*. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

8. Certain Prescription Drug Products for tobacco cessation.

9. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

10. The amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

11. The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

12. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

13. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee.

14. Prescribed, dispensed or intended for use during an Inpatient Stay.

15. Prescribed, dispensed for appetite suppression, and other weight loss products.

16. Prescribed to treat infertility.

17. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that UnitedHealthcare and Adams County Government determines do not meet the definition of a Covered Health Service.

18. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

19. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

20. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Unit dose packaging or repackagers of Prescription Drug Products.

22. Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Adams County Government have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*.

23. Used for cosmetic purposes

24. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

25. General vitamins, except for the following which require a Prescription Order or Refill:

- Prenatal vitamins.
- Vitamins with fluoride.
- Single entity vitamins.

26. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury.

27. A Prescription Drug Product that contains marijuana, including medical marijuana.

28. Dental products, including but not limited to prescription fluoride topicals.

29. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

30. Diagnostic kits and products.

31. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Glossary - Outpatient Prescription Drugs

Annual Drug Deductible (or Prescription Drug Deductible) - the amount that you are required to pay for covered Tier 2 and Tier 3 Prescription Drug Products in a calendar year before the Plan begins paying for Prescription Drug Products. The Annual Prescription Drug Deductible is shown in the table at the beginning of this section.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that UnitedHealthcare identifies as a Brand-name product, based on available data resources including, but not limited to, medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drug Products including, but not limited to, Specialty Prescription Drug

Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that UnitedHealthcare identifies as a Generic product based on available data resources including, but not limited to, medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with UnitedHealthcare or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by UnitedHealthcare as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by UnitedHealthcare's Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

Out-of-Network Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax.

Prescription Drug Charge - the rate the Plan has agreed to pay UnitedHealthcare on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration*. This list is subject to UnitedHealthcare's periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting UnitedHealthcare at the number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Glucose meters. This does not include continuous glucose monitors. Benefits for continuous glucose monitors are provided as described in Section 5, *Plan Highlights* and Section 6, *Additional Coverage Details*.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the number on your ID card.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You

may access a complete list of Specialty Prescription Drug Products through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Insurance Company. The named fiduciary of Plan is Adams County Government, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

This Plan is considered a Non-Grandfathered as defined under the Patient Protection and Affordable Care Act (healthcare reform). Therefore, additional benefits may be available to you and your eligible dependents.

- Coverage for approved clinical trials
- Expanded claims appeal
- Habilitative coverage
- Well woman preventive services; i.e. contraceptives paid 100 percent as outlined under the health care reform law
- All co-pays, including prescription drug co-pays, deductibles and co-insurance apply to your out-of-pocket maximum

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

ATTACHMENT III - HEALTH SAVINGS ACCOUNT

What this attachment includes:

- About Health Savings Accounts.
- Who is eligible and how to enroll.
- Contributions.
- Additional medical expense coverage available with your Health Savings Account.
- Using the HSA for Non-Qualified Expenses.
- Rolling over funds in your HSA.

Introduction

This attachment to the Summary Plan Description (SPD) describes some key features of the Health Savings Account (HSA) that you could establish to complement the Adams County Government health benefit Plan, which is a high deductible medical plan. In particular, and except as otherwise indicated, this attachment will address the Health Savings Account, and not the high deductible health plan that is associated with the "HSA".

Adams County Government has entered into an agreement with United Healthcare Services, Inc., Minnetonka, MN, ("UnitedHealthcare") under which UnitedHealthcare will provide certain administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this attachment. Further, note that it is the Plan's intention to comply with *Department of Labor* guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

The HSA described in this section is not an arrangement that is established and maintained by Adams County Government. Rather, the HSA is established and maintained by the HSA trustee. However, for administrative convenience, a description of the HSA is provided in this section.

About Health Savings Accounts

You gain choice and control over your health care decisions and expenditures when you establish your HSA to complement the high deductible medical plan described in the SPD.

An HSA is an account funded by you, your employer, or any other person on your behalf. The HSA can help you to cover, on a tax free basis, medical plan expenses that require you to pay out-of-pocket, such as Deductibles, Copayments or Coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses, however, these amounts are subject to income tax and may be subject to 20% penalty.

You have three tools you can use to meet your health care needs:

- Adams County Government health benefit Plan, a high deductible medical plan which is discussed in your Summary Plan Description.
- An HSA you establish.
- Health information, tools and support.

Benefits available under your medical plan are described in your medical plan Summary Plan Description (SPD).

What is an HSA?
An HSA is a tax-advantaged account Participants can use to pay for qualified health expenses they or their eligible dependents incur, while covered under a high deductible medical plan. HSA contributions:

- Accumulate over time with interest or investment earnings.
- Are portable after employment.
- Can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

Who Is Eligible And How To Enroll

Eligibility to participate in the Health Savings Account is described in the SPD for your high deductible medical plan. You must be covered under a high deductible medical plan in order to participate in the HSA. In addition, you:

- Must not be covered by any high deductible medical plan considered non-qualified by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.)
- Must not participate in a full health care Flexible Spending Account (FSA).
- Must not be entitled to Benefits under Medicare (i.e., enrolled in Medicare).
- Must not be claimed as a dependent on another person's tax return.

Contributions

Contributions to your HSA can be made by you, by your employer or by any other individual. All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee.

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum.

Note that if coverage under a qualified high deductible health plan terminates, no further contributions may be made to the HSA.

The contribution maximum is the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds monthly to their HSA up to the maximum allowed by federal regulations. The maximum limits set by federal regulations may be found on the IRS website at www.irs.gov.

If you enroll in your HSA within the year (not on January 1) you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and HSA until the end of the 12th month from your initial enrollment or you will be subject to tax implications and an additional tax of 10%.

Note: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year.

Reimbursable Expenses

The funds in your HSA will be available to help you pay your or your eligible dependents' out-of-pocket costs under the medical plan, including Annual Deductibles, Copayments and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". Please see the description of *Additional Medical Expense Coverage Available With Your Health Savings Account* below, for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the medical expenses of you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

HSA funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

Additional Medical Expense Coverage Available with Your Health Savings Account

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services and you have funds in your HSA, you may use the funds in your HSA to pay for the medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your Annual Deductible or Out-of-Pocket Maximum.

Using the HSA for Non-Qualified Expenses

You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for COBRA premiums and Medicare premiums.

Rollover Feature

If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will roll-over. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the accompanying high deductible health plan, as described in your medical plan SPD.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

Important
Be sure to keep your receipts and medical records. If these records verify that you paid qualified health expenses using your HSA, you can deduct these expenses from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. Adams County Government and UnitedHealthcare will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. Adams County Government and the Claims Administrator are not responsible or liable for the misuse by Participants of HSA funds by, or for the use by Participants of HSA funds for non-qualified health expenses.

Additional Information About the HSA

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, UnitedHealthcare and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will UnitedHealthcare provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this

information disclosed, you must notify the Claims Administrator and the financial institution in writing.

You can obtain additional information on your HSA online at www.irs.gov. You may also contact your tax advisor. Please note that additional rules may apply to a Dependent's intent to opening an HSA.

ATTACHMENT IV – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to UnitedHealthcare Service, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130
The toll-free member phone number listed on your health plan ID card, TTY 711

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

Your can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

ATTACHMENT V – THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA)

This group health plan does not discriminate in premium amounts, contributions charged or eligibility for coverage based on any individual's genetic information. The plan does not use, request or require genetic information about anyone covered by the plan. Genetic information, within the context of GINA, includes the following: an individual's genetic tests; the genetic tests of an individual's family members (up to fourth-degree relatives by birth, marriage or adoption); manifestation of disease or disorder in family members of an individual; an individual's request for or receipt of genetic services; and genetic information of a fetus carried by an individual or his or her family.

ANY HEALTH RISK ASSESSMENT (HRA) COMPLETED BY A PERSON COVERED BY THIS PLAN IS IN COMPLIANCE WITH REGULATIONS UNDER GINA.

ATTACHMENT VI – MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) FREE OR LOW COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

Medicaid and the Children's Health Insurance Program (CHIP) Free or Low Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or **dial 1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 1, 2010. You should contact your State for further information on eligibility**.**

GEORGIA – Medicaid	**MONTANA** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	**NEBRASKA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	**NEVADA** – Medicaid and CHIP

Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	**NEW MEXICO –** Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	**NEW YORK –** Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP

Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since September 1, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid.1-877-267-2323, Ext. 61565

ATTACHMENT VII – THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Under the federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to protect the confidentiality of your Protected Health Information (PHI). Protected Health Information is individually identifiable health information related to your condition, services provided to you, or payments made for your care, which is created or received by a health plan, a health care clearinghouse, or a health care provider and identifies you or provides a means by which you could be identified. The Plan and the Plan Sponsor will not use or disclose PHI except for treatment, payment, health plan operations (collectively known as "TPO"), or as permitted or required by other state and federal law, or to Business Associates to help administer the Plan.

Further, the Plan Sponsor will take reasonable steps to ensure that any use or disclosure is the minimum necessary to accomplish the task.

In addition, under the federal security regulations enacted pursuant to HIPAA, your health plans are required to safeguard the confidentiality and ensure the integrity and availability of your Electronic Protected Health Information (ePHI). ePHI is PHI that is maintained or transmitted in electronic form. The Plan and the Plan Sponsor will reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.

The Plan and Plan Sponsor are separate and independent legal entities, which exchange information to coordinate your Plan coverage. In order to receive PHI from the Plan, the Plan Sponsor agrees to, and has certified to the Plan, that it will:

- Restrict the use or further disclosure of PHI except as permitted by HIPAA or as required by law;
- Ensure that any other entity to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan;
- Not use genetic information that is PHI for underwriting purposes;
- Report to the Privacy Officer any use or disclosure of the information that is inconsistent with the permitted uses or disclosures;
- Make PHI available to Plan participants, consider their amendments and, upon request, provide them with an accounting of PHI disclosures as required by law;
- Make internal practices and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request;
- Provide adequate safeguards to protect PHI;

- Provide legally required notices of unauthorized acquisition, access or disclosures of your health information as required by law; and
- If feasible, upon termination of the plan, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible.

In order to receive ePHI from the Plan, the Plan Sponsor agrees that it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that access to, and use and disclosure of ePHI by the employees or classes of employees described in the Plan document is supported by reasonable and appropriate security measures; and
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides this information agrees to implement reasonable and appropriate security measures to protect the information

Only limited members of the workforce of the Group Health Plan may be permitted to use and/or disclose PHI. Under this Plan the following individuals are permitted to have access to, use and/or disclose PHI:

- Employees of the Plan Sponsor who perform administrative services on behalf of the Plan, including payment, health care operations, design and administration. This includes County Administrator, Director of Human Resources, Benefits Manager, Benefits Administrator, Human Resources Specialists.
- Employees of the Plan Sponsor who have access to PHI for purposes of its use by the Employer in performing services for the Plan, including procurement of insurance, financial transactions and accounting. This includes Director of Finance, Administrative Coordinators, Payroll Accountants, Payroll Technicians, General Accounting Managers, Budget Managers and Budget Analysts.
- Service providers to the Plan. This includes County Attorneys, Benefit Consultants, Third Party Administrators, and IT Personnel.

The Plan will limit the use, disclosure or request for PHI to the minimum amount that is reasonably necessary to fulfill a request as set forth in this Agreement. Requests for disclosures other than by legal authority or by the participant will be reviewed by the Privacy Officer or his/her designee.

Where PHI is used or disclosed for the purposes of the Plan's own payment activity, whether through a TPA or Carrier, the employees of the Plan are permitted to use and disclose information to perform these functions using the minimum necessary to accomplish the purpose.

If you believe that your privacy rights have been violated, you may file a complaint with the privacy officer or with the Secretary of the United States Department of Health and Human Services. All complaints must be submitted in writing. You will not be retaliated against in any way for filing a complaint.

You may receive a complete copy of the Plan's Notice of Privacy Practices by contacting the Privacy Officer.

PRIVACY OFFICER

The Plan Administrator has designated a privacy officer who is the contact person for all issues regarding your privacy rights. You may contact the privacy officer at the following address and telephone number.

Director of Human Resources
4430 S. Adams County Parkway, Suite C4000B.
Brighton, CO 80601
phone: 720.523.6070
fax: 720.523.6069

ATTACHMENT VIII– HEALTH INSURANCE MARKETPLACE NOTIFICATION

General Information
When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes (pre-tax premiums). Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This Plan provides minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." This Plan does meet the minimum value standard for the benefits it provides**.**

ATTACHMENT VIV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

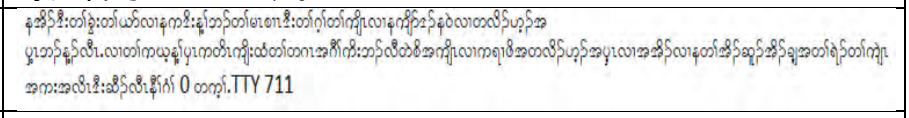
You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አለችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջէլու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամնէրի հէռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꮷ ᏏᏁ ᏗCZᏋᏗ Ꮧ4ᏯᏗ ᏂAᏪᏫW it, ᏣᏉᏁ VᎯ ᏏR ᏗJAVᏗ ACᏯVᏗ IΘᏂᏯᏗT, ᏣᏐ0ᏯᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, ૦ દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee

Language	Translated Taglines
	hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟੋਲ ਫ਼੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-	E iai lou āiā tatau e maua atu ai se fesoasoani ma

Language	Translated Taglines
Fa'asamoa	fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܐܲܚܬܘܼܢ ܐܝܼܬܠܵܘܟ݂ܘܿܢ ܙܸܕܩܵܐ ܕܦܵܠܛܸܠܘܼܟ݂ܘܿܢ ܗܲܝܵܪܬܵܐ ܘܡܘܼܕܥܵܢܘܼܬܵܐ ܒܠܸܫܵܢܵܘܟ݂ܘܿܢ ܡܲܓܵܢܵܐܝܼܬ ܠܡܫܵܐܠܬܵܐ ܡܢ ܚܕ ܡܬܲܪܓܡܵܢܵܐ، ܩܪܘܿܢ ܥܲܠ ܡܸܢܝܵܢܵܐ ܕܬܸܠܝܦܘܿܢ ܕܐܝܼܬܠܹܗ ܟܬܝܼܒܵܐ ܐܝܼܠܹܗ̇ ܦܸܬܩܵܐ ܕܚܘܼܠܡܵܢܵܐ ܘܕܘܼܣܘܼܢ 0 .TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొందడానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేయ్యో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta'etotongi ma'ae kau memipa 'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe

Language	Translated Taglines
	aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:
UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.Unitedhealthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important:
You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.Unitedhealthallies.com** or by calling the number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description illustrates the benefits you may be eligible for under the ParentSteps® program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:
ParentSteps® is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps® will collect the provider payment from you online via the ParentSteps® website and forward the payment to the provider on your behalf. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description Section 5, *Plan Highlights*, when a benefit is available.

What is ParentSteps®?

ParentSteps® is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- Guidance to help you make informed decisions on where to receive care.
- Education and support resources through experienced infertility nurses.
- Access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services.
- Discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *Glossary*.

Registering for ParentSteps®

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at **www.myoptumhealthparentsteps.com** or by calling ParentSteps® toll-free at 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps® facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see

the specific rates negotiated by ParentSteps® with each provider for select types of infertility treatment in order to make an informed decision.

Visiting Your Selected Health Care Professional

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps® member. ParentSteps® will validate your choice and send a validation email to you and the clinic.

Obtaining a Discount

If you and your provider choose a treatment in which ParentSteps® discounts apply, the provider will enter in your proposed course of treatment. ParentSteps® will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps® website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps® will notify your provider with a statement saying that treatments may begin.

Speaking with a Nurse

Once you have successfully registered for the ParentSteps® program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps® nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps® nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

Additional ParentSteps® Information

Additional information on the ParentSteps® program can be obtained online at **www.myoptumhealthparentsteps.com** or by calling 1-877-801-3507 (toll-free).

SUMMARY PLAN DESCRIPTION

Adams County Government Medical
Select Doctors Plan

Effective: January 1, 2019

Group Number: 701043

UnitedHealthcare®

Summary Plan Description Table of Contents

Amendments, Riders and Notices (As Applicable)

Adams County Government Medical Select Doctors Plan
Effective: January 1, 2019
Group Number: 701043

Section 5: How to File a Claim

Section 6: Questions, Complaints and Appeals

Section 7: Coordination of Benefits

Section 8: General Legal Provisions

Summary Plan Description

United Healthcare Services, Inc.

What Is the Summary Plan Description?

This *Summary Plan Description (SPD)* is a summary of the Covered Health Care Services available to you under the Adams County Government ("Plan Sponsor") Self-Funded health benefit plan. This *SPD* is a legal document that describes Benefits for the portion of the Plan for which United Healthcare Services, Inc. ("Claims Administrator") administers claims payment, either directly or in conjunction with one of the Claims Administrator's affiliates.

For the purposes of this provision "Self-Funded" means that the Plan Sponsor, on behalf of the Plan, has the sole responsibility to pay, and provide funds, to pay for all Plan benefits. The Claims Administrator has no liability or responsibility to provide these funds. The Claims Administrator is a private healthcare claims administrator. The Claims Administrator is not the Plan Administrator for the Plan. Although the Claims Administrator will assist you in many ways, it does not guarantee any Benefits. The Plan Sponsor is solely responsible for the benefit plan design and funding payment of Benefits.

In addition to this *SPD*, the Plan includes:

- The *Schedule of Benefits.*
- Amendments.
- Addendums.
- Summary Material Modification (SMM).

If there should be an inconsistency between the contents of this summary and the Plan, your rights shall be determined under the Plan and not under this summary. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of the official plan document by written request to the Plan Administrator, for a nominal charge.

Can This SPD Change?

The Plan Sponsor may, from time to time, change this *SPD* by attaching legal documents called SMMs and/or Amendments that may change certain provisions of this *SPD*. When this happens the Plan Sponsor will send you a new *SPD*, SMM or Amendment.

Other Information You Should Have

The Plan Sponsor intends to continue this Plan, but reserves the right, in its sole discretion, to change, interpret, withdraw or add Benefits, or to end the Plan, as permitted by law, without your approval.

On its effective date, this *SPD* replaces and overrules any *SPD* that the Plan Sponsor may have previously issued to you. This *SPD* will in turn be overruled by any *SPD* issued to you in the future.

The Plan will take effect on the date shown in the Plan. Coverage under the Plan starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Plan Sponsor's location.

The Plan is governed by ERISA unless the Plan Sponsor is not an employee health and welfare plan as defined by ERISA.

Introduction to Your SPD

This *SPD* and the other Plan documents describe your Benefits, as well as your rights and responsibilities, under the Plan.

What Are Defined Terms?

Certain capitalized words have special meanings. The Plan Sponsor has defined these words in *Section 9: Defined Terms.*

When the Plan Sponsor uses the words "you" and "your," the Plan Sponsor is referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms.*

How Do You Use This Document?

Read your entire *SPD* and any attached Summary Material Modifications (SMMs) and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *SPD* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *SPD* at www.myuhc.com.

Review the Benefit limitations of this *SPD* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *SPD* and your Benefits work. Call the Claims Administrator if you have questions about the limits of the coverage available to you.

If there is a conflict between this *SPD* and any summaries provided to you by the Plan Sponsor, this *SPD* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact the Claims Administrator?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact the Claims Administrator for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Plan. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Plan issued to your Plan Sponsor, including the eligibility requirements.
- You must qualify as a Participant or a Dependent as those terms are defined in *Section 9: Defined Terms.*

Your Plan Sponsor may require you to make certain payments to them, in order for you to remain enrolled under the Plan. If you have questions about this, contact your Plan Sponsor.

Be Aware the Plan Does Not Pay for All Health Care Services

The Plan does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Physician. The Claims Administrator and the Plan Sponsor do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver your care. The Claims Administrator arranges for Physicians and other health care professionals and facilities to participate in a Network. The Claims Administrator's credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds the Allowed Amount.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Plan's exclusions.

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Plan. You must file the claim in a format that contains all of the information the Claims Administrator requires to process the claim, as described in *Section 5: How to File a Claim.*

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, the Plan will not pay Benefits for health care services for that condition or disability until the prior coverage ends. The Plan will pay Benefits as of the day your coverage begins under the Plan for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Claims Administrator and Plan Sponsor Responsibilities

Determine Benefits

Plan Sponsor and the Claims Administrator make administrative decisions regarding whether the Plan will pay for any portion of the cost of a health care service you intend to receive or have received. Plan Sponsor's and the Claims Administrator's decisions are for payment purposes only. Plan Sponsor and the Claims Administrator do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

Plan Sponsor and the Claims Administrator have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *SPD*, the *Schedule of Benefits* and any SMMs and/or Amendments.
- Make factual determinations relating to Benefits.

Plan Sponsor and the Claims Administrator may assign this discretionary authority to other persons or entities that may provide administrative services for the Plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

Process Payment for the Plan's Portion of the Cost of Covered Health Care Services

The Claims Administrator processes the Plan's payment of Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means the Claims Administrator processes only the payment of the Plan's portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Plan.

Process Plan Payment to Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from the Plan. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to the Plan.

Process Plan Payment for Covered Health Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, the Claims Administrator processes the Plan's payment of Benefits after receiving your request for payment that includes all required information. See *Section 5: How to File a Claim.*

Review and Determine Benefits in Accordance with the Claims Administrator's Reimbursement Policies

The Claims Administrator develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that the Claims Administrator accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), the Claims Administrator's reimbursement policies are applied to provider billings the Claims Administrator shares its reimbursement policies with Physicians and other providers in the Claims Administrator's Network through the Claims Administrator's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by the Claims Administrator's reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts the Plan does not pay, including amounts that are denied because one of the Claims Administrator's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of the Claims Administrator's reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

The Claims Administrator may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, the Claims Administrator will use comparable methodology(ies). The Claims Administrator and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to the Claims Administrator's website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

The Claims Administrator may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but it is recommended that you discuss them with your Physician.

UnitedHealthcare Select

United Healthcare Services, Inc.

Schedule of Benefits

How Do You Access Benefits?

Selecting a Network Primary Care Physician

You must select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Participant in order to obtain Benefits. In general health care terminology, a Primary Care Physician may also be referred to as a *PCP*. A Network Primary Care Physician will be able to coordinate all Covered Health Care Services and promote continuity of care. If you are the custodial parent of an Enrolled Dependent child, you must select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Participant for that child.

You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable state law) as the Network Primary Care Physician for an Enrolled Dependent child. You do not need a referral from a Primary Care Physician and may seek care directly from a Specialist, including a Physician who specializes in obstetrics or gynecology.

You may change your Network Primary Care Physician by calling the telephone number shown on your ID card.

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits,* Benefits are not available for services provided by out-of-Network providers. This Benefit plan does not provide an out-of-Network level of Benefits.

Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider.

Benefits for facility services apply when Covered Health Care Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or an out-of-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Benefits also include Emergency Health Care Services.

Depending on the geographic area and the service you receive, you may have access through the Claims Administrator's Shared Savings Program to out-of-Network providers who have agreed to discount their billed charges for Covered Health Care Services. Refer to the definition of Shared Savings Program in *Section 9: Defined Terms* of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Plan Sponsor, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

The Claims Administrator requires prior authorization for certain Covered Health Care Services. In general, Network providers are responsible for obtaining prior authorization before they provide these

services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call the Claims Administrator at the telephone number on your ID card.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, the Claims Administrator's final coverage determination will be changed to account for those differences, and the Plan will only pay and the Claims Administrator will only process payments for Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Claims Administrator processes payments for Benefits under the Plan), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Claims Administrator will process payments for the Plan as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain prior authorization before receiving Covered Health Care Services.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Limits are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term and Description Table

Payment Term And Description	Amounts
	The Amount You Pay Network
Annual Deductible	

Payment Term And Description	Amounts
	The Amount You Pay **Network**
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	***Network*** No Annual Deductible.
Out-of-Pocket Limit	
The maximum you pay per year for Copayments or Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts. • Copayments or Coinsurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit. • Copayments or Coinsurance for Covered Health Care Services provided under the *Outpatient Prescription Drug Plan*.	***Network*** For single coverage, the Out-of-Pocket Limit is $2,000. If more than one person in a family is covered under the Plan, the single coverage Out-of-Pocket Limit stated above does not apply. For family coverage, the family Out-of-Pocket Limit is $4,500. The Out-of-Pocket Limit includes the Annual Deductible.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

Payment Term And Description	Amounts
	The Amount You Pay **Network**
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

Schedule of Benefits Table

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Ambulance Services		
Prior Authorization Requirement In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible before transport.		
Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 20% *Air Ambulance:* 20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	
Does the Annual Deductible Apply?	*Ground Ambulance:* Not Applicable *Air Ambulance:* Not Applicable	
Non-Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 20% *Air Ambulance:* 20%	Ground or air ambulance, as the Claims Administrator determines appropriate.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	*Ground Ambulance:* Not Applicable *Air Ambulance:* Not Applicable	
Cellular and Gene Therapy		
Prior Authorization Requirement For Network Benefits you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization and if, as a result, the services are not received from a Designated Provider, Network Benefits will not be paid.		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Clinical Trials		
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Congenital Heart Disease (CHD) Surgeries		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$250 per Inpatient Stay	Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Dental Services - Accident Only		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Diabetes Self-Management Items What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Plan*.	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Plan*.	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Not Applicable	
Durable Medical Equipment (DME), Orthotics and Supplies		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every zero years. You must purchase, rent, or obtain the DME from the vendor the Claims Administrator identifies or purchase it directly from the prescribing Network Physician.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Emergency Health Care Services - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$500 per Visit	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		appropriate, Benefits will not be provided.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Gender Dysphoria		
Prior Authorization Requirement for Surgical Treatment You must obtain prior authorization as soon as the possibility of surgery arises. **Prior Authorization Requirement for Non-Surgical Treatment** Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Plan*.	
Habilitative Services		
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Chiropractic/Manipulative Treatment $30 per visit All other therapies $15 per Visit	Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. • Cognitive therapy.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Home Health Care		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. For the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Hospice Care		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Hospital - Inpatient Stay		

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$250 per Inpatient Stay	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Infertility Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Diagnosis and treatment of medical condition causing infertility. No coverage for: • Services and related expenses for infertility treatments. • Surrogate parenting, donor eggs, donor sperm and host uterus.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$25 per service $150 per service at a Hospital-based lab	If the service is provided in a doctor's office, additional co-pays, deductible or co-insurance may apply. Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
X-Ray and Other Diagnostic Testing - Outpatient	$25 per service	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$150 per service at an outpatient Hospital-based diagnostic center	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Prostate Specific Antigen Test What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Major Diagnostic and Imaging - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$100 per service $250 per service at an outpatient Hospital-based diagnostic center	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Mental Health Care and Substance-Related and Addictive Disorders Services		
Inpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$250 per Inpatient Stay	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Not Applicable	
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None per visit *Partial Hospitalization/Intensive Outpatient Treatment* $250 per session for Partial Hospitalization/ Intensive Outpatient Treatment	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Ostomy Supplies		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.		No coverage for: • deodorants • filters • lubricants • tape • appliance cleaners • adhesive and remover • other items not listed
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Pharmaceutical Products - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Physician Fees for Surgical and Medical Services		

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Physician's Office Services - Sickness and Injury		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Primary Care Physician* None per visit for a Primary Care Physician office visit or $75 per visit for a Specialist office visit	In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		• Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy* and *Manipulative Treatment*. • Habilitative therapy services described under *Habilitative Services*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Pregnancy - Maternity Services		
It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.		
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Preventive Care Services		
Physician office services What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	Not Applicable	
Lab, X-ray or other preventive tests What Is the Copayment or Coinsurance You Pay? This	None	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
May Include a Copayment, Coinsurance or Both.		
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	Not Applicable	
Breast pumps What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	Not Applicable	
Prosthetic Devices		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** 20% ***Network***	Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998.*

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Reconstructive Procedures		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Chiropractic/Manipulative Treatment $30 per visit Pulmonary Rehabilitation Therapy $30 per visit All other therapies $15 per Visit	Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 24 Manipulative Treatments. • 20 visits of speech therapy. • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 days per calendar year combined with *Habilitative Inpatient Services*. No coverage for: • Custodial care or maintenance care • Domiciliary care • Respite care, except when part of hospice care. • Services of personal care attendants • Individualized treatment programs designed to prepare a person for work.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Surgery - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$200 per date of service	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Not Applicable	
Therapeutic Treatments - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Transplantation Services		
Prior Authorization Requirement You must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Transplantation services must be received from a Designated Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider.
Urgent Care Center Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		• Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Virtual Visits		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Vision Exams		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Covered only for children up to age 18. Limited to 1 exam every 2 years. No coverage for: • Glasses and contact lenses, including fitting charges. • Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Surgery that allows you to see better without glasses or other vision correction (such as Lasik surgery).
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	

Allowed Amounts

Allowed Amounts are the amount the Claims Administrator determines that the Plan will pay for Benefits. For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills. Allowed Amounts are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines, as described in the *SPD*.

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are the Claims Administrator's contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as a result of an Emergency or as arranged by the Claims Administrator, Allowed Amounts are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Provider Network

The Claims Administrator or its affiliates arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not Adams County Government or the Claims Administrator's employees. It is your responsibility to choose your provider.

The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with the Claims Administrator to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of the Claims Administrator's products. Refer to your provider directory or contact the Claims Administrator for help.

Additional Network Availability

Certain Covered Health Care Services defined below may also be provided through the *W500* Network. Contact **www.myuhc.com** or the telephone number on your ID card for the *W500* provider directory. You are eligible for Benefits when these certain Covered Health Care Services are received from providers who are contracted with the Claims Administrator through the *W500* Network.

These Covered Health Care Services are limited to the services listed below, as described in *Section 1: Covered Health Care Services*:

- *Emergency Health Care Services - Outpatient.*
- *Hospital - Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Care Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Care Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if the Claims Administrator determines that specific Covered Health Care Services are not available from a Doctors Plan Network provider, you may be eligible for Benefits when Covered Health Care Services are received from a *W500* Network provider. In this situation, before you receive these Covered Health Care Services, your Doctors Plan Plus Network Physician will notify the Claims Administrator and, if the Claims Administrator confirms that the Covered Health Care Services are not available from a Doctors Plan Plus Network provider, the Claims Administrator will work with you and your Doctors Plan Plus Network Physician to coordinate these Covered Health Care Services through a *W500* Network provider.

Designated Providers

If you have a medical condition that the Claims Administrator believes needs special services, the Claims Administrator may direct you to a Designated Provider chosen by the Claims Administrator. If you require certain complex Covered Health Care Services for which expertise is limited, the Claims Administrator may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, the Plan may reimburse certain travel expenses.

In both cases, Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by the Claims Administrator.

You or your Network Physician must notify the Claims Administrator of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify the Claims Administrator in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Benefits will not be paid.

Health Care Services from Out-of-Network Providers

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify the Claims Administrator and, if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers

If the Claims Administrator determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, the Claims Administrator may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date the Claims Administrator notifies you, the Claims Administrator will select a single Network Physician for you.

If you do not use the selected Network Physician, Benefits will not be paid.

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Plan is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Plan.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Plan.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying the Claims Administrator.

Please note that in listing services or examples, when the Plan says "this includes," it is not the Claims Administrator's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Plan states specifically that the list "is limited to."

Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as the Claims Administrator determines appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.

  - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.

- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Plan.

Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for CHD services.

Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME), Orthotics and Supplies. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Plan*.

Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *SPD*.

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998*.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

Benefits do not include:

- Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
- Powered exoskeleton devices.

The Claims Administrator will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Medical Supplies and Equipment*.

Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn or improve skills and functioning for daily living. The Claims Administrator will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
    - Licensed speech-language pathologist.
    - Licensed audiologist.
    - Licensed occupational therapist.
    - Licensed physical therapist.

  - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

The Claims Administrator may require the following be provided:

- Treatment plan.
- Medical records.
- Clinical notes.
- Other necessary data to allow the Claims Administrator to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, the Claims Administrator may request a treatment plan that includes:

- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.
- Frequency of treatment plan updates.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices*.

Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's guidelines for hospice care.

Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Infertility Services

Diagnosis and treatment of medical condition causing infertility.

Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Presumptive Drug Tests and Definitive Drug Tests.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis* (*ABA*)) that are the following:
    - Focused on the treatment of core deficits of Autism Spectrum Disorder.
    - Provided by a *Board Certified Behavior Analyst* (*BCBA*) or other qualified provider under the appropriate supervision.
    - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

  This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *SPD*.

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by the Claims Administrator), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *SPD*. Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Plan.*

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, the Claims Administrator may direct you to a Designated Dispensing Entity. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

The Claims Administrator may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.

- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

The Claims Administrator also has special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify the Claims Administrator regarding your Pregnancy.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

  If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

  - Which pump is the most cost effective.

- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of purchase or rental.

Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Devices, Appliances and Prosthetics*.

Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.

- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic Endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.

- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow including CAR-T cell therapy.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small bowel.
- Pancreas.
- Small bowel.
- Cornea.

Donor costs that are directly related to organ removal are Covered Health Care Services for which Benefits are payable through the organ recipient's coverage under the Plan.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for transplant services.

Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Virtual Visits

Virtual visits for Covered Health Care Services that include the diagnosis and treatment of less serious medical conditions through live audio and video technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of live audio and video technology outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Please Note: Not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Vision Exams

Routine vision exams received from a health care provider in the provider's office for Covered Persons over the age of 18.

Section 2: Exclusions and Limitations

How Are Headings Used in this Section?

To help you find exclusions, this section contains headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

Plan Does Not Pay Benefits for Exclusions

The Plan will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through an SMM or Amendment to the Plan.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when the exclusion or limitation says that "this includes," it is not the Plan's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the exclusion or limitation will state specifically that the list "is limited to."

Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
7. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

5. Devices and computers to help in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.

6. Oral appliances for snoring.
7. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their traits (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 1, *Covered Health Care Services*.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.

Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*

Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

Gender Dysphoria

1. Cosmetic Procedures, including the following:
   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.

- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices* in *Section 1: Covered Health Care Services*. This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under Diabetes Services in *Section 1: Covered Health Care Services*.
2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.

Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
    - Nutritional education is required for a disease in which patient self-management is a part of treatment.
    - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
    - Air conditioners, air purifiers and filters and dehumidifiers.
    - Batteries and battery chargers.
    - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
    - Car seats.
    - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
    - Exercise equipment.
    - Home modifications such as elevators, handrails and ramps.
    - Hot and cold compresses.
    - Hot tubs.
    - Humidifiers.
    - Jacuzzis.
    - Mattresses.
    - Medical alert systems.
    - Motorized beds.

- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Skin abrasion procedures performed as a treatment for acne.
    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
    - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
    - Treatment for spider veins.
    - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Habilitative services for maintenance/preventive treatment.
7. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident or stroke.
8. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
9. Biofeedback.
10. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Surgical and non-surgical treatment of obesity.
13. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
15. Helicobacter pylori (H. pylori) serologic testing.

Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

    - Has not been involved in your medical care prior to ordering the service, or
    - Is not involved in your medical care after the service is received.

    This exclusion does not apply to mammography.

Reproduction

1. The following infertility treatment-related services:

    - Cryo-preservation and other forms of preservation of reproductive materials.
    - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
    - Donor services.
2. Gestational carrier (surrogate parenting), donor eggs, donor sperm and host uterus.
3. The reversal of voluntary sterilization.
4. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of infertility.

Services Provided under another Plan

1. Health care services for which other coverage is required by federal, state or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Plan Sponsor's that are not required by law to buy or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)
3. Health care services for transplants involving permanent mechanical or animal organs.

Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back at the Claims Administrator's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.*

Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
6. Rest cures.
7. Services of personal care aides.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
3. Eye exercise or vision therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
5. Cost and related fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices.

All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this *SPD* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Plan when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Plan ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Plan ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services the Claims Administrator would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Plan Sponsor. The Plan Sponsor will submit the completed forms to the Claims Administrator, along with any required contribution. The Plan will not provide Benefits for health care services that you receive before your effective date of coverage.

To enroll, call the Plan Sponsor within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. If you wish to change your benefit elections due to your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Plan Sponsor within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

Cost of Coverage

You and the Plan Sponsor share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld. In most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of the Plan Sponsor's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and the Plan Sponsor reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Plan Sponsor.

What If You Are Hospitalized When Your Coverage Begins?

The Plan will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Plan.

These Benefits are subject to your previous carrier's obligations under state law or contract.

You should notify the Claims Administrator of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network providers.

What If You Are Eligible for Medicare?

Your Benefits may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but do not follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Who Is Eligible for Coverage?

The Plan Sponsor determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

You are eligible to enroll in the Plan if you are a regular full-time employee or project designated employee of the Plan Sponsor who is scheduled to work at his or her job at least 40 hours per week or a regular part-time employee or project designated employee of the Plan Sponsor who is scheduled to work at least 30 hours per week.

An eligible person also includes designated elected officials who are serving in an active capacity and Economic Development employees working at least 30 hours per week.

An Eligible Person also includes a Retired Employee, as defined under *Section 9: Defined Terms*.

Retirees over 65 years of age, actively enrolled in Medicare are not eligible for coverage. Please contact the Plan Administrator for more information regarding your options after Medicare eligibility.

Eligible Person usually refers to an employee of the Plan Sponsor who (or other person whose connection with the Plan Sponsor) meets the eligibility rules. When an Eligible Person enrolls, the Claims Administrator refers to that person as a Participant. For a complete definition of Eligible Person, Plan Sponsor and Participant, see *Section 9: Defined Terms*.

Eligible Persons must live within the United States.

Dependent

An eligible Dependent is considered to be:

- Your legal Spouse by marriage or common law (a copy of the marriage certificate or common law affidavit is required).
- Civil Union partners (certificate required).
- Domestic Partner (effective 6/1/2019, certificate required) as defined in Section 14, *Glossary.*
- You and/or your Spouse's, Domestic Partner's or civil union partner's biological children under the age of 26.
    - Children born through a gestational carrier or surrogate are not Dependents under the terms of the Plan unless the surrogate is an eligible Dependent under the terms of the plan and submits legal guardianship of the child to the Plan Administrator.
- A child of any age who is medically certified as disabled and dependent upon you or your Spouse for their total support.
- Children placed for adoption or for whom you have obtained legal guardianship.
- A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled, except under certain circumstances. Contact the Plan Administrator for details.

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Plan Sponsor purchases coverage under the Plan from the Claims Administrator, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Plan. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Plan Sponsor sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Plan Sponsor. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Plan Sponsor. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Participant's may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

Coverage for the Dependent begins on the date of the event. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the event.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.

- Marriage.
- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including legal separation, divorce or death).
    - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.
    - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
    - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
    - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. The Plan Sponsor must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, the Plan Sponsor may end the Plan and/or all similar benefit plans at any time for the reasons explained in the Plan.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Claims Administrator will still process Plan payments on claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, the Claims Administrator will not process Plan payments on claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Participant's coverage ends.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Plan Ends**

  Your coverage ends on the date the Plan ends. In this event, the Plan Sponsor is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Participant," "Dependent" and "Enrolled Dependent."

- **The Claims Administrator Receives Notice to End Coverage**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends on the last day of the calendar month in which the Claims Administrator receives the required notice from the Plan Sponsor to end your coverage, or on the date requested in the notice, if later.

- **Participants Retires or Is Pensioned**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends the last day of the calendar month in which the Participant is retired or receiving benefits under the Plan Sponsor 's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Plan, and only if the Participant continues to meet any applicable eligibility requirements. The Plan Sponsor can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

The Plan will provide at least 30 days advance required notice to the Participant that coverage will end on the date identified in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If the Claims Administrator and the Plan Sponsor find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact the Plan Sponsor has the right to demand that you pay back all Benefits the Plan paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. The Plan will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental or physical handicap or disability.
- The Enrolled Dependent child depends mainly on the Participant for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Plan.

You must furnish the Plan Sponsor with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before the Plan Sponsor agrees to this extension of coverage for the child, the Plan Sponsor may require that a Physician examine the child. The Plan Sponsor will choose the Physician and the Plan will pay for that examination.

The Plan Sponsor may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at the Plan's expense. The Plan Sponsor will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of the Plan Sponsor's request as described above, coverage for that child will end.

Continuation of Coverage

If your coverage ends under the Plan, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Plan Sponsors that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Plan Sponsor is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

The Claims Administrator is not the Plan Sponsor's designated "plan administrator" as that term is used in federal law, and the Claims Administrator does not assume any responsibilities of a "plan administrator" according to federal law.

The Claims Administrator is not obligated to provide continuation coverage to you if the Plan Sponsor or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Plan Sponsor or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying the Claims Administrator in a timely manner of your election of continuation coverage.

Section 5: How to File a Claim

Claims Procedures

You can obtain a claim form by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. If you do not have a claim form, attach the bill from your provider to a brief letter of explanation. Verify that your provider's bill contains the *Required Information* listed below. If any *Required Information* is missing from the bill, you can include it in your letter.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Claims Administrator. You must file the claim in a format that contains all of the information the Claims Administrator requires, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to the Claims Administrator within one year of the date of service, Benefits for that health care service will be denied or reduced, as determined by the Claims Administrator. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

How Are Outpatient Prescription Drug Benefits Paid?

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
- You pay Coinsurance and you believe that the amount of the Coinsurance was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

Required Information

When you request payment of Benefits from the Claims Administrator, you must provide the Claims Administrator with all of the following information:

- The Participant's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with the Claims Administrator at the address on your ID card.

Payment of Benefits

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to an out-of-Network provider without the Claims Administrator's consent. When an assignment is not obtained, the Claims Administrator will send the reimbursement directly to the Participant for reimbursement to an out-of-Network provider. The Claims Administrator reserves the right, in its discretion, to process Plan payment to an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network provider, the Plan has the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan.

When you assign your Benefits under the Plan to an out-of-Network provider with the Claims Administrator's consent, and the out-of-Network provider submits a claim for payment, you and the out-of-Network provider represent and warrant the following:

- The Covered Health Care Services were actually provided.
- The Covered Health Care Services were medically appropriate.

When the Claims Administrator has not consented to an assignment, the Claims Administrator will send the reimbursement directly to you (the Participant) for you to reimburse the provider upon receipt of their bill. However, the Claims Administrator reserves the right, in its discretion, to pay the provider directly for services rendered to you. When exercising its discretion with respect to payment, the Claims Administrator may consider whether you have requested that payment of your Benefits be made directly to the provider. Under no circumstances will the Claims Administrator pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a provider shall not be deemed to constitute consent by the Claims Administrator to an assignment or to waive the consent requirement. When the Claims Administrator in its discretion directs payment to a provider, you remain the sole beneficiary of the payment, and the provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, the Claims Administrator may in its discretion send information concerning the Benefits to the provider as well. If payment to a provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to Refund of Overpayments in *Section 8: General Legal Provisions.*

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in a form of other consideration that the Claims Administrator in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes to other plans for which the Claims Administrator processes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to the Claims Administrator in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. The Claims Administrator will notify you of the decision regarding your complaint within 60 days of receiving it.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact the Claims Administrator in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

For medical claims, the appeals address is:

UnitedHealthcare - Appeals

P.O. Box 30432,

Salt Lake City, Utah 84130-0432

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by the Claims Administrator during the determination of the appeal, the Claims Administrator will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the decision letter to you.

Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. The Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If the Claims Administrator needs more information from your Physician to make a decision, the Claims Administrator will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Federal External Review Program

You may be entitled to request an external review of the Claims Administrator's determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by the Claims Administrator.
- The Claims Administrator fails to respond to your appeal within the timeframe required by the applicable regulations.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting the Claims Administrator at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received the Claims Administrator's final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)*. The Claims Administrator have entered into agreements with three or more *IRO*s that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review includes all of the following:

- A preliminary review by the Claims Administrator of the request.
- A referral of the request by the Claims Administrator to the *IRO*.
- A decision by the *IRO.*

After receipt of the request, the Claims Administrator will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes this review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an *IRO* to conduct such review. The Claims Administrator will assign requests by either rotating the assignment of claims among the *IRO*s or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days after the date you receive the *IRO's* request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

The Claims Administrator will provide to the assigned *IRO* the documents and information considered in making the Claims Administrator's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by the Claims Administrator.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. The Claims Administrator will include it with the documents forwarded to the *IRO.*

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The *IRO* will provide written notice of its determination (the *"Final External Review Decision"*) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and the Claims Administrator, and it will include the clinical basis for the determination.

If the Claims Administrator receives a *Final External Review Decision* reversing the Claims Administrator's determination, the Claims Administrator will provide coverage or payment for the Benefit claim at issue according to the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the *Final External Review Decision* agrees with the determination, the Claims Administrator will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive either of the following:

- An adverse benefit determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:
    - The life or health of the individual.
    - The individual's ability to regain maximum function.

In addition, you must have filed a request for an expedited internal appeal.

- A final appeal decision, that either:
    - Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
    - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Claims Administrator will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an *IRO* in the same manner the Claims Administrator utilizes to assign standard external reviews to *IRO*s. The Claims Administrator will provide all required documents and information the Claims Administrator used in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available method in a timely manner. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the IRO's final external review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call the Claims Administrator at the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to the Claims Administrator within:	48 hours after receiving notice of additional information required

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial request for Benefits is complete, within:	15 days
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*The Claims Administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial claim is complete, within:	30 days
• after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
    - The parents are married or living together whether or not they have ever been married and not legally separated.
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:

  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary, it determines the amount it will pay for a Covered Health Care Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan, as long as this amount is not more than the Plan would have paid had it been the only plan involved.
- At the end of the calendar year, the benefit reserve returns to zero. A new benefit reserve is created for each calendar year.

You will be responsible for any applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is an allowable expense? For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "*Determining the Allowable Expense When this Plan is Secondary to Medicare*".

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).

- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge - often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare - typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses under Part A of Medicare (hospital expenses) expenses under Part B (Physician office visits) and DME Medicare expenses or expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Who has the Right to Receive and Release Needed Information?

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Allowed Amounts.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of you, you, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Section 8: General Legal Provisions

What Is Your Relationship with the Claims Administrator and Plan Sponsor?

It is important for you to understand the Claims Administrator's role with respect to the Plan and how it may affect you. The Claims Administrator helps administer the claims payment for the Plan Sponsor's Plan in which you are enrolled. The Claims Administrator and the Plan Sponsor do not provide medical services or make treatment decisions. This means:

- The Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Care Services, which are more fully described in this *SPD*.
- The Plan may not pay for all treatments you or your Physician may believe are needed. If the Plan does not pay, you will be responsible for the cost.

The Plan Sponsor and the Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan Sponsor and the Claims Administrator will use individually identifiable information about you as permitted or required by law, including in the Claims Administrator's operations and in the Claims Administrator's research. The Plan Sponsor and the Claims Administrator will use de-identified data for commercial purposes including research.

Please refer to the Claims Administrator's *Notice of Privacy Practices* for details.

What Is the Claims Administrator's Relationship with Providers and Plan Sponsors?

The relationships between the Claims Administrator and Network providers and Plan Sponsors are solely contractual relationships between independent contractors. Network providers and Plan Sponsors are not the Claims Administrator's agents or employees. Neither the Claims Administrator nor any of the Claims Administrator's employees are agents or employees of Network providers or the Plan Sponsor's.

Plan Sponsors and the Claims Administrator do not provide health care services or supplies, or practice medicine. Plan Sponsors and the Claims Administrator arrange for health care providers to participate in a Network and the Claims Administrator processes the Plan's payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. Network providers are not the Plan Sponsor's employees. Network providers are not the Claims Administrator's employees. The Plan Sponsor and the Claims Administrator do not have any other relationship with Network providers such as principal-agent or joint venture. The Plan Sponsor and the Claims Administrator are not responsible for any act or omission of any provider.

The Claims Administrator is not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator is not responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

The Plan Sponsor is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Plan's Service Fee to the Claims Administrator.
- The funding of Benefits on a timely basis.
- Notifying you of when the Plan ends.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Plan Sponsors?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a participant responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Plan Sponsor is that of employer and employee, Dependent or other classification as defined in the Plan.

Notice

When the Claims Administrator provides written notice regarding administration of the Plan to an authorized representative of the Plan Sponsor, that notice is deemed notice to all affected Participants and their Enrolled Dependents. The Plan Sponsor is responsible for giving notice to you.

Statements by the Plan Sponsor or Participants

All statements made by the Plan Sponsor or by a Participant shall, in the absence of fraud, be deemed representations and not warranties. The Claims Administrator will not use any statement made by the Plan Sponsor to void the Plan after it has been in force for two years unless it is a fraudulent statement.

Does the Claims Administrator Pay Incentives to Providers?

The Claims Administrator pays Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's

contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Are Incentives Available to You?

Sometimes the Claims Administrator may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, you should discuss taking part in such programs with your Physician. Contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card if you have any questions.

Does the Claims Administrator Receive Rebates and Other Payments?

The Plan Sponsor and the Claims Administrator may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. The Plan Sponsor and the Claims Administrator do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Who Interprets Benefits and Other Provisions under the Plan?

The Plan Sponsor and the Claims Administrator have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions set out in the Plan, including this *SPD*, the *Schedule of Benefits* and any *Summary Material Modifications (SMM)*, and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

The Plan Sponsor and the Claims Administrator may assign this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Sponsor may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that the Plan Sponsor does so in any particular case shall not in any way be deemed to require the Plan Sponsor to do so in other similar cases.

Who Provides Administrative Services?

The Claims Administrator provides claims administrative services or, as the Claims Administrator determines, the Claims Administrator may arrange for various persons or entities to provide claims administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as the Claims Administrator determines. The Claims Administrator is not required to give you prior notice of any such change, nor is the Claims Administrator required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

What is the Future of the Plan?

Although Plan Sponsor expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or *Employee Retirement Income Security Act of 1974 (ERISA)*, or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Amendments to the Plan

To the extent permitted by law, the Plan Sponsor has the right, as it determines and without your approval, to change, interpret, withdraw or add Benefits or end the Plan.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of applicable state law provisions not otherwise preempted by ERISA or federal statutes or regulations (of the jurisdiction in which the Plan is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Plan unless it is made by an Amendment or SMM. All of the following conditions apply:

- Amendments to the Plan are effective upon the Plan's next anniversary date, except as otherwise permitted by law.
- SMMs to the Plan are effective on the date the Plan Sponsor specifies.
- No agent has the authority to change the Plan or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Plan.

How Does the Claims Administrator Use Information and Records?

The Claims Administrator may use your individually identifiable health information as follows:

- To administer the Plan and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

The Claims Administrator may request additional information from you to decide your claim for Benefits. The Claims Administrator will keep this information confidential. The Claims Administrator may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how the Claims Administrator may use or disclose your information is found in the Claims Administrator *Notice of Privacy Practices.*

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Claims Administrator with all information or copies of records relating to the services provided to you. The Claims Administrator has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Participant's enrollment form. UnitedHealthcare agrees that such information and records will be considered confidential.

The Claims Administrator has the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Plan.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Plan, the Claims Administrator and the Claims Administrator's related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to the Claims Administrator *Notice of Privacy Practices.*

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from the Claims Administrator, the Claims Administrator also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as needed. The Claims Administrator's designees have the same rights to this information as the Claims Administrator has.

Does the Plan Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, the Plan Sponsor may require that a Network Physician of its choice examine you at the Plan's expense.

Is Workers' Compensation Affected?

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

How Are Benefits Paid When You Are Medicare Eligible?

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan Sponsor's Plan is the secondary payer as described in *Section 7: Coordination of Benefits,* the Claims Administrator will process the Plan Sponsors payment of Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan Sponsor's Plan is the secondary payer, the Claims Administrator will process the Plan Sponsor's payment of any Benefits available to you under the Plan as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

The Plan has the right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation Example:

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.

- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or the Plan's agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.
    - Obtaining the Plan's consent or the Plan's agents' consent before releasing any party from liability or payment of medical expenses.
    - Complying with the terms of this section.

    Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect

include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile Plan - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without the Plan's written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of the Plan's interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of the Plans discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

When Does the Plan Receive Refunds of Overpayments?

If the Plan pays Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to the Plan if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

You cannot bring any legal action against the Plan or the Claims Administrator to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against the Plan or the Claims Administrator you must do so within three years of the date the Plan notified you of its final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

What Is the Entire Plan?

The *SPD*, the *Schedule of Benefits*, and any SMMs and/or Amendments, make up the entire Plan.

Section 9: Defined Terms

Addendum - any attached written description of additional or revised provisions to the Plan. The Benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Allowed Amounts - for Covered Health Care Services, incurred while the Plan is in effect, Allowed Amounts are determined by the Claims Administrator as shown in the *Schedule of Benefits*.

Allowed Amounts are determined solely in accordance with the Claims Administrator reimbursement policy guidelines. The Claims Administrator develops these guidelines, as the Claims Administrator determines, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Plan. It is effective only when distributed by the Plan Sponsor or Plan Administrator. It is subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Annual Deductible - the total of the Allowed Amount you must pay for Covered Health Care Services per year before the Plan will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Care Services that are available under the Plan.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Claims Administrator - the organization that provides certain claim administration and other services for the Plan.

Coinsurance - the charge, stated as a percentage of the Allowed Amount, that you are required to pay for certain Covered Health Care Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Copayment.
- The Allowed Amount.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Medically Necessary.
- Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *SPD* under *Section 2: Exclusions and Limitations*.
- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness and Substance-Related and Addictive Disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available and prevailing medical standards and clinical guidelines. In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:
    - "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
    - "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Provided to a Covered Person who meets the Plan's eligibility requirements.
- Not excluded in this *SPD* under *Section 2: Exclusions and Limitations.*

Covered Person - the Participant or a Dependent, but this term applies only while the person is enrolled under the Plan. The Plan Sponsor uses "you" and "your" in this *SPD* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Dependent – An eligible Dependent is considered to be:

- Your legal Spouse by marriage, Domestic Partner as defined in Section 14, *Glossary* or common law (a copy of the marriage certificate or common law affidavit is required).
- Civil Union partners (certificate required).
- You and/or your Spouse’s, Domestic Partner’s or civil union partner’s biological children under the age of 26.

- Children born through a gestational carrier or surrogate are not Dependents under the terms of the Plan unless the surrogate is an eligible Dependent under the terms of the plan and submits legal guardianship of the child to the Plan Administrator.
- A child of any age who is medically certified as disabled and dependent upon you or your Spouse for their total support.
- Children placed for adoption or for whom you have obtained legal guardianship.
- A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled, except under certain circumstances. Contact the Plan Administrator for details.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that the Claims Administrator has identified as Designated Providers. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Care Service for the treatment of specific diseases or condition; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Care Services through live audio and video technology.

Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.

- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.
- They must be financially interdependent.

The Participant and Domestic Partner must jointly register their domestic partnership with either Denver or Boulder in order to add the Domestic Partner onto Benefits (an affidavit will not be accepted). The following requirements apply for each:

Denver

Committed Partnership Registry

The City and County of Denver allows couples who are not married to recognize their commitment through the Committed Partnership Registry.

The Registry is open to any two partners who:

- Are unmarried, eighteen years of age or older, and competent to enter into a contract;
- Are not prohibited from marrying each other under the law of this state by reason of a blood relationship or other comparable domestic partnership;
- Are sharing a common household; and
- Do not already have different partners under the provisions of the Denver Committed Partnership Ordinance, the Colorado Civil Unions Act or any other comparable domestic partnership provision.

Boulder

Who are Domestic Partners:

Domestic Partners are two people who have signed an affidavit swearing that they are:

- Are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship;
- Are each other's sole domestic partner;
- Are both at least 18 years of age and competent to contract;
- Share a life and home together;
- Are not related by kinship closer than would bar marriage in the State of Colorado; and
- Are not married.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Plan Sponsor or other person connected to the Plan Sponsor who meets the eligibility requirements shown in both the Plan Sponsor's Plan and supporting documents. An Eligible Person must live within the United States.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Health Care Services - with respect to an Emergency:

- A medical screening exam (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

Enrolled Dependent - a Dependent who is properly enrolled under the Plan.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- The Claims Administrator may, as the Claims Administrator determines, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
    - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*: and
    - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;

- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medicaid - a federal program administered and operated individually by participating state and territorial governments. The program provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - health care services that are all of the following as determined by the Claims Administrator or the Claims Administrator's designee.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator has the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by the Claims Administrator.

The Claims Administrator develops and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting the Claims Administrator's determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Care Services - Covered Health Care Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by the Claims Administrator, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with the Claims Administrator's affiliate to participate in the Claims Administrator's Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of the Claims Administrator's products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date it is placed on a tier by the Claims Administrator's PDL Management Committee.
- December 31st of the following calendar year.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Plan. The Plan Sponsor sets the period of time that is the Open Enrollment Period.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Participant - a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan. A Participant must live and/or work in the United States.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications, products or devices administered in connection with a Covered Health Care Service by a Physician.

Pharmaceutical Product List - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration* (*FDA*). This list is subject, from time to time, to the Claims Administrator's review and change. You may find out which tier a particular Pharmaceutical

Product has been placed by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that the Claims Administrator describes a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - the Plan Sponsor's Self-Funded group health benefit plan.

The "What Is the *Summary Plan Description*?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Plan Sponsor - the employer, or other defined or otherwise legally established group, to whom the Plan is issued. The "What Is the *Summary Plan Description*?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Prescription Drug List (PDL) Management Committee - the committee that the Claims Administrator designates for, among other responsibilities, placing Pharmaceutical Products into specific tiers.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:

- Room and board.
- Evaluation and diagnosis.
- Counseling.
- Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee - an Employee under the age of 65 who meets the retirement eligibility rules as defined by Adams County policy guidelines. Retirees over 65 years of age actively enrolled in Medicare are not eligible for coverage.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Service Fee - the periodic fee required for each Participant and each Enrolled Dependent, in accordance with the terms of the Plan.

Shared Savings Program - a program in which the Claims Administrator may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider. When this happens, you may experience lower out-of-pocket amounts. Coinsurance and any applicable deductible would still apply to the reduced charge. Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by the Claims Administrator. In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by the Claims Administrator. If this happens, you should call the telephone number shown on your ID card. Shared Savings Program providers are not Network providers and are not credentialed by the Claims Administrator.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *SPD* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse - an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance-Related and Addictive Disorders Services - Covered Health Care Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Summary Material Modification (SMM) - any attached written description of additional Covered Health Care Services not described in this *SPD.* Covered Health Care Services provided by a SMM may be subject to payment of additional Service Fees. SMMs are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the SMM.

Transitional Living - Mental health care services and substance-related and addictive disorders services provided through facilities, group homes and supervised apartments which provide 24-hour supervision and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

The Claims Administrator has a process by which the Claims Administrator compiles and reviews clinical evidence with respect to certain health care services. From time to time, the Claims Administrator issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) the Claims Administrator may, as the Claims Administrator determines, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

Amendment: Wellness

This Amendment to the Plan is issued by the Plan Sponsor as described below.

Because this Amendment is part of a legal document, the Plan wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings. The Plan has defined these words in the *Summary Plan Description* in *Section 9: Defined Terms*.

What is the Wellness Amendment?

This Amendment describes the health and wellness tool that applies digital experiences, tools, games and rewards designed to engage Covered Persons in managing their health.

Who Is Eligible?

Participation is available to Covered Persons age 13 years and older; however, wellness rewards are only available to Covered Persons age 18 years and older.

What Are the Wellness Opportunities?

The health and wellness tool includes a wide range of wellness engagement opportunities. Engagement opportunities include the following:

- Interactive social media and games, which may include taking part in wellness challenges and health communities.
- *Health Survey*.
- *Online Personal Health Record*.
- An *Invite* to create personal missions.
- Integration with a variety of wellness devices (for example, wearable wireless trackers and mobile tools).

What Are the Rewards?

Covered Persons, age 18 years and older, receive wellness rewards for taking part in health and wellness opportunities as described above. When you take part in a health and wellness opportunity, you earn "coins" as a reward. For example, you may earn 40 coins for completing a *Health Survey*. You can save up coins and use the coins to enter into sweepstakes.

If you cannot meet a standard for a certain wellness reward, then you might qualify to earn the same reward by different means. You may call the Claims Administrator at the telephone number listed on your identification (ID) card who will work with you (and, if needed, with your doctor) to find another way for you to earn the same reward.

Clinical Programs and Resources

Care Management

Care Management Solutions

Standard Care Coordination

The Claims Administrator provides a program called Care Coordination℠ designed to encourage personalized, efficient care for you and your covered Dependents.

Care Coordination℠ nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

Care Coordination℠ nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Care Coordination℠ process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Care Coordination℠ program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- **Inpatient care management** - If you are hospitalized, a Care Coordination℠ nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Care Coordination℠ nurse to confirm that medications, needed equipment, or follow-up services are in place. The nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Care Coordination℠ nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Care Coordination℠ nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Complex Medical Conditions, Programs and Services

Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about CRS, visit www.myoptumhealthcomplexmedical.com or call the number on the back of your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Congenital Heart Disease (CHD) Resource Services

The Claims Administrator provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call the Claims Administrator at the number on the back of your ID card.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Care Service under the Plan.

Kidney Disease Programs

Kidney Resource Services program (KRS) program

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit www.myoptumhealthcomplexmedical.com or call the number on the back of your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Travel and Lodging Assistance Program*.

Travel and Lodging Assistance Program

Your Plan Sponsor is providing you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Allowed Amounts are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Allowed Amount for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Facility.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Decision Support

NurseLine[SM]

NurseLine[SM] is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information to help you make more informed health care decisions. When you call, a registered nurse may refer you to any additional resources that Plan Sponsor has available that may help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- A recent diagnosis.
- A minor Sickness or Injury.
- Men's, women's, and children's wellness.
- How to take Prescription Drug Products safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

NurseLine[SM] gives you another way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine[SM] is available to you at no additional cost. To use this service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine[SM].

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLine[SM] any time, 24 hours a day, seven days a week. You can count on NurseLine[SM] to help answer your health questions.

Disease Management

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
    - Education about the specific disease and condition.
    - Medication management and compliance.
    - Reinforcement of on-line behavior modification program goals.
    - Preparation and support for upcoming Physician visits.
    - Review of psychosocial services and community resources.
    - Caregiver status and in-home safety.
    - Use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

Wellness Management/Preventive Care

HealtheNotes℠

The Claims Administrator provides a service called HealtheNotes℠. HealtheNotes℠ provides you and your Physician with information regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes℠ report may include health tips and other wellness information.

The Claims Administrator provides this information through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified who may benefit from this information using the established standards of evidence based medicine as described in *Section 9: Defined Terms* under the definition of Covered Health Care Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes℠ report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the information the Claims Administrator provides. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Women's Health/Reproductive

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the number on your ID card. This program offers:

- Pregnancy consultation to identify special needs.
- Written and on-line educational materials and resources.

- 24-hour access to experienced maternity nurses.
- A phone call from a care coordinator during your Pregnancy, to see how things are going.
- A phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

Neonatal Resource Services

Neonatal Resource Services (NRS) is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

When you enroll in this program, the Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Provider's participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions.

To take part in the NRS program, call a neonatal nurse at 1-866-534-7209. The Plan will only pay Benefits under the NRS program if NRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

You or a covered Dependent may also:

- Call the Claims Administrator.
- Call NRS at 1-888-936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under the Covered Health Care Service Category.

Consumer Solutions and Self-Service Tools

Plan Sponsor believes in giving you tools to help you be an educated health care consumer. To that end, Plan Sponsor has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE: Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. The Claims Administrator and the Plan Sponsor are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

www.myuhc.com

UnitedHealthcare's member website, www.myuhc.com, provides information at your fingertips anywhere and anytime you have access to the Internet. www.myuhc.com opens the door to a wealth of health information and self-service tools.

With www.myuhc.com you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Access all of the content and wellness topics from NurseLine[SM].
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

If you have not already registered on www.myuhc.com, simply go to www.myuhc.com and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit www.myuhc.com and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to www.myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Health Survey

You and your Spouse are invited to learn more about health and wellness at www.myuhc.com and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to www.myuhc.com. logging in, access your personalized Health & Wellness page. If you need any assistance with the online survey, please call the number on the back of your ID card.

Outpatient Prescription Drug Schedule of Benefits

United Healthcare Services, Inc.

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Copayment and/or Coinsurance may change or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that the Claims Administrator has developed. Supply limits are subject, from time to time, to the Claims Administrator's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from the Claims Administrator or the Claims Administrator's designee. The reason for obtaining prior authorization from the Claims Administrator is to determine whether the Prescription Drug Product, in accordance with the Claims Administrator's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

The Plan may also require you to obtain prior authorization from the Claims Administrator or the Claims Administrator's designee so the Claims Administrator can determine whether the Prescription Drug Product, in accordance with the Claims Administrator's approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from the Claims Administrator.

If you do not obtain prior authorization from the Claims Administrator before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to the Claims Administrator's review and change. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

If you do not obtain prior authorization from the Claims Administrator before the Prescription Drug Product is dispensed, you can ask the Claims Administrator to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Claims Administrator as described in this *Summary Plan Description (SPD)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after the Claims Administrator reviews the documentation provided and the Claims Administrator determines that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

The Claims Administrator may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Outpatient Prescription Drug Plan are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

What Do You Pay?

The Claims Administrator may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table. You are not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

The amount you pay for any of the following under this Outpatient Prescription Drug Plan will not be included in calculating any Out-of-Pocket Limit stated in this *SPD*:

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. The Claims Administrator's contracted rates (the Claims Administrator's Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Coinsurance*** Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. ***Copayment and Coinsurance*** Your Copayment and/or Coinsurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. **Special Programs:** The Claims Administrator may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

Payment Term And Description	Amounts
Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, the Claims Administrator may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status. **Coupons:** The Claims Administrator may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.	

Outpatient Prescription Drug Schedule of Benefits Table

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits.

Outpatient Prescription Drug Benefits	**What Is the Amount You Pay?** **This May Include a Copayment, Coinsurance or Both**	**Description and Supply Limits**
Specialty Prescription Drug Products		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	For a Tier 1 Specialty Prescription Drug Product: $100 per Prescription Order or Refill up to 31 days. For a Tier 1 Specialty Prescription Drug Product: $250 per Prescription Order or Refill up to 90 days.	The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at Network

Outpatient Prescription Drug Benefits	What Is the Amount You Pay? This May Include a Copayment, Coinsurance or Both	Description and Supply Limits
		Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.
Prescription Drugs from a Retail Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	For a Tier 1 Prescription Drug Product: $10 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $35 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $50 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $50 of the Prescription Drug Charge per Prescription Order or Refill.	• A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.
Prescription Drug Products from a Mail Order Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.	For a Tier 1 Prescription Drug Product: $25 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $87.50 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $125 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: $125 of the Prescription Drug Charge per Prescription Order or Refill.	When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. To maximize your Benefit, ask your Physician to write your Prescription Order or

Outpatient Prescription Drug Benefits	What Is the Amount You Pay? This May Include a Copayment, Coinsurance or Both	Description and Supply Limits
		Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.

Outpatient Prescription Drug Plan

United Healthcare Services, Inc.

This portion of the Plan provides Benefits for Prescription Drug Products.

Because this section is part of a legal document, the Plan Sponsor wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings. The Claims Administrator has defined these words in either the *Summary Plan Description (SPD)* in *Section 9: Defined Terms* or in this Plan in *Outpatient Prescription Drug Defined Terms*.

When the Plan Sponsor uses the words "you" and "your" the Plan Sponsor is referring to people who are Covered Persons, as the term is defined in *Section 9: Defined Terms*.

NOTE: The Coordination of Benefits provision in this *SPD* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Outpatient Prescription Drug Plan. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the *SPD*.

Introduction Outpatient Prescription Drug Plan

Coverage Policies and Guidelines

The Claims Administrator's Prescription Drug List (PDL) Management Committee makes tier placement changes on the Claims Administrator's behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat, or according to whether it was prescribed by a Specialist.

The Claims Administrator may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the Claims Administrator during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from the Plan as described in this *SPD* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Springs, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom the Claims Administrator has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Prescription Drug Product.

When Does the Claims Administrator Limit Selection of Pharmacies?

If the Claims Administrator determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, the Claims Administrator may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date the Claims Administrator notifies you, the Claims Administrator will choose a Network Pharmacy for you.

Rebates and Other Payments

The Claims Administrator and Pinnacol Assurance may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. As determined by the Claims Administrator, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

The Claims Administrator, and a number of the Claims Administrator's affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Plan*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Plan*. The Claims Administrator is not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, the Claims Administrator may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

The Claims Administrator may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, the Claims Administrator may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy but do not inform the Claims Administrator, no Benefit will be paid.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products

are subject to Benefit enhancement, reduction or no Benefit by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom the Claims Administrator has an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid.

Please see *Outpatient Prescription Drug Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy supply limits apply.

Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Outpatient Prescription Drug Plan Exclusions

Exclusions from coverage listed in this *SPD* also apply to this Outpatient Prescription Drug Plan. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by the Claims Administrator to be experimental, investigational or unproven.
7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. A Pharmaceutical Product for which Benefits are provided under the medical Benefits portion of the Plan in this *SPD*. This includes all forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
11. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in this *SPD*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
12. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
13. Unit dose packaging or repackagers of Prescription Drug Products.
14. Medications used for cosmetic purposes.
15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Claims Administrator determines do not meet the definition of a Covered Health Care Service.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

17. Prescription Drug Products when prescribed to treat infertility.
18. Certain Prescription Drug Products for tobacco cessation.
19. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
20. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Claims Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Claims Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator PDL Management Committee.
22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
23. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.
24. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
26. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
27. Certain Prescription Drug Products that have not been prescribed by a Specialist.
28. A Prescription Drug Product that contains marijuana, including medical marijuana.
29. Dental products, including but not limited to prescription fluoride topicals.
30. A Prescription Drug Product with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

31. Diagnostic kits and products.

32. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Outpatient Prescription Drug Defined Terms

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Claims Administrator identifies as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by the Claims Administrator.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with the Claims Administrator or with an organization contracting on the Claims Administrator's behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Claims Administrator identifies as a Generic product based on available data resources. This includes, data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by the Claims Administrator.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with the Claims Administrator or an organization contracting on the Claims Administrator's behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Claims Administrator as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by the Claims Administrator PDL Management Committee.
- December 31st of the following calendar year.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Prescription Drug Charge - the rate the Plan has agreed to pay the Claims Administrator on behalf of its Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to the Claims Administrator's review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that the Claims Administrator designates for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Outpatient Prescription Drug Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
    - standard insulin syringes with needles;
    - blood-testing strips - glucose;
    - urine-testing strips - glucose;
    - ketone-testing strips and tablets;
    - lancets and lancet devices; and
    - glucose meters. This does not include continuous glucose monitors. Benefits for continuous glucose monitors are provided as described in the medical portion of this *SPD*.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug

Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Federal Notice

Language Assistance Services

The Claims Administrator provides free language services to help you communicate with us. The Claims Administrator offers interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY 711. The Claims Administrator is available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به‌طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាំជូនដំណឹង: បើសិនជាអ្នកនិយាយ **ភាសាខ្មែរ(Khmer)** សេវាជំនួយផ្នែកភាសាគឺមានសំរាប់បំរើអ្នកដោយឥតគិតថ្លៃ សូមទូរស័ព្ទ 1-866-633-2446.

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

Notice of Non-Discrimination

The Claims Administrator[1] does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

United HealthCare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "The Claims Administrator" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

This group health plan does not discriminate in premium amounts, contributions charged or eligibility for coverage based on any individual's genetic information. The plan does not use, request or require genetic information about anyone covered by the plan. Genetic information, within the context of GINA, includes the following: an individual's genetic tests; the genetic tests of an individual's family members (up to fourth-degree relatives by birth, marriage or adoption); manifestation of disease or disorder in family members of an individual; an individual's request for or receipt of genetic services; and genetic information of a fetus carried by an individual or his or her family.

Any Health Risk Assessment (HRA) completed by a person covered by this plan is in compliance with regulations under GINA.

Medicaid and the Children's Health Insurance Program (CHIP) Free or Low Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or **dial 1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 1, 2010. You should contact your State for further information on eligibility**.**

GEORGIA – Medicaid	**MONTANA** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	**NEBRASKA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092

CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	
INDIANA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	**NEW MEXICO –** Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	**NEW YORK –** Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid

Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since September 1, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

1-866-444-EBSA (3272) 1-877-267-2323, Ext. 61565

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Summary Plan Description (SPD)* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below. These changes will apply to any "non-grandfathered" plan. Contact your Plan Administrator to determine whether or not your plan is a "grandfathered" or a "non-grandfathered plan". Under the *Patient Protection and Affordable Care Act (PPACA)* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

  Ambulatory patient services; emergency services, hospitalization; laboratory services; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:

  - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.
  - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.
  - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

  Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law).

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

  Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the plan is subject to the statute known as *Michelle's Law*. This law amends *ERISA*, the *Public Health Service Act*, and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or Injury.

- If you do not have a grandfathered plan, in-network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:

  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

- Retroactive rescission of coverage under the plan is permitted, with 30 days advance written notice, only in the following two circumstances:
  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
  - Direct access to OB/GYN care without a referral or authorization requirement.
  - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
  - Prior authorization is not required before you receive services in the emergency department of a hospital.

    If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Effective for plans that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or *UnitedHealthcare* for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call the Claims Administrator at the number listed on your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from the Claims Administrator will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call the Claims Administrator at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, the Claims Fiduciary will review its decision. The Claims Fiduciary will also send you its written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, the Claims Fiduciary will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call the Claims Administrator at the number listed on your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact the Claims Administrator at the number listed on your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you.

If your plan includes coverage for Mental Health or Substance Use, the following applies:

Mental Health/Substance Use Disorder Parity

Effective for grandfathered and non-grandfathered large group Plans that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and substance use disorder conditions that are Covered Health Care Services under the Plan must be treated in the same manner and provided at the same level as Covered Health Care Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance-Related and Addictive Disorders Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that

coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Plan are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Copayments, Coinsurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Plan, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
if the initial claim is complete, within:	30 days
after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Fiduciary must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, the Claims Administrator will send you written notice of the decision from the Claims Administrator within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, the Claims Administrator will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial request for Benefits is complete, within:	15 days
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Fiduciary must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

*The Claims Administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, the Claims Administrator will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to the Claims Administrator within:	48 hours after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an urgent care request for Benefits.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information through the submission of your appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by the Claims Administrator during the determination of the appeal, the Claims Administrator will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of the Claims Administrator's decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

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.

Effective January 1, 2018

The Claims Administrator[2] is required by law to protect the privacy of your health information. The Claims Administrator is also required to send you this notice, which explains how the Claims Administrator may use information about you and when the Claims Administrator can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. The Claims Administrator is required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information the Claims Administrator maintains that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. The Claims Administrator will comply with the requirements of applicable privacy laws relating to notifying you in the event of a breach of your health information.

The Claims Administrator has the right to change its privacy practices and the terms of this notice. If the Claims Administrator makes a material change to its privacy practices, the Claims Administrator will provide to you, in the Claims Administrator's next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. The Claims Administrator will provide you with this information either by direct mail or electronically in accordance with applicable law. In all cases, if the Claims Administrator maintains a website for your particular health plan, the Claims Administrator will post the revised notice on your health plan website, such as www.myuhc.com. The Claims Administrator reserves the right to make any revised or changed notice effective for information the Claims Administrator already has and for information that the Claims Administrator receives in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer the Claims Administrator's business and to provide products, services and information of importance to Plan enrollees. The Claims Administrator maintains physical, electronic and procedural security safeguards in the handling and maintenance of Plan enrollee's information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How the Claims Administrator Uses or Discloses Information

The Claims Administrator must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

The Claims Administrator has the right to use and disclose health information for your treatment, to pay for your health care and to operate the Claims Administrator's business. For example, the Claims Administrator may use or disclose your health information:

- **For Payment** of service fees due the Claims Administrator, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, the Claims Administrator may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** The Claims Administrator may use or disclose health information to aid in your treatment or the coordination of your care. For example, the Claims Administrator may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** The Claims Administrator may use or disclose health information as necessary to operate and manage its business activities related to providing and managing your health care coverage. For example, the Claims Administrator might talk to your physician to suggest a disease management or wellness program that could help improve your health or the Claims Administrator may analyze data to determine how the Claims Administrator can improve its services. The Claims Administrator may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, the Claims Administrator may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, the Claims Administrator may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes**. The Claims Administrator may use or disclose your health information for underwriting purposes; however, the Claims Administrator will not use or disclose your genetic information for such purposes.
- **For Reminders.** The Claims Administrator may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

The Claims Administrator may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** The Claims Administrator may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** The Claims Administrator may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, the Claims Administrator will use its best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when

the Claims Administrator may disclose health information to family members and others involved in a deceased individual's care. The Claims Administrator may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless the Claims Administrator is aware that doing so would be inconsistent with a preference previously expressed by the deceased.

- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** The Claims Administrator may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** The Claims Administrator may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. The Claims Administrator may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** The Claims Administrator may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on the Claims Administrator's behalf or provide the Claims Administrator with services if the information is necessary for such functions or services. The Claims Administrator's business associates are required, under contract with the Claims Administrator, and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in the Claims Administrator's contract as permitted by federal law.
- **Additional Restrictions on Use and Disclosure**. Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

- 1. HIV/AIDS;
- 2. Mental health;
- 3. Genetic tests;
- 4. Alcohol and drug abuse;
- 5. Sexually transmitted diseases and reproductive health information; and
- 6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to the Claims Administrator, it is the Claims Administrator's intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth in this notice, the Claims Administrator will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give the Claims Administrator authorization to release your health information, the Claims Administrator cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if the Claims Administrator has already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. The Claims Administrator may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while the Claims Administrator will try to honor your request and will permit requests consistent with the Claims Administrator's policies, the Claims Administrator is not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). The Claims Administrator will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, the Claims Administrator will accept your verbal request to receive confidential communications, however; the Claims Administrator may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information the Claims Administrator maintains about you such as claims and case or medical management records. If the Claims Administrator maintains your health information electronically, you will have the right to request that the Claims Administrator send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, the Claims Administrator may deny your request to inspect and copy your health information. If the Claims Administrator denies your request, you may have the right to have the denial reviewed. The Claims Administrator may charge a reasonable fee for any copies.

- **You have the right to ask to amend** certain health information the Claims Administrator maintains about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If the Claims Administrator denies your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by the Claims Administrator during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require the Claims Administrator to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll- free member phone number on your health plan ID card or you may contact the *UnitedHealth Group Customer Call Center* Representative at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to the Claims Administrator at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with the Claims Administrator at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. The Claims Administrator will not take any action against you for filing a complaint.

[2]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Mountain Health Management Corporation; Rocky Mountain HealthCare Options, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware,

Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018

The Claims Administrator[3] is committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with the Claims Administrator, the Claims Administrator may collect personal financial information about you from the following sources:

- Information the Claims Administrator receives from you on applications or other forms, such as name, address, age, medical information and *Social Security* number;
- Information about your transactions with the Claims Administrator, the Claims Administrator's affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

The Claims Administrator does not disclose personal financial information about the Plan's enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of the Claims Administrator's general business practices, the Claims Administrator may, as permitted by law, disclose any of the personal financial information that the Claims Administrator collects about you without your authorization, to the following types of institutions:

- To the Claims Administrator's corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors:
- To nonaffiliated companies for the Claims Administrator's everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for the Claims Administrator, including sending promotional communications on the Claims Administrator's behalf.

Confidentiality and Security

The Claims Administrator maintains physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446 or TTY 711.

[3]For purposes of this Financial Information Privacy Notice, the "Claims Administrator" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women's and Children's Health, LLC; AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Connextions HCI, LLC; LifePrint East, Inc.; Life Print Health, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

UNITEDHEALTH GROUP

HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2018

The first part of this Notice, which provides the Claims Administrator's privacy practices for Medical Information, describes how the Claims Administrator may use and disclose your health information under federal privacy rules. There are other laws that may limit the Claims Administrator's rights to use and disclose your health information beyond what the Claims Administrator is allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. Show the categories of health information that are subject to these more restrictive laws; and
2. Give you a general summary of when the Claims Administrator can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & **Drug Abuse Information**
The Claims Administrator is allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.
Genetic Information
The Claims Administrator is not allowed to use genetic information for underwriting purposes.

Summary of State Laws

General Health Information	
The Claims Administrator is allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, UT, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NC, NV
The Claims Administrator is not allowed to use health information for certain purposes.	CA, IA
The Claims Administrator will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
The Claims Administrator must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS
Prescriptions	

The Claims Administrator is allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
The Claims Administrator is allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
The Claims Administrator is allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
The Claims Administrator is allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
The Claims Administrator is not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
The Claims Administrator is allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
The Claims Administrator is allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
The Claims Administrator will collect HIV/AIDS-related information only with your written consent.	OR
Mental Health	

The Claims Administrator is allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, ME, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
The Claims Administrator is allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, AR, CO, IL, LA, MD, NE, NJ, NY, NM, RI, TN, TX, UT, WI

Administrative Statement

If the Plan is not subject to *ERISA*, the following information applies to you.

Claims Fiduciary: The Claims Administrator is your Plan's Claims Fiduciary and has been delegated this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan. The Claims Fiduciary shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Fiduciary shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: Your Plan is self-funded. The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Fiduciary. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Insurance Company. The named fiduciary of Plan is Adams County Government, the Plan Sponsor.

The Plan Sponsor has selected a provider Network established by UnitedHealthcare Insurance Company

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343
952-936-1300

Person designated as Agent for Service of Legal Process: Adams County Government

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: 2019 Delta Dental Benefits Contracts
FROM: Terri Lautt, Director
AGENCY/DEPARTMENT: People and Culture Services
HEARD AT STUDY SESSION ON: August 28, 2018
AUTHORIZATION TO MOVE FORWARD: ☒ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners Approves the 2019 Delta Dental of Colorado Benefits Contracts.

BACKGROUND: The Adams County Board of County Commissioners previously entered into a contract with Delta Dental of Colorado to provide Third Party Administration for the county's self-funded dental plan through the Delta Dental Premier Provider Option ("Premier") and a fully-insured dental plan through the Delta Dental Exclusive Panel Option ("EPO") for current employees, and continued dental coverage for eligible retirees through the Delta Dental Preferred Provider Option ("PPO") Plan.

The attached appendices outline the administrative fees and premiums for the 2019 contracts with Delta Dental of Colorado as approved through Study Session.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
People and Culture Services
County Manager's Office
Budget Office
County Attorney's Office

ATTACHED DOCUMENTS:
Delta Dental of Colorado Exclusive Panel Option (EPO) Contract
Delta Dental of Colorado Premier Provider Option (Premier) Contract
Delta Dental of Colorado Preferred Provider Option (PPO) Contract

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund: 19

Cost Center: 8614

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:			$847,600
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			$847,600

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

RESOLUTION APPROVING DELTA DENTAL BENEFITS CONTRACTS

WHEREAS, the Board of County Commissioners recognizes the importance of continuing to provide choice in dental plan options for active employees; and,

WHEREAS, the Adams County Board of County Commissioners previously entered into a contract with Delta Dental of Colorado to provide Third Party Administration for the county's self-funded dental plan through the Delta Dental Premier Provider Option ("Premier") and a fully-insured dental plan through the Delta Dental Exclusive Panel Option ("EPO") for current employees, and continued dental coverage for eligible retirees through the Delta Dental Preferred Provider Option ("PPO") Plan; and,

WHEREAS, the attached appendices outline the administrative fees and premiums with Delta Dental of Colorado in effect through the guarantee period, December 31, 2020.

NOW, THEREFORE, BE IT RESOLVED, that the Board of County Commissioners, County of Adams, State of Colorado, hereby approves the attached Delta Dental Benefits contracts effective January 1, 2019.

DELTA DENTAL

DELTA DENTAL OF COLORADO
4582 South Ulster Street
Denver, Colorado 80237

DELTA DENTAL BENEFITS CONTRACT

The parties of this Contract are ADAMS COUNTY GOVERNMENT, herein called the "Group," "Applicant," or "Employer" and Colorado Dental Service Inc., d/b/a Delta Dental of Colorado, herein called "Delta Dental."

The following section of the current Delta Dental EPO contract has been amended effective January 1, 2019 for a two year period. The balance of such contract is continued as if fully set forth herein except for the change as shown below.

Rate Coverage

Coverage Tier	Rate Amount
SUBSCRIBER	$ 30.71
SUBSCRIBER/SPOUSE	$ 58.14
SUBSCRIBER/CHILD(REN)	$ 75.96
SUBSCRIBER/FAMILY	$ 117.91

Countersigned:
Delta Dental of Colorado

Mark Thompson

Signature

December 7, 2018

Date

Accepted:
ADAMS COUNTY GOVERNMENT #7195, 77195, 97195

Signature

Date

APPROVED AS TO FORM
COUNTY ATTORNEY

DELTA DENTAL

DELTA DENTAL OF COLORADO
4582 South Ulster Street
Denver, Colorado 80237

DELTA DENTAL BENEFITS CONTRACT

The parties of this Contract are Adams County Colorado- Retirees, herein called the "Group," "Applicant," or "Employer" and Colorado Dental Service Inc., d/b/a Delta Dental of Colorado, herein called "Delta Dental."

The following section of the current Delta Dental PPO contract has been amended effective January 1, 2019 for a two year period. The balance of such contract is continued as if fully set forth herein except for the amended section as shown below:

Rate Coverage

Coverage Tier	Rate Amount
SUBSCRIBER	$ 40.72
SUBSCRIBER PLUS ONE	$ 81.47
SUBSCRIBER PLUS TWO OR MORE	$ 122.21

Countersigned:
Delta Dental of Colorado

Mark Thompson

Signature

January 1, 2019

Date

Accepted:
Adams County Colorado Retirees - # 7738

Signature

Date

APPROVED AS TO FORM
COUNTY ATTORNEY

DELTA DENTAL

DELTA DENTAL OF COLORADO
4582 South Ulster Street
Denver, Colorado 80237

DELTA DENTAL BENEFITS CONTRACT

The parties of this Contract are Adams County Government, herein called the "Group," "Applicant," or "Employer" and Colorado Dental Service Inc., d/b/a Delta Dental of Colorado, herein called "Delta Dental."

The following section of the current Delta Dental PPO contract has been amended effective January 1, 2019 for a two year period. The balance of such contract is continued as if fully set forth herein except for the amended section as shown below:

Rate Coverage

Composite	Admin Fee
PER MONTH PER SUBSCRIBER	$ 3.99

This Service Fee is contingent upon total enrollment of all eligible primary subscribers, in accordance with the eligibility provisions in Article III. Should enrollment vary by 10% or more, Delta Dental reserves the right to recalculate the Service Fee based upon actual enrollment. The change in Service Fee would not become effective until the next contract anniversary. If a recalculation becomes necessary, multiple-year contracts will be replaced with a new agreement based upon the new enrollment.

The Service is due the first day of each month, and as further described in Article II. The Monthly Claims Reimbursement Due Date is the 2nd, 12th, and 22nd day or the last business day closest to such date of each month and as further described in Article II.

Countersigned:
Delta Dental of Colorado

Mark Thompson

Signature

January 1, 2019
Date

Accepted:
Adams County Government - # 1200, 71200, 91200

Signature

Date

APPROVED AS TO FORM
COUNTY ATTORNEY

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: August 6, 2019
SUBJECT: Amendment to the Unum Group Disability Insurance Policy
FROM: Terri Lautt, Director
AGENCY/DEPARTMENT: People and Culture Services
HEARD AT STUDY SESSION ON: October 2, 2018
AUTHORIZATION TO MOVE FORWARD: ☒ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners approve the 2019 Amendment No. 2 to the Unum Group Insurance Policy effective April 1, 2019 to incorporate provisions of the Paid Parental Leave Program (PPL) as approved through Study Session.

BACKGROUND: The Board of County Commissioners approved the Paid Parental Leave Program (PPL) to provide eligible employees six (6) weeks paid leave for use after the birth, adoption or placement of a child for adoption or foster care in which to support the Adams County values of work-life balance; to remain an employer of choice and leader in the market; to attract and retain top talent.

And whereas, the Board of County Commissioners previously entered into a contract with Unum Life Insurance Company of America ("Unum"), to provide a Short-Term and Long-Term Disability Group Insurance Policy for all benefit-eligible employees.

The attached 2019 Amendment No. 2 to the Unum Group Disability Insurance Policy amends the original contract to incorporate provisions of the PPL program effective April 1, 2019.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

People and Culture Services
County Manager's Office
Budget Office
County Attorney's Office

ATTACHED DOCUMENTS:
2019 Amendment No. 2 to the Unum Group Disability Insurance Policy

FISCAL IMPACT:

Please check if there is no fiscal impact ☐. If there is fiscal impact, please fully complete the section below.

Fund: 19	
Cost Center: 8622	

	Object Account	Subledger	Amount
Current Budgeted Revenue:			
Additional Revenue not included in Current Budget:			
Total Revenues:			

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:	7635		$115,000
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			$115,000

New FTEs requested: ☐ **YES** ☒ **NO**

Future Amendment Needed: ☐ **YES** ☒ **NO**

Additional Note:

RESOLUTION APPROVING THE 2019 AMENDMENT NO. 2 TO THE UNUM GROUP DISABILITY INSURANCE POLICY

WHEREAS, The Board of County Commissioners approved a Paid Parental Leave Program (PPL) to provide eligible employees six (6) weeks paid leave for use after the birth, adoption or placement of a child for adoption or foster care in which to support the Adams County values of work-life balance; to remain an employer of choice and leader in the market; to attract and retain top talent; and,

WHEREAS, the Board of County Commissioners previously entered into a contract with Unum Life Insurance Company of America ("Unum"), to provide a Short-Term and Long-Term Disability Group Insurance Policy for all benefit-eligible employees; and,

WHEREAS, the attached 2019 Amendment No. 2 to the Unum Group Disability Insurance Policy amends the original contract to incorporate provisions of the PPL program effective April 1, 2019.

NOW, THEREFORE, BE IT RESOLVED, that the Board of County Commissioners, County of Adams, State of Colorado, hereby approves the attached 2019 Amendment No. 2 to the Unum Group Disability Insurance Policy effective April 1, 2019.

AMENDMENT NO. 2

This amendment forms a part of Group Policy No. 420696 002 issued to the Policyholder:

Adams County

The entire policy is replaced by the policy attached to this amendment.

The effective date of these changes is April 1, 2019. The changes only apply to disabilities which start on or after the effective date.

The policy's terms and provisions will apply other than as stated in this amendment.

Dated at Portland, Maine on May 10, 2019.

Unum Life Insurance Company of America

By _____

Secretary

If this amendment is unacceptable, please sign below and return this amendment to Unum Life Insurance Company of America at Portland, Maine within 90 days of May 10, 2019.

YOUR FAILURE TO SIGN AND RETURN THIS AMENDMENT BY THAT DATE WILL CONSTITUTE ACCEPTANCE OF THIS AMENDMENT.

Adams County

By _____
Signature and Title of Officer

APPROVED AS TO FORM
COUNTY ATTORNEY

C.AMEND-1 AMEND-1 (4/1/2019)

unum

GROUP INSURANCE POLICY
NON-PARTICIPATING

POLICYHOLDER: Adams County

POLICY NUMBER: 420696 002

POLICY EFFECTIVE DATE: January 1, 2016

POLICY ANNIVERSARY DATE: January 1

GOVERNING JURISDICTION: Colorado

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under this policy. Unum makes this promise subject to all of this policy's provisions.

The policyholder should read this policy carefully and contact Unum promptly with any questions. This policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. This policy consists of:

- all policy provisions and any amendments and/or attachments issued;
- employees' signed applications; and
- the certificate of coverage.

This policy may be changed in whole or in part. Only an officer or a registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for Unum at Portland, Maine on the Policy Effective Date.

President Secretary

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

TABLE OF CONTENTS

BENEFITS AT A GLANCE

SHORT TERM DISABILITY PLAN

This short term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: January 1, 2016

POLICY NUMBER: 420696 002

ELIGIBLE CLASS(ES):

All Full-Time and Part-Time Employees excluding Project Designated, Temporary, Seasonal, or Contract Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Active Full-Time Employees scheduled to work 40 hours per week.

Active Part-Time Employees scheduled to work 30 or more hours per week.

Active Full-Time Employees of the Adams County Economic Development scheduled to work 40 hours per week.

Active Part-Time Employees of the Adams County Economic Development scheduled to work 30 or more hours per week.

WAITING PERIOD:

For employees in an eligible class on or before January 1, 2016: None

For employees entering an eligible class after January 1, 2016: First of the month coincident with or next following 45 days of continuous active employment

REHIRE:

If your employment ends and you are rehired within 30 days, your previous work while in an eligible class will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

The latest of:

- 14 days for disability due to an injury; or
- 14 days for disability due to a sickness; or
- the date your accumulated sick leave or paid parental leave payments end, if applicable.

Benefits begin the day after the elimination period is completed.

WEEKLY BENEFIT:

60% of weekly earnings to a maximum benefit of $1,200 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

MAXIMUM PERIOD OF PAYMENT:

11 weeks

Premium payments are required for your coverage while you are receiving payments under this plan.

Your Short Term Disability plan does not cover disabilities due to an occupational sickness or injury.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $250 per week.

In addition, we will make weekly payments to you for 3 weeks following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

OTHER FEATURES:

Minimum Benefit

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: January 1, 2016

POLICY NUMBER: 420696 002

ELIGIBLE CLASS(ES):

All Full-Time and Part-Time Employees excluding Project Designated, Temporary, Seasonal, or Contract Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Active Full-Time Employees scheduled to work 40 hours per week.

Active Part-Time Employees scheduled to work 30 or more hours per week.

Active Full-Time Employees of the Adams County Economic Development scheduled to work 40 hours per week.

Active Part-Time Employees of the Adams County Economic Development scheduled to work 30 or more hours per week.

WAITING PERIOD:

For employees in an eligible class on or before January 1, 2016: None

For employees entering an eligible class after January 1, 2016: First of the month coincident with or next following 45 days of continuous active employment

REHIRE:

If your employment ends and you are rehired within 30 days, your previous work while in an eligible class will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

The later of:

- 90 days; or
- the date your accumulated sick leave payments end, if applicable.

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT:

60% of monthly earnings to a maximum benefit of $5,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MAXIMUM PERIOD OF PAYMENT:

Age at Disability	Maximum Period of Payment To Social Security Normal Retirement Age
Less than Age 62	60 months
Age 62	48 months
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	24 months
Age 67	18 months
Age 68	12 months
Age 69 or older	

Year of Birth	Social Security Normal Retirement Age
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

No premium payments are required for your coverage while you are receiving payments under this plan.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $1,000 per month.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

DEPENDENT CARE EXPENSE BENEFIT:

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain dependent care expenses limited to the following amounts:

Dependent Care Expense Benefit Amount: $350 per month, per dependent

Dependent Care Expense Maximum Benefit Amount: $1,000 per month for all eligible dependent care expenses combined

TOTAL BENEFIT CAP:

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

OTHER FEATURES:

Continuity of Coverage

Minimum Benefit

Pre-Existing: 3/12

Survivor Benefit

Work Life Assistance Program

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

CLAIM INFORMATION

SHORT TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim should be sent within 30 days after the date your disability begins. In addition, you must send Unum proof of your claim no later than one year after the date your disability begins unless your failure to do so is due to your lack of legal capacity. In no event can proof of your claim be submitted after the expiration of the time limit for commencing a legal proceeding as stated in the policy, even if your failure to provide proof of claim is due to a lack of legal capacity or if state law provides an exception to the one year time period.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE PROOF OF CLAIM?

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

The form to use to submit your proof of claim is available from your Employer, or you can request the form from us. If you do not receive the form from Unum or your Employer within 15 days of your request, send Unum proof of claim without waiting for the form.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation;
- that you are under the **regular care** of a **physician**;
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians; and
- the appropriate documentation of your weekly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending you payments, if you fail to comply with our requests.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim;
- disability earnings; or
- deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made which may include reducing or withholding future payments including the minimum weekly payment.

Unum will not recover more money than the amount we paid you.

Any unpaid premium due for your coverage under this policy may be recovered by us from your Employer.

CLAIM INFORMATION

LONG TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim should be sent within 30 days after the date your disability begins. In addition, you must send Unum proof of your claim no later than one year after the date your disability begins unless your failure to do so is due to your lack of legal capacity. In no event can proof of your claim be submitted after the expiration of the time limit for commencing a legal proceeding as stated in the policy, even if your failure to provide proof of claim is due to a lack of legal capacity or if state law provides an exception to the one year time period.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE PROOF OF CLAIM?

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

The form to use to submit your proof of claim is available from your Employer, or you can request the form from us. If you do not receive the form from Unum or your Employer within 15 days of your request, send Unum proof of claim without waiting for the form.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation or of any other gainful occupation for which you are reasonably fitted by education, training, or experience;
- that you are under the **regular care** of a **physician**;
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians; and
- the appropriate documentation of your monthly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending you payments, if you fail to comply with our requests.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim;
- disability earnings; or
- deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made which may include reducing or withholding future payments including the minimum monthly payment.

Unum will not recover more money than the amount we paid you.

Any unpaid premium due for your coverage under this policy may be recovered by us from your Employer.

POLICYHOLDER PROVISIONS

WHAT IS THE COST OF THIS INSURANCE?

SHORT TERM DISABILITY

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

Premium payments are required for an insured while he or she is receiving Short Term Disability payments under this plan.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

LONG TERM DISABILITY

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

WAIVER OF PREMIUM

Unum does not require premium payments for an insured while he or she is receiving Long Term Disability payments under this plan.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

WHEN IS PREMIUM DUE FOR THIS POLICY?

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The **Policyholder** must send all premiums to Unum on or before their respective due date. The premium must be paid in United States dollars.

WHEN ARE INCREASES OR DECREASES IN PREMIUM DUE?

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Unum will only adjust premium for the current policy year and the prior policy year. In the case of fraud, premium adjustments will be made for all policy years.

WHAT INFORMATION DOES UNUM REQUIRE FROM THE POLICYHOLDER?

The Policyholder must provide Unum with the following on a regular basis:

- information about employees:
  - who are eligible to become insured;
  - whose amounts of coverage change; and/or
  - whose coverage ends;
- occupational information and any other information that may be required to manage a claim; and
- any other information that may be reasonably required.

Policyholder records that, in Unum's opinion, have a bearing on this policy will be available for review by Unum at any reasonable time.

Clerical error or omission by Unum will not:

- prevent an employee from receiving coverage;
- affect the amount of an insured's coverage; or
- cause an employee's coverage to begin or continue when the coverage would not otherwise be effective.

WHO CAN CANCEL OR MODIFY THIS POLICY OR A PLAN UNDER THIS POLICY?

This policy or a plan under this policy can be cancelled:

- by Unum; or
- by the Policyholder.

Unum may cancel or modify this policy or a plan if:

- there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for a Policyholder paid plan;
- the Policyholder does not promptly provide Unum with information that is reasonably required;
- the Policyholder fails to perform any of its obligations that relate to this policy;
- fewer than 10 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of this policy that specify whether the Policyholder, the employee, or both, pay(s) the premiums;
- the Policyholder does not promptly report to Unum the names of any employees who are added or deleted from the eligible class;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible class as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Policyholder and/or its employees; or
- the Policyholder fails to pay any portion of the premium within the 45 day **grace period**.

If Unum cancels or modifies this policy or a plan for reasons other than the Policyholder's failure to pay premium, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date. The Policyholder may cancel this policy or a plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or plan automatically at the end of the grace period. The Policyholder is liable for premium for coverage during the grace period. The Policyholder must pay Unum all premium due for the full period each plan is in force.

The Policyholder may cancel this policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, this policy or a plan can be cancelled on an earlier date. If Unum or the Policyholder cancels this policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If this policy or a plan is cancelled, the cancellation will not affect a **payable claim**.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE UNDER THIS POLICY WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

We will continue the employee's coverage in accordance with the policyholder's Human Resource policy on family and medical leaves of absence if premium payments continue and the policyholder approved the employee's leave in writing.

Coverage will be continued until the end of the later of:

1. the leave period required by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period required by applicable state law.

If the policyholder's Human Resource policy doesn't provide for continuation of an employee's coverage during a family and medical leave of absence, the employee's coverage will be reinstated when he or she returns to active employment.

We will not:

- apply a new waiting period;
- apply a new pre-existing conditions exclusion; or
- require evidence of insurability.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

FOR SHORT TERM DISABILITY:

NAME/LOCATION (CITY AND STATE)

Adams County Economic Development
Westminster, Colorado

FOR LONG TERM DISABILITY:

NAME/LOCATION (CITY AND STATE)

Adams County Economic Development
Westminster, Colorado

CERTIFICATE SECTION

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible class, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

Your Employer pays 100% of the cost of your coverage under a plan. You will be covered at 12:01 a.m. on the date you are eligible for coverage.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

For Short Term Disability:
If you are on a temporary **layoff**, and if premium is paid, you will be covered for up to 90 days following the date your temporary layoff begins.

If you are on a **leave of absence** other than a paid parental leave of absence, and if premium is paid, you will be covered for up to 90 days following the date your leave of absence begins.

If you are on a paid parental leave of absence, and if premium is paid, you will be covered for up to 6 weeks following the date your paid parental leave of absence begins.

For Long Term Disability:
If you are on a temporary **layoff**, and if premium is paid, you will be covered for up to 90 days following the date your temporary layoff begins.

If you are on a **leave of absence**, and if premium is paid, you will be covered for up to 90 days following the date your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage will take effect immediately if you are in active employment or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible class;
- the date your eligible class is no longer covered; or
- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the later of when original proof of your claim was first required to have been given; or your claim was denied; or your benefits were terminated, unless otherwise provided under federal law.

Except as preempted by federal law, if your claim is denied in whole or in part and you have exhausted your administrative remedies under the policy/plan, you have the right to have your claim newly reviewed in any court with jurisdiction and to a trial by jury, if such rights are mandated by state law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application as a basis for doing this.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

SHORT TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in weekly earnings due to the same sickness or injury.

If you have a Cesarean section, you will be considered disabled for a minimum period of 8 weeks beginning on the date of your Cesarean section, unless you return to work prior to the end of the 8 weeks.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, your elimination period is the later of:

- 14 days; or
- the date your accumulated sick leave or paid parental leave payments end, if applicable.

If your disability is the result of a sickness, your elimination period is the later of:

- 14 days; or
- the date your accumulated sick leave or paid parental leave payments end, if applicable.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes, provided you meet the definition of disability.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment weekly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

1. Multiply your weekly earnings by 60%.
2. The maximum **weekly benefit** is $1,200.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

WHAT ARE YOUR WEEKLY EARNINGS?

"Weekly Earnings" means your gross weekly income from your Employer including shift differential and car allowance, in effect just prior to the date of disability. It includes your total income before taxes and any Employer contributions made on your behalf to a qualified 457(b) deferred compensation arrangement. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan (other than any Employer contributions made on your behalf to a qualified 457 (b) deferred compensation arrangement). Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR WEEKLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your weekly earnings from your Employer in effect just prior to the date your absence begins.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?

We will send you the weekly payment if you are disabled and your weekly **disability earnings**, if any, are less than 20% of your weekly earnings.

If you are disabled and your weekly disability earnings are from 20% through 80% of your weekly earnings, you will receive payments based on the percentage of income you are losing due to your disability. We will follow this process to figure your payment:

1. Subtract your disability earnings from your weekly earnings.
2. Divide the answer in Item 1 by your weekly earnings. This is your percentage of lost earnings.
3. Multiply your weekly payment as shown above by the answer in Item 2.

This is the amount Unum will pay you for each week.

Unum may require you to send proof of your disability earnings each week. We will adjust your weekly payment based on your disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income.

HOW DO WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings have fluctuated from week to week, Unum may determine your benefit eligibility based on the average of your disability earnings over the most recent 3 weeks.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:

   - state compulsory benefit **act** or **law**.
   - group plan sponsored by your Employer.
   - other group insurance plan.
   - **governmental retirement system**.

2. The amount that you receive:

   - under the mandatory portion of any "no fault" motor vehicle **plan**.
   - under a **salary continuation** plan.
   - under Title 46, United States Code Section 688 (The Jones Act).
   - from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

3. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

   Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

4. The amount that you:

   - receive as disability payments under your Employer's **retirement plan**.
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

Unum will only subtract deductible sources of income which are payable as a result of the same disability.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(a) and 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- **accumulated sick leave** plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum weekly payment is: $25.

Unum may apply this amount toward an outstanding overpayment.

However, the minimum weekly payment will not be paid if you are receiving salary continuation or accumulated sick leave payments from your Employer.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Short Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of the maximum period of payment.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each week up to the **maximum period of payment.** Your maximum period of payment is 11 weeks during a continuous period of disability.

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- when you are able to work in your regular occupation on a **part-time basis** and you do not;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- the date your disability earnings exceed the amount allowable under the plan;
- the date you die.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- **occupational sickness or injury**, however, Unum will cover disabilities due to occupational sicknesses or injuries for partners or sole proprietors who cannot be covered by a workers' compensation law.
- intentionally self-inflicted injuries while sane.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME AND YOUR DISABILITY OCCURS AGAIN?

1. If your current disability is related to or due to the same cause(s) as your prior disability for which Unum made a payment:

   Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for 14 consecutive days or less.

   If you return to work on the 15th day, your current disability will be treated as a new claim. The new claim will be subject to all of the provisions of this plan and you will be required to satisfy a new elimination period.

2. If your current disability is unrelated to your prior disability for which Unum made a payment:

   Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for less than 1 full day.

Your disability, as outlined above, will be subject to the same terms of the plan as your prior claim.

If you do not satisfy Item 1 or 2 above, your disability will be treated as a new claim and will be subject to all of the policy provisions.

If you become entitled to payments under any other group short term disability plan, you will not be eligible for payments under the Unum plan.

SHORT TERM DISABILITY

OTHER BENEFIT FEATURES

HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $250 per week.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

In addition, we will make weekly payments to you for 3 weeks following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which weekly payments would stop in accordance with this plan.

LONG TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.

After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period**. Unum will treat your disability as continuous if your disability stops for 45 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

Your elimination period is the later of:

- 90 days; or
- the date your **accumulated sick leave** payments end, if applicable.

You are not required to have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness to be considered disabled during the elimination period.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes. If you are working while you are disabled, the days you are disabled will count toward your elimination period.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment monthly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

1. Multiply your monthly earnings by 60%.
2. The maximum **monthly benefit** is $5,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **monthly payment**.

Your monthly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 month, we will send you 1/30 of your monthly payment for each day of disability and 1/30 of any additional benefits for each day of disability.

WILL UNUM EVER PAY MORE THAN 100% OF MONTHLY EARNINGS?

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

WHAT ARE YOUR MONTHLY EARNINGS?

"Monthly Earnings" means your gross monthly income from your Employer including shift differential and car allowance, in effect just prior to the date of disability. It includes your total income before taxes and any Employer contributions made on your behalf to a qualified 457(b) deferred compensation arrangement. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan (other than any Employer contributions made on your behalf to a qualified 457 (b) deferred compensation arrangement). Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR MONTHLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?

We will send you the monthly payment if you are disabled and your monthly **disability earnings**, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are from 20% through 80% of your indexed monthly earnings, due to the same sickness or injury, Unum will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer in Item 1 to your indexed monthly earnings.

If the answer from Item 1 is less than or equal to 100% of your indexed monthly earnings, Unum will not further reduce your monthly payment.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, Unum will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, we will subtract 50% of your disability earnings from your monthly payment.

This is the amount Unum will pay you each month.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income.

After the elimination period, if you are disabled for less than 1 month, we will send you 1/30 of your payment for each day of disability.

HOW DO WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings have fluctuated from month to month, Unum may determine your benefit eligibility based on the average of your disability earnings over the most recent 3 months.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive under:

   - a workers' compensation law.
   - an occupational disease law.
   - any other **act** or **law** with similar intent.

2. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:

   - state compulsory benefit **act** or **law**.
   - group plan sponsored by your Employer.
   - other group insurance plan.
   - **governmental retirement system**.

3. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:

   - the United States Social Security Act.
   - the Canada Pension **Plan**.
   - the Quebec Pension Plan.
   - any similar plan or act.

4. The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under:

   - the United States Social Security Act.
   - the Canada Pension Plan.
   - the Quebec Pension Plan.
   - any similar plan or act.

5. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

   Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

6. The amount that you:

   - are entitled to receive as disability payments under your Employer's **retirement plan**.
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

   Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

   Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

   Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any

eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

7. The amount that you receive under Title 46, United States Code Section 688 (The Jones Act).

8. The amount that you receive under a **salary continuation** plan.

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable as a result of the same disability.

We will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(a) and 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- no fault motor vehicle plans
- **accumulated sick leave** plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum monthly payment is the greater of:

- $100; or
- 10% of your gross disability payment.

Unum may apply this amount toward an outstanding overpayment.

WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME?

Once Unum has subtracted any deductible source of income from your gross disability payment, Unum will not further reduce your payment due to a cost of living increase from that source.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1, 2 and 3 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Long Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1, 2 and 3 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable one.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each month up to the **maximum period of payment**. Your maximum period of payment is based on your age at disability as follows:

Age at Disability	Maximum Period of Payment
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

Year of Birth	Social Security Normal Retirement Age
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months

1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- during the first 24 months of payments, when you are able to work in your regular occupation on a **part-time basis** and you do not;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis and you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

WHAT DISABILITIES HAVE A LIMITED PAY PERIOD UNDER YOUR PLAN?

The lifetime cumulative maximum benefit period for all disabilities due to **mental illness** is 24 months. Only 24 months of benefits will be paid even if the disabilities:

- are not continuous; and/or
- are not related.

However, Unum will send you payments beyond the 24 month period if you meet one of these conditions:

1. If you are confined to a **hospital or institution** at the end of the 24 month period, Unum will continue to send you payments during your confinement.

   If you are still disabled when you are discharged, Unum will send you payments for a recovery period of up to 90 days.

   If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that additional confinement and for one additional recovery period up to 90 more days.

2. If you are not confined to a hospital or institution but become confined for a period of at least 14 days within 90 days after the 24 month period for which you have received payments, Unum will send payments during the length of the confinement.

Under no circumstances will Unum pay beyond the maximum period of payment as indicated in the **BENEFITS AT A GLANCE** section of your policy.

Unum will not apply the mental illness limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries while sane.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

WHAT IS A PRE-EXISTING CONDITION?

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME WITH THE POLICYHOLDER AND YOUR DISABILITY OCCURS AGAIN?

If you have a **recurrent disability**, Unum will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- you were continuously insured under the plan for the period between the end of your prior claim and your recurrent disability; and
- your recurrent disability occurs within 6 months from the end of your prior claim.

Your recurrent disability will be subject to the same terms of the plan as your prior claim and will be treated as a continuation of that disability.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the elimination period.

If you become entitled to payments under any other group long term disability plan, you will not be eligible for payments under the Unum plan.

LONG TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)

When Unum receives proof that you have died, we will pay your **eligible survivor** a lump sum benefit equal to 6 months of your gross disability payment if, on the date of your death:

- your disability had continued for 90 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your 6 month survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay you a lump sum amount equal to 6 months of your gross disability payment if:

- you have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to less than 12 months; and
- you are receiving monthly payments.

Your right to exercise this option and receive payment is subject to the following:

- you must make this election in writing to Unum; and
- your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 6 month survivor benefit will be payable upon your death.

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

When the plan becomes effective, Unum will provide coverage for you if:

- you are not in active employment because of a sickness or injury; and
- you were covered by the prior policy.

Your coverage is subject to payment of premium.

Your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which your prior carrier is liable.

WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the monthly benefit that would have been payable under the terms of the prior plan if it had remained inforce; or
b. the monthly payment under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.

HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the Total Benefit Cap will apply.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which monthly payments would stop in accordance with this plan.

WHAT ADDITIONAL BENEFIT IS AVAILABLE FOR DEPENDENT CARE EXPENSES TO ENABLE YOU TO PARTICIPATE IN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, we will pay a Dependent Care Expense Benefit when you are disabled and you:

1. are incurring expenses to provide care for a child under the age of 15; and/or
2. start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment of the Dependent Care Expense Benefit will begin immediately after you start Unum's Rehabilitation and Return to Work Assistance program.

Our payment of the Dependent Care Expense Benefit will:

1. be $350 per month, per **dependent**; and
2. not exceed $1,000 per month for all dependent care expenses combined.

To receive this benefit, you must provide satisfactory proof that you are incurring expenses that entitle you to the Dependent Care Expense Benefit.

Dependent Care Expense Benefits will end on the earlier of the following:

1. the date you are no longer incurring expenses for your dependent;
2. the date you no longer participate in Unum's Rehabilitation and Return to Work Assistance program; or
3. any other date payments would stop in accordance with this plan.

OTHER SERVICES

These services are also available from us as part of your Unum Long Term Disability plan.

IS THERE A WORK LIFE ASSISTANCE PROGRAM AVAILABLE WITH THE PLAN?

We do provide you and your dependents access to a work life assistance program designed to assist you with problems of daily living.

You can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to your Employer.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week or online through a website.

Information about this program can be obtained through your plan administrator.

HOW CAN UNUM HELP YOUR EMPLOYER IDENTIFY AND PROVIDE WORKSITE MODIFICATION?

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and Unum.

When this occurs, Unum will reimburse your Employer for the cost of the modification, up to the greater of:

- $1,000; or
- the equivalent of 2 months of your monthly benefit.

This benefit is available to you on a one time only basis.

HOW CAN UNUM'S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?

In order to be eligible for assistance from Unum's Social Security claimant advocacy program, you must be receiving monthly payments from us. Unum can provide expert advice regarding your claim and assist you with your application or appeal.

Receiving Social Security benefits may enable:

- you to receive Medicare after 24 months of disability payments;
- you to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:

- helping you find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.

GLOSSARY

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Class(es) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Project designated, temporary, seasonal and contract workers are excluded from coverage.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DEPENDENT means:

- your child(ren) under the age of 15; and
- your child(ren) age 15 or over or a family member who requires personal care assistance.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your **maximum capacity**.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that is or can be expected to provide you with an income within 12 months of your return to work, that exceeds:

80% of your indexed monthly earnings, if you are working; or
60% of your indexed monthly earnings, if you are not working.

GOVERNMENTAL RETIREMENT SYSTEM means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar

retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INDEXED MONTHLY EARNINGS means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working and in the determination of gainful occupation.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Injury which occurs before you are covered under the plan will be treated as a sickness. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

LAW, PLAN OR ACT means the original enactments of the law, plan or act and all amendments.

LAYOFF or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIMITED means what you cannot or are unable to do.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

- For Short Term Disability:

MAXIMUM CAPACITY means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

- For Long Term Disability:

MAXIMUM CAPACITY means, based on your restrictions and limitations:

- during the first 24 months of disability, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.
- beyond 24 months of disability, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience.

MAXIMUM PERIOD OF PAYMENT means the longest period of time Unum will make payments to you for any one period of disability.

MENTAL ILLNESS means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders relatable to stress. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

MONTHLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

MONTHLY EARNINGS means your gross monthly income from your Employer as defined in the plan.

MONTHLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

OCCUPATIONAL SICKNESS OR INJURY means a sickness or injury that was caused by or aggravated by any employment for pay or profit.

- For Short Term Disability:

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your weekly earnings.

- For Long Term Disability:

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your indexed monthly earnings.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

POLICYHOLDER means the Employer to whom the policy is issued.

PRE-EXISTING CONDITION means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

RECURRENT DISABILITY means a disability which is:

- caused by a worsening in your condition; and
- due to the same cause(s) as your prior disability for which Unum made a disability payment.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

REGULAR OCCUPATION means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

- For Short Term Disability:

SALARY CONTINUATION, ACCUMULATED SICK LEAVE OR PAID PARENTAL LEAVE means continued payments to you by your Employer of all or part of your weekly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation, accumulated sick leave or paid parental leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your weekly payment.

- For Long Term Disability:

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your monthly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your monthly payment.

SICKNESS means an illness or disease. Disability must begin while you are covered under the plan.

SURVIVOR, ELIGIBLE means your lawful spouse, if living; otherwise your children under age 25 equally.

"Spouse" wherever used includes:

- your civil union partner as established under Colorado law; or
- your partner in a civil union, registered domestic partnership or substantially similar legal relationship created in another jurisdiction.

TOTAL COVERED PAYROLL means the total amount of monthly earnings for which employees are insured under this plan.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible class before you are eligible for coverage under a plan.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

WEEKLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

WEEKLY EARNINGS means your gross weekly income from your Employer as defined in the plan.

WEEKLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

YOU means an employee who is eligible for Unum coverage.

Additional Claim and Appeal Information
Relative to policy issued by Unum Life Insurance Company of America ("Unum")

APPLICABILITY OF ERISA

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your Employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the policy, including your certificate of coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the policy, your certificate of coverage, and the information in this document.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or policy and effective for claims filed on or after April 1, 2018.

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or policy conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(l).

Our Commitment to Privacy

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

COVERAGE DECISIONS

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

ACCESS TO INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

SAFEGUARDING INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

CONTACTING US

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, C476, Portland, Maine 04122.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company and The Paul Revere Life Insurance Company.

MK-1883 (09/15)

NOTICE OF PROTECTION PROVIDED BY LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

This notice provides a **brief summary** of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at colorado.lhiga.com, email jkelldorf@gmail.com or contact:

Colorado Life and Health Insurance Protection Association
P. O. Box 36009
Denver, Colorado 80236
(303) 292-5022

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.

COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

CASE NO.: RCU2018-00032
CASE NAME: JAMASO PIPELINE

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COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

STAFF REPORT

Board of County Commissioners August 6, 2019

CASE No.: **RCU2018-00032**	CASE NAME: **Jamaso Pipeline**
Applicant's Name:	Janice Kinnin, Rocky Mountain Midstream, LLC
Applicant's Address:	540 E. Bridge Street, Brighton, CO 80601
Location of Request:	Multiple Parcels see Exhibit 3.2
Nature of Request:	Conditional Use Permit to allow construction of four 24-inch pipelines to transport natural gas, crude oil, wastewater, and fresh water, and a 6-inch electrical power line for approximately 4.18 miles.
Zone District:	Agricultural-1, Agricultural-2, and Agriculture-3 (A-3)
Site Size:	Approximately 4.18 miles
Proposed Uses:	Oil and Gas Infrastructure (Pipeline)
Existing Use:	Vacant, Agricultural, and Residential
Hearing Date(s):	**PC: July 11, 2019 / 6:00 pm** **BOCC: August 6, 2019 / 9:30 am**
Report Date:	July 3, 2019
Case Manager:	Greg Barnes
PC Recommendation:	APPROVAL with 33 Findings-of-Fact and 1 condition

SUMMARY OF APPLICATION

Background:

The applicant, Rocky Mountain Midstream, LLC, is requesting a conditional use permit to allow construction of approximately 4.18 miles of four new 24-inch pipelines to transport natural gas, crude oil, wastewater, and fresh water, and a 6-inch electrical power line. According to the applicant, advances in oil and gas extraction technology have increased production throughout the state. Pipeline infrastructure near exiting well pads is nearing capacity or has not been developed for new well pads currently under construction. The alternative transportation option

for crude oil, produced liquids, and natural gas is by individual trucks from each well pad to processing facilities throughout the state. This request for a centralized transportation system (pipeline) would reduce local truck traffic in the County while increasing capacity of the overall system to gather, process, transport, and market natural resources from Adams County.

Site Characteristics:

The preferred alignment is approximately 4.18 miles beginning at the Matador Central Gathering Facility near the intersection of Manilla Road and Interstate-70 (parcel 0181700000149), which is within the City of Aurora. The preferred route then heads south, crossing I-70 into Arapahoe County, where it continues westward. Eventually, the proposed pipelines will cross under I-70 again as it turns north back into Adams County (on parcel number 0181700000298), still within the City of Aurora. The proposed alignment then continues north under U.S. Highway 36 and the Union Pacific Railroad line. The alignment first enters unincorporated Adams County at parcel number 0181731300006 and continues westward on the northern side of the Union Pacific Railroad line and north of Watkins. The proposed pipeline will continue in a southwesterly direction, re-entering Arapahoe County, and ultimately connecting to the Jamaso well pad site.

Parcels along the preferred alignment are primarily designated as Agricultural-1 (A-1), Agricultural-2 (A-2), and Agricultural-3 (A-3). These zone districts are intended for rural lifestyles, low-density residential, farming, pasturage, or other food production related uses. A total of five parcels within unincorporated Adams County are affected by the preferred alignment. Four of these parcels are undeveloped. The other parcel is developed as a single-family residential use.

In addition, the parcels in the preferred alignment are located within the Airport Noise (ANO) and Airport Influence Zone (AIZ) Overlays. The ANO restricts certain land uses, specifically development that may include occupied buildings, to reduce conflicts associated with noise levels generated by airport uses. The AIZ designation is intended to provide areas within the County suitable for economic development related to general aviation uses. The proposed development does not include any occupied buildings and will be located entirely underground. Pipelines are typically buried a minimum of 48-inches deep. The proposed development will not produce glare or attract wildlife and will not be detrimental to flight operations or future development of the area.

Development Standards and Regulations Requirements:

Oil and gas development is overseen by federal, state, and local regulations. Section 4-10-02-03-03 of the County's Development Standards and Regulations outlines requirements for oil and gas well drilling and production activities in the County. This Section defines oil and gas facilities as "the site associated with equipment used for production, treatment, and storage of oil and gas waste products, an individual well pad built with one or more wells, temporary storage of oil and gas, or any other oil and gas operation which may cause significant degradation to the environment."

Section 4-10-02-03-03-06 of the Development Standards and Regulations further outlines the county's process for permitting new oil and gas development. Specifically, the process follows a

two pronged approach: 1) Obtain a Special Use Permit from the Board of Adjustment; or 2) Execute a Memorandum of Understanding (MOU) with the County and submit for approval an Administrative Use by Special Review permit for each well pad. The MOU allows administrative review and approval for well connects that are "10 inches or less inside a diameter and 2 miles or less in length, laid running from the custody transfer point or production facility for a new well (s) to an existing gathering line connection point". However, in cases where pipelines do not meet the definition of well connects, a Conditional Use Permit is required. Therefore, the proposed pipeline requires a Conditional Use Permit, as it exceeds two miles in total length.

Section 2-02-08-06 of the County's Development Standards and Regulations outlines the criteria for approval of a conditional use permit. These include compliance with the County's Development Standards and Regulations; compatibility with the surrounding area, the request must be permitted in the zone district, and must address all off-site impacts. In addition, the proposed use is required to be harmonious with the character of the neighborhood, and must not be detrimental to the immediate area, or to the health, safety, or welfare of the inhabitants of the area and the County. The conditional use must also not result in excessive traffic generation, noise, vibration, dust, glare, odors, or operate during odd hours that will be inconvenient to the neighborhood. Further, the site must be suitable for the conditional use including adequate usable space, access, and absence of environmental constraints.

In addition to the conditional use permit, the applicant is required to address review items outlined in Section 6-07-02 of the County's Development Standards and Regulations pertaining to Areas and Activities of State Interest permits. These items include:

- Information describing the applicant
- Information describing the project, including at least 3 alternatives
- Information on property rights, permits, and other approvals
- Financial feasibility of the project
- Land use
- Local governmental services
- Financial burden on residents
- Local economy
- Recreational opportunities
- Environmental impact analysis including water (surface and ground water), visual impacts, air quality, wetland and riparian areas, flora and fauna, soils, geologic conditions, and areas of paleontological, historic or archaeological importance.

According to the applicant, the proposed 24-inch natural gas, crude oil, wastewater, and fresh water pipelines, and 6-inch electrical power line are necessary to transport product from oil and gas facilities. Crude oil produced liquids (condensate and produced water) impede production of natural gas and required processing, treatment, and either disposal or sale to regional markets. The applicant would be required to apply for permits for any construction work in county right-of-way.

As part of the site selection process for the proposed pipeline, the applicant considered multiple alternative alignments and the potential impacts of each route. Alternative #1 would be slightly

longer, adding an additional mile of length, and have a greater impact on residents than the preferred alignment. Alternative #2 would also be slightly longer than the preferred alignment. This route would also add an additional mile in length, but would cause an even greater impact on residents. The preferred alignment does not cross any major bodies of water, wetlands, or riparian areas within unincorporated Adams County. The applicant would coordinate construction schedules to occur outside of seasonal nesting times.

In order to avoid impacts on more populated areas of the county, the preferred alignment was selected, as it is the most direct route, has the fewest impacts on property owners and sensitive environmental areas, and requires the least amount of land disturbance during construction.

Development Agreement

As part of this request, the applicant has agreed to enter into a Development Agreement (Exhibit 3.4) with the County. The development agreement addresses pre-construction requirements, construction and operational standards, and maintenance of the pipeline.

The proposed request conforms to the criteria for approval of a conditional use permit including compatibility with the surrounding area, addressing off-site impacts, and not being detrimental to health, safety, or welfare of the residents and the County. The pipeline route is the best alternative that minimizes potential impacts on existing residential developments. The majority of the property that the pipeline traverses through is predominately vacant land, or used for agriculture and construction of the pipeline will not impede current or future use of these properties. There will be minimal noise, vibration, dust, or traffic associated with after construction is complete.

Future Land Use Designation/Comprehensive Plan:

The future land use designation on the preferred alignment is property is Agriculture and Urban Residential. Per Chapter 5 of the County's Comprehensive Plan, Agriculture areas are not expected to develop, except for very low density residential at one dwelling per 35 acres. Urban Residential designated areas are intended for residential use at densities greater than one dwelling unit per acre.

The request conforms to the goals of the Comprehensive Plan, as the areas in the preferred alignment are not intended to be developed. In addition, the Airport Height and Noise Overlays restrict future development of occupied buildings near the airport. This limitation is due to potential nuisance conditions created by noise generated from aviation activities. The proposed pipeline also supports reduction in air emissions by limiting truck traffic generated by new well pads.

Compatibility with the Surrounding Area:

A majority of the surrounding properties to the preferred alignment are designated with agricultural zoning and developed with agricultural uses. The request to allow buried pipelines will be compatible with uses on the surrounding properties and character of the neighborhood. In addition, the plans provided with the application shows the alignment will be designed and constructed to mitigate potential noise, odor, and traffic that may be associated with the pipeline.

Staff is also recommending conditions of approval to ensure the applicant adheres to all federal, state, and local regulations as well as pre-construction, construction, and operational standards.

Referral Comments:
Union Pacific Railroad reviewed the request and had no concerns. CDOT stated a permit will be required for any work in state highways (Colfax Avenue). Tri-County Health Department reviewed the request and provided the applicant with best management practices for locating onsite wastewater treatment systems and water wells on the impacted parcels to ensure construction does not impact this infrastructure. Tri-County also noted a discharge permit would be required if trench dewatering is necessary during construction. Xcel Energy reviewed the proposed alignment and noted the presence of existing electric transmission lines along a portion of the route. The applicant shall coordinate with Xcel for any permitting requirements.

PLANNING COMMISSION UPDATE:
The Planning Commission (PC) considered this case on July 11, 2019. The applicant spoke at the meeting, and had no concerns with the staff report or presentation. There were no members of the public present to speak at the public hearing. The PC voted 6-1 to recommend approval to the Board of County Commissioners with 33 findings-of-fact and 1 condition.

Staff Recommendations:
Based upon the application, the criteria for approval for a conditional use permit, areas and activities of state interest permit, and a recent site visit, staff recommends Approval of this request with 33 findings-of-fact and 1 condition:

RECOMMENDED FINDINGS OF FACT

1. The conditional use is permitted in the applicable zone district.
2. The conditional use is consistent with the purposes of these standards and regulations.
3. The conditional use will comply with the requirements of these standards and regulations including, but not limited to, all applicable performance standards.
4. The conditional use is compatible with the surrounding area, harmonious with the character of the neighborhood, not detrimental to the immediate area, not detrimental to the future development of the area, and not detrimental to the health, safety, or welfare of the inhabitants of the area and the County.
5. The conditional use permit has addressed all off-site impacts.
6. The site is suitable for the conditional use including adequate usable space, adequate access, and absence of environmental constraints.
7. The site plan for the proposed conditional use will provide the most convenient and functional use of the lot including the parking scheme, traffic circulation, open space, fencing, screening, landscaping, signage, and lighting.
8. Sewer, water, storm water drainage, fire protection, police protection, and roads are to be available and adequate to serve the needs of the conditional use as designed and proposed.
9. Documentation that prior to site disturbance associated with the Proposed Project, the Applicant can and will obtain all necessary property rights, permits and approvals. The Board may, at its discretion, defer making a final decision on the application until outstanding

property rights, permits and approvals are obtained or the Board may grant a Permit with conditions and/or conditions precedent which will adequately address outstanding concerns.

10. The Proposed Project considers the relevant provisions of the regional water quality plans
11. The Applicant has the necessary expertise and financial capability to develop and operate the Proposed Project consistent with all requirements and conditions.
12. The Proposed Project is technically and financially feasible.
13. The Proposed Project is not subject to significant risk from Natural Hazards.
14. The Proposed Project is in general conformity with the applicable comprehensive plans.
15. The Proposed Project does not have a significant adverse effect on the capability of local government to provide services or exceed the capacity of service delivery systems.
16. The Proposed Project does not create an undue financial burden on existing or future residents of the County.
17. The Proposed Project does not significantly degrade any substantial sector of the local economy.
18. The Proposed Project does not unduly degrade the quality or quantity of recreational opportunities and experience.
19. The planning, design and operation of the Proposed Project reflects principals of resource conservation, energy efficiency and recycling or reuse.
20. The Proposed Project does not significantly degrade the environment. Appendix A includes the considerations that shall be used to determine whether there will be significant degradation of the environment. For purposes of this section, the term environment shall include:
    - Air quality,
    - Visual quality,
    - Surface water quality,
    - Groundwater quality,
    - Wetlands, flood plains, streambed meander limits, recharge areas, and riparian areas,
    - Terrestrial and aquatic animal life,
    - Terrestrial and aquatic plant life, and
    - Soils and geologic conditions.
21. The Proposed Project does not cause a nuisance and, if a nuisance has been determined to be created by the Proposed Project, the nuisance has been mitigated to the satisfaction of the County.
22. The Proposed Project does not significantly degrade areas of paleontological, historical, or archaeological importance.
23. The Proposed Project does not result in unreasonable risk of releases of hazardous materials. In making this determination as to such risk, the Board's consideration shall include:
    - Plans for compliance with Federal and State handling, storage, disposal and transportation requirements,
    - Use of waste minimization techniques, and
    - Adequacy of spill prevention and counter measures, and emergency response plans.
24. The benefits accruing to the County and its citizens from the proposed activity outweigh the losses of any resources within the County, or the losses of opportunities to develop such resources.

25. The Proposed Project is the best alternative available based on consideration of need, existing technology, cost, impact and these Regulations.
26. The Proposed Project shall not unduly degrade the quality or quantity of agricultural activities.
27. The proposed Project does not negatively affect transportation in the area.
28. All reasonable alternatives to the Proposed Project, including use of existing rights-of-way and joint use of rights-of-way wherever uses are compatible, have been adequately assessed and the Proposed Project is compatible with and represents the best interests of the people of the County and represents a fair and reasonable utilization of resources in the Impact Area.
29. The nature and location of the Proposed Project or expansion will not unduly interfere with existing easements, rights-of-way, other utilities, canals, mineral claims or roads.
30. Adequate electric, gas, telephone, water, sewage and other utilities exist or shall be developed to service the site.
31. The proposed project will not have a significantly adverse Net Effect on the capacities or functioning of streams, lakes and reservoirs in the impact area, nor on the permeability, volume, recharge capability and depth of aquifers in the impact area.
32. The purpose and need for the Proposed Project are to meet the needs of an increasing population within the County, the area and community development plans and population trends demonstrate clearly a need for such development
33. The Proposed Project is compatible with the surrounding area, harmonious with the character of the neighborhood, not detrimental to the immediate area, not detrimental to the future development of the area, and not detrimental to the health, safety, or welfare of the inhabitants of the area.

Recommended Conditions:

1. The applicant shall comply with all terms and conditions of the Development Agreement between Rocky Mountain Midstream, LLC and Adams County.

PUBLIC COMMENTS

Notifications Sent	Comments Received
60	0

Property owners and residents within one-thousand (1,000) feet of each of the three alignments were notified of the subject request. As of writing this report, staff has not received any comments on the request.

REFERRAL AGENCY COMMENTS

Responding with Concerns:

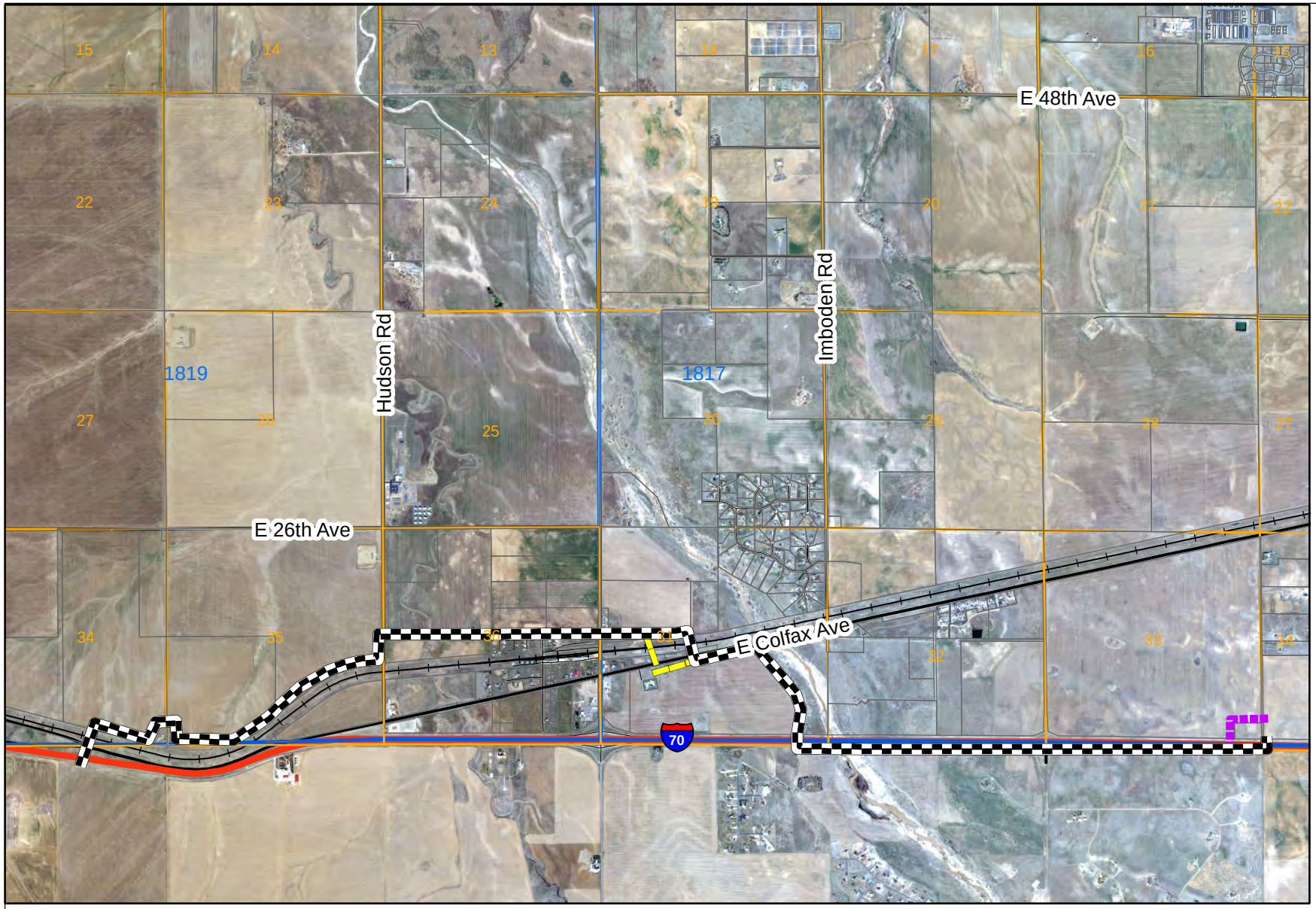
Colorado Department of Transportation
Tri-County Health Department
Xcel Energy

Responding without Concerns:

Union Pacific Railroad

Notified but not Responding / Considered a Favorable Response:

Adams County Sheriff
Bennett Fire
Bennett Parks & recreation
Bennett School District 27J
Box Elder Water & Sanitation District
CDPHE
Colorado Division of Parks and Wildlife
Century Link
City of Aurora
Comcast
Metro Wastewater Reclamation
Regional Transportation District



Jamasco Pipeline RCU2018-00032

Preferred Route

Alternative #2

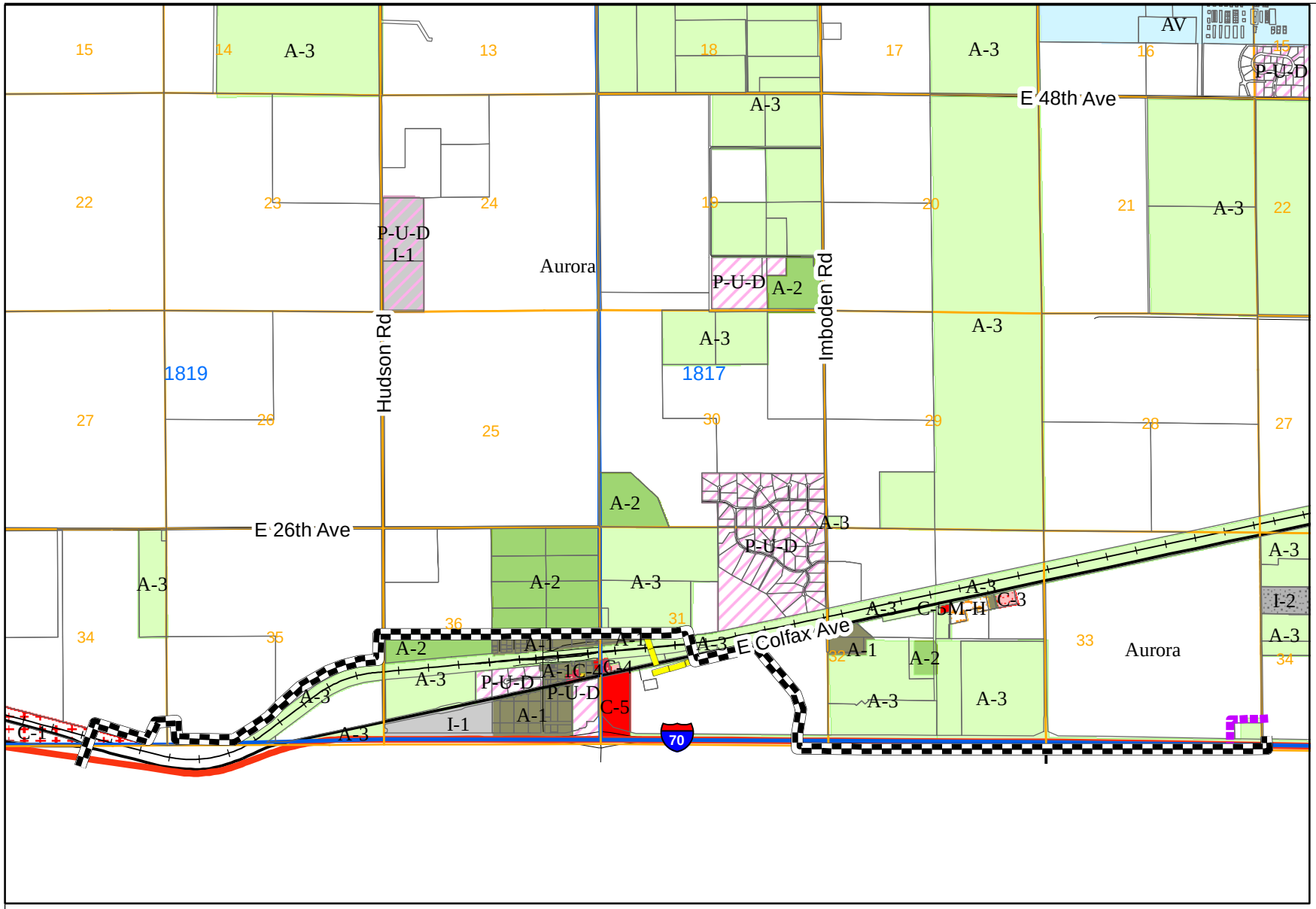
Alternative #3

N

For display purposes only.

ADAMS COUNTY COLORADO

This map is made possible by the Adams County GIS group, which assumes no responsibility for its accuracy



Legend

- Railroad
- Major Water
- Zoning Line
- Sections

Zoning Districts

- A-1
- A-2
- A-3
- R-E
- R-1-A
- R-1-C
- R-2
- R-3
- R-4
- M-H
- C-0
- C-1
- C-2
- C-3
- C-4
- C-5
- I-1
- I-2
- I-3
- CO
- PL
- AV
- DIA
- P-U-D
- P-U-D(P)

Jamasco Pipeline RCU2018-00032

- Preferred Route
- Alternative #2
- Alternative #3

N

For display purposes only.

ADAMS COUNTY COLORADO

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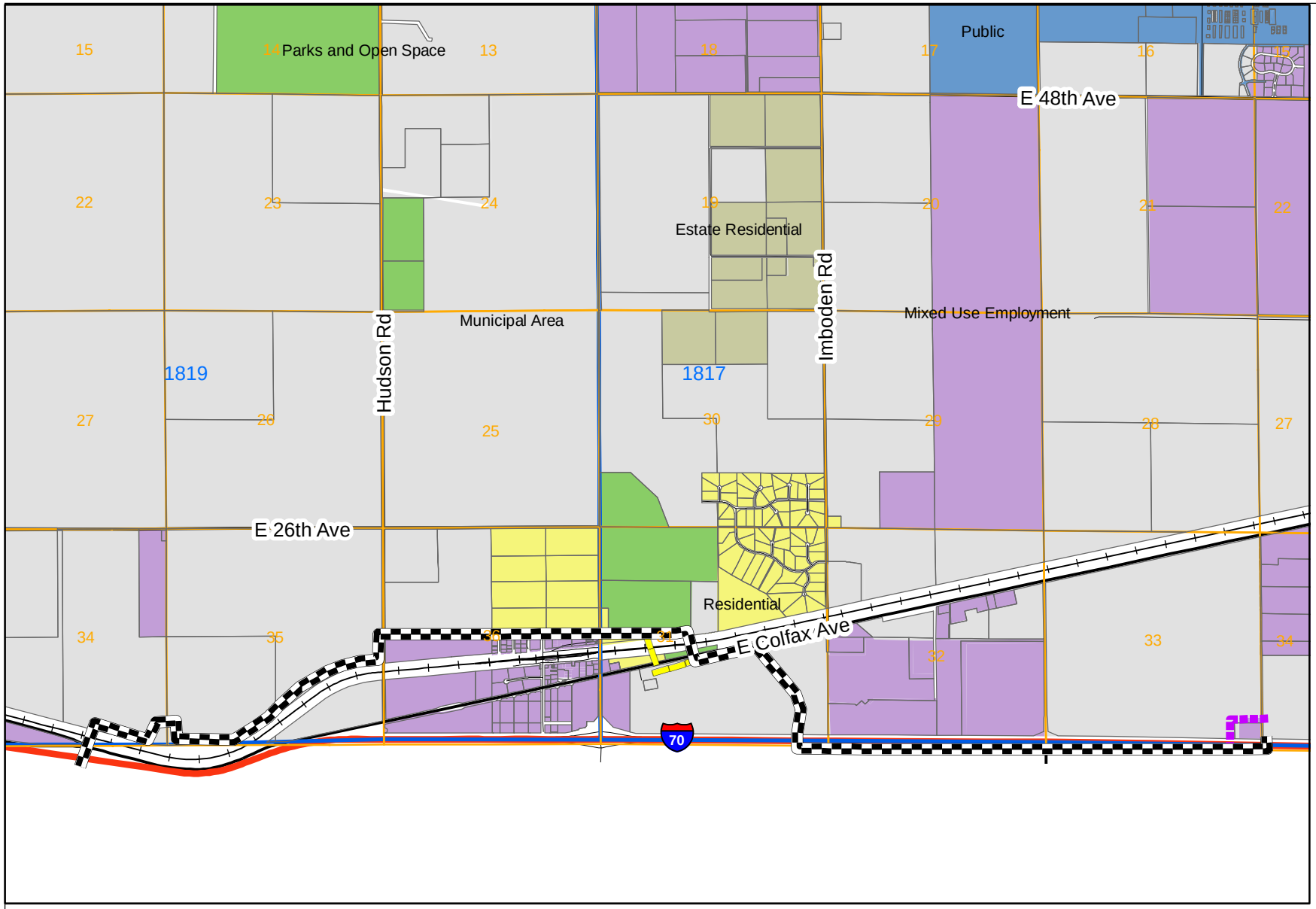


Jamasco Pipeline RCU2018-00032

Preferred Route

Alternative #2

Alternative #3

N

For display purposes only.

ADAMS COUNTY COLORADO

This map is made possible by the Adams County GIS group, which assumes no responsibility for its accuracy

3. WRITTEN EXPLANATION OF THE PROJECT

INTRODUCTION

Discovery DJ Services, LLC is submitting additional requested criteria for the Adams County Area and Activities of State Interest ("AASI" (1041)) Checklist, as outlined during the conceptual review process and subsequent Adams County Development Review Team Comments summary letter dated July 18, 2018.

PURPOSE & NEED

Advances in oil and gas extraction technologies have resulted in a substantial increase in oil and gas activities across Colorado. Crude oil produced liquids (condensate, produced water) from these wells impede the natural gas production and require transportation to oil and gas facilities for processing, treatment, and either disposal or sale to regional markets. Currently, these liquids are transported by truck from the individual well pads resulting in an increasing number of loads per day on the local city and county roads and state highways. Similarly, the existing natural gas infrastructure in and around these wells is at capacity or doesn't exist within areas of new drilling. Centralized collection of these liquids and more efficient means of transportation are required to reduce the local truck traffic and facilitate transportation of the natural gas and produced liquids to locations where they can be processed and sold to meet market demands. The project is necessary component of the overall system to gather, process, transport and market the area's natural resources.

EXPLANATION OF THE REQUEST

Pursuant to ACDSR Section 2-02-08-01, a conditional use is a land use which is "presumptively compatible with other land uses authorized or permitted in a zone district, but if approved, requires more discretionary review than these uses which are authorized." Through consultation with the ACDP, Discovery has been advised that the proposed respective pipelines use is classified as Industrial Use and subject to the County Conditional Use Permit review and approval. Consequently, Discovery respectfully submits this Application for the Board of County Commissioners' review and approval pursuant to regulations, procedures, and criteria for approval under the ACDSR Section 2-02-08.

CONSTRUCTION SCHEDULE

Construction activities in Adams County will commence upon approval of the CUP and completion of all conditions of approval. A final schedule for construction of the project has not yet been developed, however it is anticipated that the pipeline construction within the County will take approximately 3-5 months.

PREFERRED ROUTE CONSIDERATIONS & REASONING

The preferred route within Adams County is approximately 22,060 feet, or 4.18 miles long and was selected to mitigate the impacts to residential neighborhoods, conform with the comprehensive plans for Adams County, and minimize impacts to the environment. The preferred route is located on lands within Adams County that are zoned as agricultural and residential. Discovery worked with each respective landowner to develop the preferred alignment to mitigate impacts residential properties and to actively cultivated fields and productive areas, along with landowners' consideration and preferences.

In addition to zoning and landowner considerations, numerous other factors were included in the decision process for the selection of the preferred route. Discovery has reviewed and considered the Adams County Comprehensive Plan as well as the Adams County Transportation Plan in selection of the preferred route, keeping the permanent right-of-way outside of County Roads.

DESCRIPTION OF PREFERRED PIPELINE ROUTE

The proposed pipeline project begins in Adams County, Parcel # 0181700000149, located in Section 34, Township 3 South, Range 64 West, referred to as the Matador site, connecting to Discovery's proposed Watkins pipeline (PRE2018-00019). The preferred route then heads south crossing under I-70 into Arapahoe County where it then continues west through Sections 03, 04, 05, and 06, all located in Township 4 South, Range 64 West, before turning north and crossing back under I-70, re-entering Adams County in Parcel # 0181700000298 located in Section 31, Township 3 South, Range 64 West. The proposed Jamasco pipeline will continue in a northwest by west direction through Section 31, continue in a westerly direction through Section 36, Township 3 South, Range 65 West; continue in a southwest by west direction through Section 35, continue in a west by northwest direction through Section 34, and then in a southerly direction crossing under I-70 and re-entering Arapahoe County ending at the Jamasco pad site. The approximate length of the preferred route located in Adams County will be 22,060 feet or 4.18 miles. The approximate total length of the preferred route both in Adams County and Arapahoe County will be 42,010 feet or 7.95 miles.

The proposed pipelines will be constructed within the following Township, Range and Sections:

Township	Range	Section
3S	64W	34
3S	64W	31
3S	65W	36
3S	65W	35
3S	65W	34

DESCRIPTION OF PROJECT ALTERNATVIES

Discovery has considered two alternative route alignments for this Project. Alternative Route #1 would be a slightly longer route (less than 1-mile difference). This route would have a greater impact on residents. Alternative route #2 is also slightly longer (less than 1 mile difference) but would cause a greater impact on residents.

ALTERNATE ROUTE #1

The proposed pipeline project begins in Adams County, Parcel # 0181700000149, located in Section 34, Township 3 South, Range 64 West, referred to as the Matador site, connecting to Discovery's proposed Watkins pipeline (PRE2018-00019). Alternature route #1 then heads south crossing under I-70 into Arapahoe County where it then continues west through Sections 03, 04, 05, and 06, all located in Township 4 South, Range 64 West, before turning north and crossing back under I-70, re-entering Adams County in Parcel # 0181700000298 located in Section 31, Township 3 South, Range 64 West. The proposed Jamasco pipeline will continue in a northwest direction, and then southwest direction, heading north and crossing under E. Colfax Ave, then heading in a west direction through Section 31, continue in a westerly direction through Section 36, Township 3 South, Range 65 West; continue in a southwest by west direction through Section 35, continue in a west by northwest direction through Section 34, and then in a southerly direction crossing under I-70 and re-entering Arapahoe County ending at the Jamasco pad site. The approximate length of alternate route # 1 located in Adams County will be 22,611 feet or 4.28 miles.

ALTERNATE ROUTE #2

The proposed pipeline project begins in Adams County, Parcel # 0181700000149, located in Section 34, Township 3 South, Range 64 West, referred to as the Matador site, connecting to Discovery's proposed Watkins pipeline (PRE2018-00019). Alternate route #2 then heads west into Parcel # 018170000250 and then heads south crossing under I-70 into Arapahoe County where it then continues west through Sections 03, 04, 05, and 06, all located in Township 4 South, Range 64 West, before turning north and crossing back under I-70, re-entering Adams County in Parcel # 0181700000298 located in Section 31, Township 3 South, Range 64 West. The proposed Jamasco pipeline will continue in a northwest by west direction through Section 31, continue in a westerly direction through Section 36, Township 3 South, Range 65 West; continue in a southwest

by west direction through Section 35, continue in a west by northwest direction through Section 34, and then in a southerly direction crossing under I-70 and re-entering Arapahoe County ending at the Jamasco pad site. The approximate length of alternate route #2 located in Adams County will be 23,317 feet or 4.42 miles.

ROAD CROSSINGS

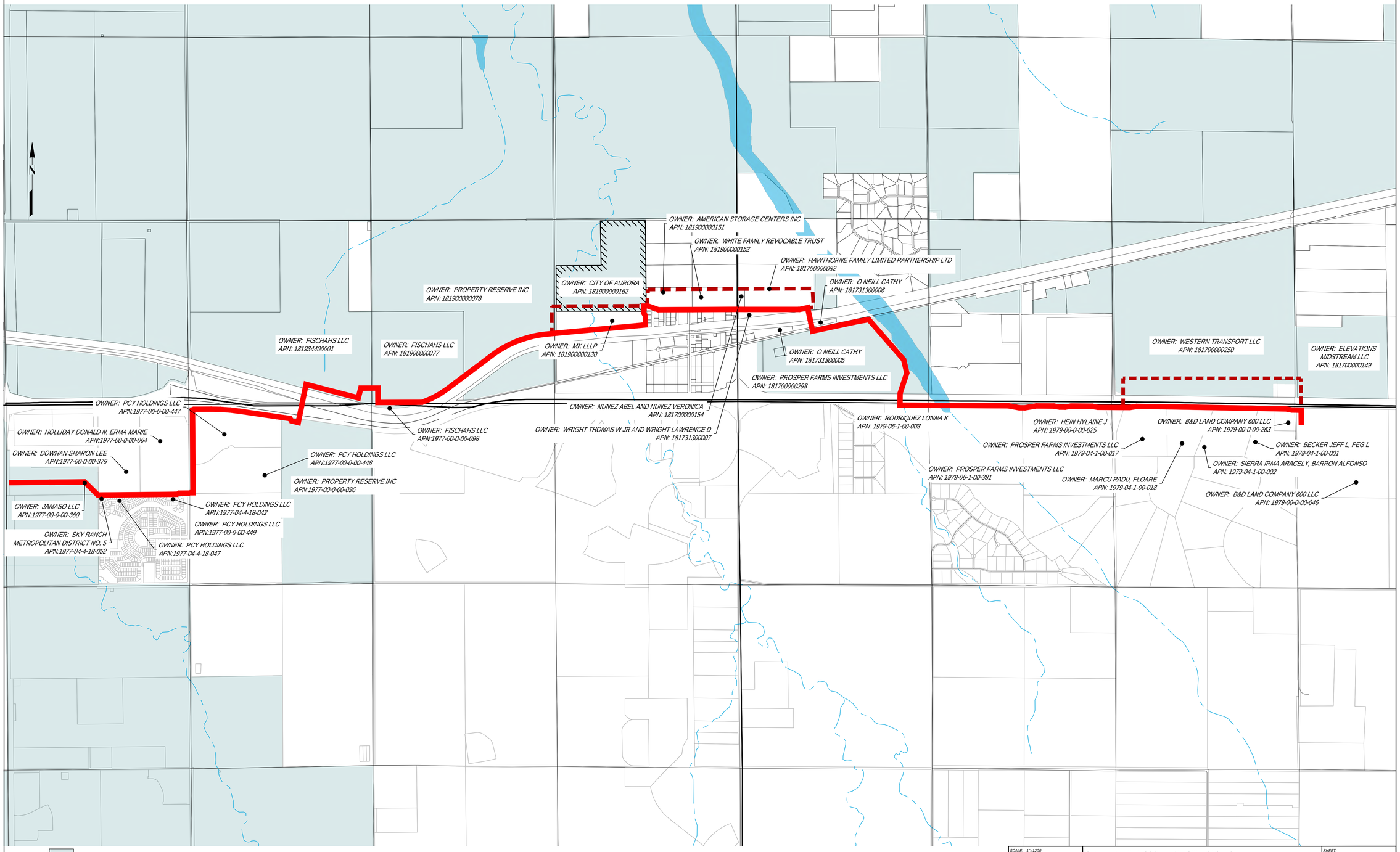
A total of 7 road crossings have been identified.

The road crossings that are along the preferred route are summarized below.

Watkins 20-inch Natural Gas Pipeline and up-to a Proposed 20-inch Oil Pipeline Project Road Crossing			
No.	**Road Crossed**	**Nearest Intersection**	**Distance to Intersection (Approximate)**
1	I-70	CR 27 & E. Colfax Ave	5,143'
2	I-70	I-70 & Watkins Rd.	4,669'
3	E. Colfax Ave.	E. Colfax Ave. & Watkins Rd.	2,198'
4	CR 24 / Watkins Rd.	CR 24 / Watkins Rd. & East Front Street N	137'
5	CR 23 / Hudson Mile Rd.	CR 23 / Hudson Mile Rd. & E. Colfax Ave.	2,100'
6	E. Colfax Ave.	E. Colfax Ave. & CR 23 / Hudson Mile Rd.	7,532'
7	I-70	I-70 & Watkins Rd.	12,705'

Following completion of all design activities and the applicable construction contractor has been selected, Discovery will provide the ACDP a detailed schedule prior to starting construction.

DISCOVERY DJ SERVICES, LLC
JAMASO GAS PIPELINE PROJECT



SCALE: 1"=1200'	CLIENT NAME: DISCOVERY DJ SERVICES LLC		SHEET:
DATE: 01/17/19	REV. #	REVISION DATE	1 OF 1
JOB No.: 180005	C	09/28/18 - ROUTE REVISION	
JOB NAME: JAMASO	D	10/15/18 - REVISED ALTERNATES	
DRAWN: JMC CHK:	F	01/17/19 - ROUTE AND ALTERNATES REVISED	
REV: F	-	-	
AFE No.:			

Acklam, Inc.
133 S. 27th Avenue
Brighton CO, 80601

FILE: Z:\ACKLAM JOBS\2018\DISCOVERY\180007 JAMASO\DRAWINGS_COUNTY_APPLICATIONS_REV_F.DWG PLOTTED:Jan 17, 2019 9:12am

OWNER / CONTACT

OWNER: FISCHAHS LLC
APN: 181900000077

150+84

OWNER: PROPERTY RESERVE INC C/O LDS TAX DIVISION
APN: 181900000078

169+84

HUDSON MILE ROAD

182+74

OWNER: CITY OF AURORA
APN: 181900000162

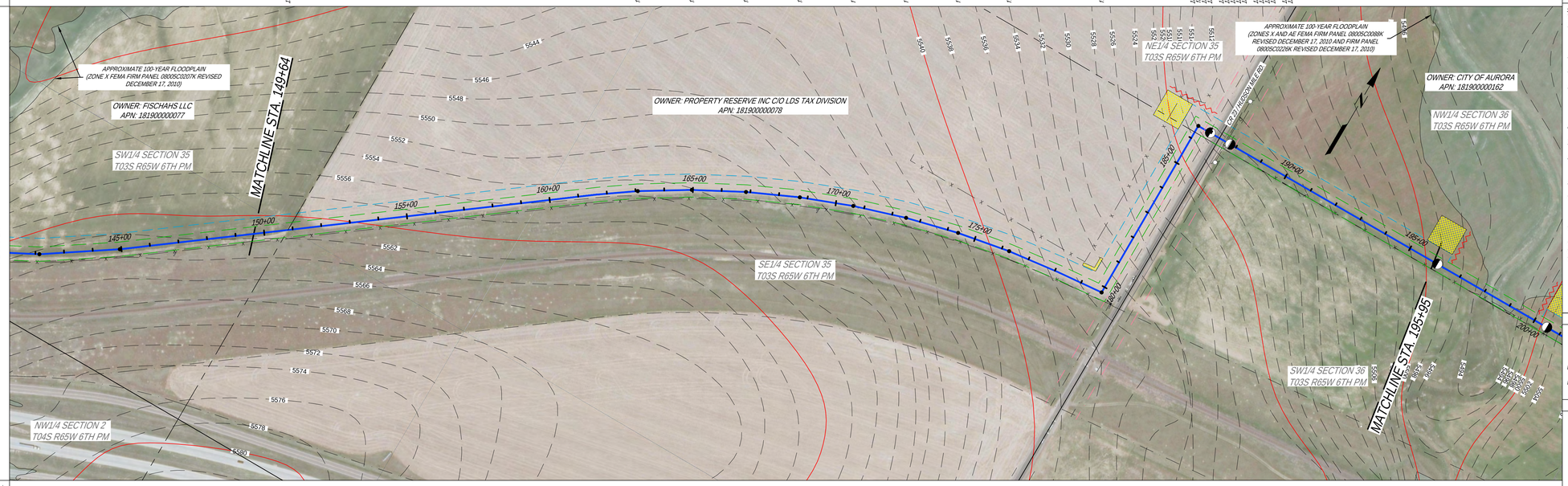
PIPELINE / WORK SPACE SCHEME
NOT TO SCALE

30' TEMPORARY WORKSPACE
25'
50' PERMANENT EASEMENT
100'
25'
CENTERLINE RIGHT OF WAY
100'
100'
100'

STATION / DESCRIPTION

150+84 QUARTER / PROPERTY LINE
163+08 83°29'34" RIGHT
164+86 83°29'34" RIGHT
168+65 83°29'34" RIGHT
169+73 83°29'34" RIGHT
173+61 83°29'34" RIGHT
172+60 83°29'34" RIGHT
174+38 83°29'34" RIGHT
176+26 83°29'34" RIGHT
179+79 84°59'58" LEFT
185+14 QUARTER LINE
185+49 PROPERTY LINE
185+84 CR 23/HUDSON MILE RD. R.O.W. / PROPERTY LINE
186+97 ENTER R.O.W.
187+35 CROSS CR 23 / HUDSON MILE RD.
187+35 CENTER LINE
187+35 EXIT R.O.W.
187+49 OVERHEAD POWERLINE
187+49 CROSS CR 23 / HUDSON MILE RD.
187+74 PROPERTY LINE
187+99 CR 23 / HUDSON MILE RD. R.O.W.

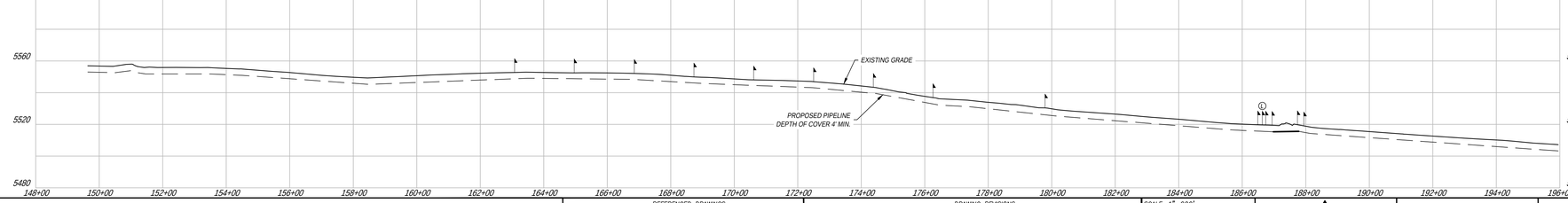
PLAN VIEW



MATERIAL
DESIGN FACTOR NOT TO SCALE

PIPE DETAIL
NOT TO SCALE

GROUND PROFILE
H: 1"=200' V: 1"=40'



BILL OF MATERIALS

ID	SIZE	DESCRIPTION	QUANTITY
A	12.000"	12.750" O.D. PIPE, (0.250), SMLS/ERW, CS API 5L, PSL2, X-52, BBE, 14-16 MILS FBE COATED CLASS I.	4551'
B	12.000"	12.750" O.D. PIPE, (0.330), SMLS/ERW, CS API 5L, PSL2, X-52, BBE, 14-16 MILS FBE COATED CLASS II.	0
C	12.000"	12.750" O.D. PIPE, (0.375), SMLS/ERW, CS API 5L, PSL2, X-52, BBE, 14-16 MILS FBE COATED CLASS III.	0
D	12.000"	12.750" O.D. PIPE, (0.375), SMLS/ERW, CS API 5L, PSL2, X-52, BBE, 20-30 MILS ARO COATED.	80'
E	12.000"	ELBOW, 90 DEG, 3R, SEGMENTABLE BEND, STD WALL, CS, MSS-SP-75, GR. Y-52, API 5L PSL2, ERW, GR X-52	2
F	12.000"	ELBOW, 45 DEG, 3R, SEGMENTABLE BEND, STD WALL, CS, MSS-SP-75, GR. Y-52, API 5L PSL2, ERW, GR X-52	0
G	12.000"	ELBOW, 30 DEG, 3R, SEGMENTABLE BEND, STD WALL, CS, MSS-SP-75, GR. Y-52, API 5L PSL2, ERW, GR X-52	0
H	12.000"	ELBOW, 22.5 DEG, 3R, SEGMENTABLE BEND, STD WALL, CS, MSS-SP-75, GR. Y-52, API 5L PSL2, ERW, GR X-52	0
J	12.000"	ELBOW, 15.0 DEG, 3R, SEGMENTABLE BEND, STD WALL, CS, MSS-SP-75, GR. Y-52, API 5L PSL2, ERW, GR X-52	0
K	12.000"	ELBOW, 12.5 DEG, 3R, SEGMENTABLE BEND, STD WALL, CS, MSS-SP-75, GR. Y-52, API 5L PSL2, ERW, GR X-52	0
L		TYPE I TEST STATION W/ MARKER	1
M		TYPE II TEST STATION W/ MARKER	0
N		ZINC RIBBON	0

FIELD NOTES

CONSTRUCTION:

1. RADIOGRAPH: PER API 1104 STANDARDS LATEST EDITION
2. CODES: THIS PIPELINE(S) INSTALLED UNDER THE FOLLOWING:
   A. 49 CFR 192
   B. ALL APPLICABLE PERMITS
   C. COMPANY STANDARDS
3. TEST STATIONS WILL BE INSTALLED EVERY 5280' UNLESS OTHERWISE SPECIFIED.
4. PIPELINE LINE MARKERS WILL BE INSTALLED AT EVERY ROAD CROSSING AND POINT OF INTERSECTION AND WITHIN LINE OF SIGHT.
5. UNLESS OTHERWISE NOTED, PIPELINE SHALL BE INSTALLED A MINIMUM OF (10) FEET FROM DISTRIBUTION POWER POLE. IN CASES WHERE A MINIMUM OF (10) FEET CANNOT BE ACHIEVED, THE CONTRACTOR IS RESPONSIBLE FOR SUPPORTING POWER POLES DURING CONSTRUCTION.
6. TO ACHIEVE ABOVE GROUND SUPPORT ELEVATIONS, CONTRACTOR TO FIELD BEND PIPE AS NECESSARY.
7. DRILL PROFILE INTENDED AS A GUIDE ONLY. DRILLER IS RESPONSIBLE FOR FINAL PROFILE.
8. PIPELINE TO BE INSTALLED WITH A MINIMUM VERTICAL CLEARANCE OF 24" AT ALL FOREIGN PIPELINE CROSSINGS UNLESS OTHERWISE NOTED.
9. PIPELINE TO BE INSTALLED WITH A MINIMUM DEPTH OF 48" UNLESS OTHERWISE NOTED.
10. 8 HOUR HYDROTEST PERFORMED AT 2160 – 2210 PSI FOR 8 HOURS.
    TESTING MUST ACHIEVE NO PRESSURE LOSS FOR THE LAST TWO HOURS OF HYDROTEST.
11. FIELD JOINT COATING: SP-2888 PER SEC. 9.9, DISCOVERY CONSTRUCTION SPECIFICATIONS.
12. DESIGN PRESSURE: 1440 psig.
13. DESIGN TEMP: 100°F
14. MAOP @ 20KSMYS: GAS-1440 psig

SCALE & PROJECTION

0' 200' 400'

SCALE: 1"=200'

LOCATION: SECTIONS 35 & 36 T03S, R65W 6TH P.M.

PROJECTION: COLORADO STATE PLANE, NAD83
NORTH ZONE, US FOOT (GRID)

LEGEND

- PERMANENT R.O.W.
- TEMPORARY WORKSPACE
- EXISTING PIPELINE
- PROPOSED PIPELINE ALIGNMENT
- APPROX. EROSION CONTROL DEVISE
- OVERHEAD POWER LINE
- SECTION LINE
- QUARTER LINE
- SIXTEENTH LINE
- PROPERTY LINE
- FENCE
- DITCH
- TREE LINE
- RIGHT OF WAY
- RIGHT OF WAY RESERVED
- EDGE OF GRAVEL
- EDGE OF ASPHALT
- EDGE OF CONCRETE
- RAILROAD
- ADDITIONAL TEMPORARY WORKSPACE
- FLOOD EXTENTS

- PIPELINE MARKER
- TEST STATION
- DRILL ENTRY/EXIT
- POINT OF INTERSECTION
- TEST STATION/CP TEST STATION
- TELEPHONE/FIBER OPTIC PEDESTAL
- ELECTRIC METER
- WELL
- MARKER
- POWER POLE
- GUY WIRE
- AIR RELEASE VALVE
- SIGN
- MILE MARKER
- HYDRANT
- CULVERT
- SANITARY SEWER MANHOLE
- TREE/SHRUB

DRAFT FOR REVIEW

NOTES
1.) LOCATIONS OF UTILITIES AND FOREIGN PIPELINES WERE DETERMINED FROM VISIBLE SURFACE EVIDENCE. THESE LOCATIONS AS SHOWN MAY NOT BE ACCURATE OR COMPLETE. OTHER UTILITIES MAY EXIST AND ARE TO BE FIELD LOCATED BY OTHERS PRIOR TO EXCAVATION.
2.) BEARINGS SHOWN HEREON ARE BASED ON GPS OBSERVATIONS AND/OR THE ONLINE POSITIONING USER SERVICE OFFERED BY THE N.G.S. AND PROJECTED TO "COLORADO COORDINATE SYSTEM OF 1983 NORTH ZONE" (C.R.S. 38-52-105 & 106). DISTANCES SHOWN HEREON ARE IN US SURVEY FEET GRID. THE COMBINED FACTOR USED TO OBTAIN THE GRID DISTANCES IS 0.99972585.
3.) THE PROPOSED PIPELINE AND GROUND PROFILE, IF SHOWN, IS INTENDED TO REPRESENT TYPICAL CLEARANCES FOR PERMITTING PURPOSES. THE VERTICAL POSITION IS NOT BASED ON AN ENGINEERING DESIGN AND IS NOT TO BE USED FOR CONSTRUCTION.

REFERENCED DRAWINGS

ID	DRAWING NUMBER	TITLE

DRAWING REVISIONS

NO.	DESCRIPTION	BY	CHK	APVD	DATE

SCALE: 1"=200'
DATE: 07/27/18
JOB No.: 180007
JOB NAME: JAMASO
DRAWN: RWC CHK: DWC
REV: -
AFE No.: EXG009-EX1

DISCOVERY MIDSTREAM PARTNERS
PSI

Acklam, Inc.
133 S. 27th Avenue
Brighton CO, 80601

DISCOVERY DJ SERVICES LLC
JAMASO 24" GAS AFE EXG009-EX1
STA. 149+64 TO STA. 195+95

PROPOSED 24" GAS PIPELINE

SHEET:
5 OF 10

EGX009-USR-005

Community & Economic
Development Department
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
Brighton, CO 80601-8218
PHONE 720.523.6800
FAX 720.523.6967

Development Review Team Comments

Date: 10/5/18
Project Number: RCU2018-00032
Project Name: Jamasco Pipeline

For submission of revisions to applications, a cover letter addressing each staff review comments must be provided. The cover letter must include the following information: restate each comment that require a response and provide a response below the comment; respond to each comment with a description of the revisions and the page of the response on the site plan. And identify any additional changes made to the original document other than those required by staff.

A re-submittal is required. Please submit 1 hard copy and 1 electronic copy to the Community and Economic Development Department front desk with the re-submittal form.

An additional 20% review fee will be required after the third review and upon submittal of the fourth review.

Commenting Division: Development Services, Planning
Name of Reviewer: Emily Collins
Email: ecollins@adcogov.org

PLN1. REQUEST: A Conditional Use Permit for 5 parallel pipelines.
- a. Preferred Route: 4.18 miles. 24-inch natural gas, crude oil, waste-water, fresh-water, and a 6-inch 480-volt power line. Request included a Development Agreement.

PLN2. PROPERTY:
- a. Pipeline originates at 0181700000149 (proposed Matador wellpad in City of Aurora) and ends at 0181900000118 (proposed Jamasco wellpad in City of Aurora).
- b. All properties designated are Agriculture-2 (A-2) or Agriculture-3 (A-3).The Future Land Use designation includes, Parks and Open Space and Urban Residential. Buried pipeline and temporary construction should not negatively impact purpose of these designations and future development of the properties.

PLN3. COMMENTS:
- a. Sheet 7 of the submitted plans do not accurately reflect parcels 0181731300006 and 0181731300007 (not labeled).
- b. Please provide a revised written narrative clearly describing the number, size, and types of lines included in this request. The narrative only describes the route. Staff

assumes this request is for 5 parallel lines; however, this was not specifically stated in the written portion of the application.

c. Please describe why the lines are labeled either Jamasco or Hooulihan on the Matador facility site plan. Please describe the overall transportation of the various products and where they are going to or from.
d. The Development Agreement must be updated to specify the number, types, and size of lines (updated second paragraph).
e. **The proposed alternative alignments are not sufficient**. The majority of the route is the same and the small changes in alignment do not demonstrate any significant differences. Please provide 2 new alternative alignments including analysis (road crossing, residential, environmental impacts) for staff review.

PLN4. ANTICIPATED CONDITIONS OF APPROVAL:

a. Development Agreement to address pre-construction requirements, construction and operational standards, etc.
b. Submit all executed easement agreements along the approved route prior to issuance of construction or building permits.
c. Provide a shapefile or legal description of the approved route for resolution and mapping.

Commenting Division: Development Services, Engineering:
Name of Review: Greg Labrie
Email: glabrie@adcogov.org

ENG1: The engineer or contractor must submit an application and the associated construction plans to obtain an Adams County Utility Permit. Traffic control plans are also required to be submitted for review and approval for all construction activity within the public right-of-way. After the plans are reviewed and approved, a construction permit will be issued by the One Stop Permit Center.

Commenting Division: Development Services, Right-of-Way:
Name of Review: Marissa Hillje
Email: mhillje@adcogov.org

ROW1: Prior to public hearing owner authorization of the preferred route or the signed and recorded easements will be required.

Commenting Division: Development Services, Building Safety:
Name of Review: Justin Blair
Email: jblair@adcogov.org

BSD1- No comment.

Commenting Division: Parks and Open Space:
Name of Review: Aaron Clark
Email: aclark@adcogov.org

PKS: No comment.

Commenting Division: Environmental Programs
Name of Review: Jen Rutter
Email: jrutter@adcogov.org

ENV1. The BMPs outlined in the Environmental Impact Analysis should be included in the permit as conditions of approval:
1. Horizontal directional drilling shall be used to avoid impacts to wetlands and waterbodies.
2. The Natural Resources Conservation Service (NRCS) shall be consulted when determining seed mixtures and seeding rates for disturbed areas.
3. If any construction is planned to occur within a prairie dog colony between March 15 and October 31, preconstruction surveys shall be completed using the protocol approved by Colorado Parks and Wildlife (CPW).
4. If additional raptor nests are discovered or activity status changes, impacts to nest locations shall be minimized using the buffer zones and seasonal restrictions approved by CPW.

Emily Collins

From: Loeffler - CDOT, Steven [steven.loeffler@state.co.us]
Sent: Monday, September 17, 2018 7:35 AM
To: Emily Collins
Subject: RCU2018-00032, Jamasco Pipelines

Emily,

I have reviewed the request for CUP to allow construction of up to 24-inch natural gas, crude oil, waste-water, and fresh water pipelines, and a 6-inch electrical power line generally between I-70 and Hayesmount Rd. to I-70 and Manilla Rd. and have the following comments:

- Permits from our office are required for any work in or installation in CDOT Right-of-Way. Utility Permits are applied for on our website at the following link: https://www.codot.gov/business/permits/utilitiesspecialuse/online-permit-application Point of contact for this permitting is Robert Williams who can be reached at 303-916-3542 or robert.williams@state.co.us
- CDOT Right-of-Way must be shown and labeled on the Plan sheets.
- A bore underneath Interstate 70 must be a minimum of 10 feet deep and be done from outside to outside of the Right-of-Way due to the Access control lines adjacent to the Interstate.
- For any liquid pipeline in Right-of-Way, it must be cased.
- For any bore under I-70, please label the start and end bore on the plan sheets.
- For any questions regarding permitting, please contact Robert Williams at 303-916-3542 or robert.williams@state.co.us

Thank you for the opportunity to review this referral.

Steve Loeffler
Permits Unit

COLORADO
Department of Transportation
Region 1

P 303.757.9891 | F 303.757.9886
2829 W. Howard Pl. 2nd Floor, Denver, CO 80204
steven.loeffler@state.co.us | www.codot.gov | www.cotrip.org

September 11, 2018

Emily Collins
Adams County Community and Economic Development
4430 South Adams County Parkway, Suite W2000A
Brighton, CO 80601

RE: Jamaso Pipelines, RCU2018-00032
TCHD Case No. 5153

Dear Ms. Collins,

Thank you for the opportunity to review and comment on the Conditional Use Permit to install a 24-inch natural gas, crude oil, wastewater, and fresh water pipelines, and 6-inch electrical power line for approximately 4.18 miles located generally from I-70 and Hayesmount Road to I-70 and Manilla Road. Tri-County Health Department (TCHD) staff has reviewed the application for compliance with applicable environmental and public health regulations and principles of healthy community design. After reviewing the application, TCHD has the following comments.

On-Site Wastewater Treatment Systems
Houses and other buildings equipped with plumbing facilities on properties located along the preferred and alternate pipeline routes are serviced by Onsite Wastewater Treatment Systems (OWTS). Our review of the pipeline routes indicates that sections of the pipeline routes may encroach on OWTS on some properties. TCHD recommends that the applicant review the locations of the pipeline routes to determine if they may encroach on OWTS. If it appears that encroachment will occur, it may be necessary to revise the pipeline location or relocate the OWTS. OWTS records are available online and can be found at http://ehreports.tchd.org/.

Groundwater Quality Protection
A scan of the area proposed for the pipeline routes indicates that there may be water wells on the properties where the pipeline(s) are located. Heavy equipment may inadvertently drive over wells during construction, causing damage that may expose the water in the wells to contamination. Where wells are within or close to pipeline routes, we recommend the applicant protect the wells by identifying the areas around wells so that they are visible to vehicle operators/construction crews. This can be accomplished by delineating the area around each well with stakes, colored tape or orange plastic netting.

If the pipeline routes cross over streams and/or wetlands, alluvial groundwater flow could be impacted if trenching intersects the shallow groundwater. If trench dewatering is necessary, the water will be pumped and discharged to alluvia/colluvial sediments

close to the stream channel. If discharge of groundwater is necessary during construction, a discharge permit from the Colorado Department of Public Health and Environment (CDPHE), Water Quality Control Division will be necessary

Protection of Above-Ground Valves
Above-ground valves may be damaged or vandalized once they are installed and placed into use. If above ground values are to be utilized, the applicant should consider methods for ensuring the valve site is secure.

Sanitary and Solid Waste Disposal
The application does not specify how sanitary and solid waste will be provided during the construction for construction workers. We anticipate that trash dumpsters and portable toilets will be necessary during construction. TCHD has no objection to the use of portable toilets, provided they are properly maintained. TCHD recommends that the applicant address these, in terms of numbers, locations, and vendor.

Please feel free to contact me at 720-200-1585 or aheinrich@tchd.org if you have any questions on TCHD's comments.

Sincerely,

Annemarie Heinrich, MPH/MURP
Land Use and Built Environment Specialist

cc: Sheila Lynch, Dylan Garrison, TCHD

Friday, September 7, 2018

Adams County Colorado
4430 South Adams County Parkway
1st Floor Suite W200B
Brighton, CO 80601-8218

*Via Certified US Mail and E-mail (*Ecollins@adcogov.org*)*

Subject: Construction of up to 24-Inch Natural Gas, Crude Oil, Waste-Water, and Fresh Water Pipelines

Dear Emily Collins:

Union Pacific Railroad Company notes that the project referenced above contemplates installation of pipeline that may parallel and/or cross the railroad's tracks at a number of locations. The information attached to your notice letter dated August 29, 2018 is insufficiently detailed to determine the actual proximity of this project to Railroad property or what, if any, impact the project may have on railroad operations and safety.

By this letter, Union Pacific requests further information to permit it to evaluate the proposal in light of railroad engineering standards and other considerations. The railroad reserves its rights to present comments on the proposal and to seek any legal, administrative, and other remedies that may be necessary to preserve Union Pacific's franchise and property rights.

Information and application forms concerning requests for pipeline crossings across Union Pacific's property may be found on the internet at: *http://www.uprr.com/reus/pipeline/install.shtml.* Proposals that call for placement of improvements on or under our property require greater evaluation and tend to be more difficult to approve, particularly where pipelines parallel our tracks.

Further information regarding requests for such encroachments may be found on the internet at: *www.uprr.com/reus/encroach/procedur.shtml and www.uprr.com/reus/encroach/encguide.shtml.* In all instances, there must also be a meeting of the minds on compensation for the right to cross the property.

Please direct all future correspondence and notices regarding this project to my attention. You may contact me at 402-544-8536 or kdcrawfo@up.com.

Cordially,

Kylan Crawford
Senior Manager-Real Estate

Real Estate

UNION PACIFIC RAILROAD
1400 Douglas Street, Stop 1690
Omaha, Nebraska 68179-1690
P: (402) 544-8536 E: kdcrawford@up.com

Right of Way & Permits

1123 West 3rd Avenue
Denver, Colorado 80223
Telephone: **303.571.3306**
Facsimile: 303. 571. 3284
donna.l.george@xcelenergy.com

September 18, 2018

Adams County Community and Economic Development Department
4430 South Adams County Parkway, 3rd Floor, Suite W3000
Brighton, CO 80601

Attn: Emily Collins

Re: Jamaso Natural Gas Pipeline Conditional Use Permit
Case # RCU2018-00032

Public Service Company of Colorado's (PSCo) Right of Way & Permits Referral Desk has reviewed the CUP documentation for **Jamaso Natural Gas Pipeline**. Please be aware PSCo owns and operates existing overhead electric and planned underground electric distribution facilities within various locations of the proposed pipeline route. Bear in mind that per the National Electric Safety Code, a minimum 10-foot radial clearance must be maintained at all times from all overhead electric facilities including, but not limited to, construction activities and permanent structures.

As a safety precaution, PSCo would like to remind the developer to call the **Utility Notification Center** at 1-800-922-1987 to have all utilities located prior to any construction.

Should the project require any modification to existing facilities, the property owner/developer/contractor must complete the **application process** via FastApp-Fax-Email-USPS (go to: https://www.xcelenergy.com/start,_stop,_transfer/new_construction_service_activation_for_builders).

If there are any questions with this referral response, please contact me at 303-571-3306 or donna.l.george@xcelenergy.com.

Donna George
Right of Way and Permits
Public Service Company of Colorado

Community & Economic
Development Department
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
Brighton, CO 80601-8218
PHONE 720.523.6800
FAX 720.523.6967

Request for Comments

Case Name:	Jamasco Pipelines
Case Number:	RCU2018-00032

August 29, 2018

Adams County Planning Commission and Board of County Commissioners are requesting comments on the following:

Conditional Use Permit to allow construction of up to 24-inch natural gas, crude oil, waste-water, and fresh water pipelines, and 6-inch electrical power line for approximately 4.18 miles.

This request is located at **Generally I-70 and Hayesmount Rd. to I-70 and Manilla Rd.**

The Assessor's Parcel Numbers is **Multiple Parcels (see attached)**

Applicant Information **DISCOVERY MIDSTREAM (MATTHEW BERGHORN)**
540 E BRIDGE ST
BRIGHTON, CO 80601

Please forward any written comments on this application to the Department of Community and Economic Development at 4430 South Adams County Parkway, Suite W2000A Brighton, CO 80601-8216. (720) 523-6820 by **September 18, 2018** in order that your comments may be taken into consideration in the review of this case. If you would like your comments included verbatim please send your response by way of e-mail to ECollins@adcogov.org.

Once comments have been received and the staff report written, the staff report and notice of public hearing dates will be forwarded to you for your information. The full text of the proposed request and additional colored maps can be obtained by contacting this office or by accessing the Adams County web site at www.adcogov.org/planning/currentcases.

Thank you for your review of this case.

Emily Collins

Emily Collins, AICP
Case Manager

Community & Economic
Development Department
Development Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
Brighton, CO 80601-8218
PHONE 720.523.6800
FAX 720.523.6967

Public Hearing Notification

Case Name:	JAMASCO PIPELINE PROJECT
Case Number:	RCU2018-00032
Planning Commission Hearing Date:	07/11/2019 at 6:00 p.m.
Board of County Commissioners Hearing Date:	08/06/2019 at 9:30 a.m.

July 1, 2019

A public hearing has been set by the Adams County Planning Commission and the Board of County Commissioners to consider the following request:

Conditional Use Permit to allow construction of up to 24-inch natural gas, crude oil, waste-water, and fresh water pipelines, and 6-inch electrical power line for approximately 4.18 miles.

The proposed use will be Industrial

The Assessor's Parcel Numbers are ; 0181700000082, 0181700000154, 0181731300005, 0181731300006, 0181731300007, 0181900000151, 0181900000152
Applicant Information:

JANICE KINNIN

BRIGHTON, CO 80601

The hearing will be held in the Adams County Hearing Room located at 4430 South Adams County Parkway, Brighton CO 80601-8216. This will be a public hearing and any interested parties may attend and be heard. The Applicant and Representative's presence at these hearings is requested. If you require any special accommodations (e.g., wheelchair accessibility, an interpreter for the hearing impaired, etc.) please contact the Adams County Community and Economic Development Department at (720) 523-6800 (or if this is a long distance call, please use the County's toll free telephone number at 1-800-824-7842) prior to the meeting date.

For further information regarding this case, please contact the Department of Community and Economic Development, 4430 S Adams County Parkway, Brighton, CO 80601, 720-523-6800. This is also the location where maps and/or text certified by the Planning Commission may be viewed.

The full text of the proposed request and additional colored maps can be obtained by contacting this office or by accessing the Adams County web site at www.adcogov.org/planning/currentcases.

Thank you for your review of this case.

Greg Barnes
Planner III

NOTICE OF PUBLIC HEARING FOR LANDUSE

NOTICE IS HEREBY GIVEN, that an application has been filed by **Discovery DJ Services, LCC** Case # **RCU2018-00032** requesting**: Conditional Use Permit to allow construction of up to 24-inch natural gas, crude oil, waste-water, and fresh water pipelines, and 6-inch electrical power line for approximately 4.18 miles** on the following property:

LEGAL DESCRIPTION:

Legal Start and End Points within Adams County:

Beginning Section 33-T3S-R64W, **Ending** Section 34-T3S-R65W

Total Project Length: 4.18 miles

Parcel/Tract Count in Adams County: 12

(**The above legal description was provided by the applicant and Adams County is not responsible for any errors and omissions that may be contained herein and assumes no liability associated with the use or misuse of this legal description.)**

APPROXIMATE LOCATION:

Preferred Alignment	Alternative #1	Alternative #2
0181700000149	0181700000149	0181700000149
0181700000298	0181700000298	0181700000250
0181731300006	0181731300005	0181700000298
0181731300007	0181731300007	0181731300006
0181700000082	0181700000082	0181731300007
0181700000154	0181700000154	0181700000082
0181900000152	0181900000152	0181700000154
0181900000151	0181900000151	0181900000152
0181900000162	0181900000162	0181900000151
0181900000078	0181900000078	0181900000162
0181900000077	0181900000077	0181900000078
0181900000118	0181900000118	0181900000077
		0181900000118

NOTICE IS HEREBY GIVEN that a public hearing will be held by the Adams County Planning Commission in the Hearing Room of the Adams County Government Center, 4430 S. Adams County Parkway, Brighton, CO – 1st Floor, on the **11th day of July, 2019**, at the hour of 6:00 p.m., where and when any person may appear and be heard and a recommendation on this application will be forwarded to the Board of County Commissioners.

NOTICE IS FURTHER GIVEN, that a public hearing will be held by the Adams County Board of County Commissioners in the Hearing Room of the Adams County Government Center, 4430 S. Adams County Parkway, Brighton, CO – 1st Floor, on the **6th day of August, 2019,** at the hour of 9:30 a.m., to consider the above request where and when any person may appear and be heard.

For further information regarding this case, please contact **Greg Barnes** at the Community and Economic Development Department, 4430 S. Adams County Pkwy, Brighton, CO 80601, 720.523.6820. This is also the location where the maps and/or text certified by the Planning Commission may be viewed.

BY ORDER OF THE BOARD OF COUNTY COMMISSIONERS
JOSH ZYGIELBAUM, CLERK OF THE BOARD

TO BE PUBLISHED IN THE July 5, 2019 ISSUE OF THE EASTERN COLORADO NEWS / I-70 SCOUT

Please reply to this message by email to confirm receipt or call **Rayleen Swarts** at 720.523.6830.

Adams County Development Services - Building
Attn: Justin Blair
4430 S Adams County Pkwy
Brighton CO 80601

BENNETT FIRE DISTRICT #7
Attn: CHIEF EARL CUMELY
825 SHARIS CT
BENNETT CO 80102

BENNETT FIRE DISTRICT #7
Attn: Captain Caleb J Connor
825 SHARIS CT
BENNETT CO 80102

BENNETT PARK AND RECREATION
Attn: Chris Raines
PO BOX 379
455 S. 1ST ST.
BENNETT CO 80102-0379

BENNETT SCHOOL DISTRICT 29J
Attn: Robin Purdy
615 7TH ST.
BENNETT CO 80102

BOX ELDER WATER AND SANITATION DISTRICT
Attn: BARBARA VANDER WALL
c/o Collins, Cockrel, & Cole P.C.
390 Union Boulevard, Suite 400
Lakewood CO 80228

Century Link, Inc
Attn: Brandyn Wiedreich
5325 Zuni St, Rm 728
Denver CO 80221

CITY OF AURORA - WATER AND SAN. DEPT.
Attn: PETER BINNEY
15151 E ALAMEDA PKWY #3600
AURORA CO 80012

CITY OF AURORA ATTN: PLANNING DEPARTMENT
Attn: Porter Ingrum
15151 E ALAMEDA PKWY 2ND FLOOR
AURORA CO 80012

Code Compliance Supervisor
Attn: Eric Guenther
eguenther@adcogov.org

COLORADO DIVISION OF WILDLIFE
Attn: Serena Rocksund
6060 BROADWAY
DENVER CO 80216

COLORADO DIVISION OF WILDLIFE
Attn: Eliza Hunholz
Northeast Regional Engineer
6060 BROADWAY
DENVER CO 80216-1000

COMCAST
Attn: JOE LOWE
8490 N UMITILLA ST
FEDERAL HEIGHTS CO 80260

COUNTY ATTORNEY- Email
Attn: Christine Fitch
CFitch@adcogov.org

Engineering Department - ROW
Attn: Transportation Department
PWE - ROW

Engineering Division
Attn: Transportation Department
PWE

ENVIRONMENTAL ANALYST
Attn: Jen Rutter
PLN

METRO WASTEWATER RECLAMATION
Attn: CRAIG SIMMONDS
6450 YORK ST.
DENVER CO 80229

NS - Code Compliance
Attn: Gail Moon
gmoon@adcogov.org

Parks and Open Space Department
Attn: Nathan Mosley
mpedrucci@adcogov.org
aclark@adcogov.org

REGIONAL TRANSPORTATION DIST.
Attn: CHRIS QUINN
1560 BROADWAY SUITE 700
DENVER CO 80202

SHERIFF'S OFFICE: SO-HQ
Attn: MICHAEL McINTOSH
nblair@adcogov.org, aoverton@adcogov.org; mkaiser@adcog
snielson@adcogov.org

Sheriff's Office: SO-SUB
Attn: SCOTT MILLER
TFuller@adcogov.org, smiller@adcogov.org
aoverton@adcogov.org; mkaiser@adcogov.org

TRI-COUNTY HEALTH DEPARTMENT
Attn: MONTE DEATRICH
4201 E. 72ND AVENUE SUITE D
COMMERCE CITY CO 80022

TRI-COUNTY HEALTH DEPARTMENT
Attn: Sheila Lynch
6162 S WILLOW DR, SUITE 100
GREENWOOD VILLAGE CO 80111

Tri-County Health: Mail CHECK to Sheila Lynch
Attn: Tri-County Health
landuse@tchd.org

UNION PACIFIC RAILROAD
Attn: Melissa Meier
280 S 400 W
Salt Lake City UT 84101

UNION PACIFIC RAILROAD
Attn: Jason Mashek
1400 DOUGLAS ST STOP 1690
OMAHA NE 68179

Xcel Energy
Attn: Donna George
1123 W 3rd Ave
DENVER CO 80223

Xcel Energy
Attn: Donna George
1123 W 3rd Ave
DENVER CO 80223

1800 WATKINS ROAD LLC
7268 S TUCSON WAY
CENTENNIAL CO 80112-3920

1950 DENVER AVE LLC
1950 CHAMBERS RD
AURORA CO 80011-4621

AMERICAN STORAGE CENTERS INC
C/O CORNELIA M WHITE
615 E PLATTE AVE
FORT MORGAN CO 80701-3338

BALL JOHN AND
BALL MARY
1981 CLAY ST
WATKINS CO 80137-6817

BONN GEORGE J AND
BONN VELMA
1130 S 97TH STREET
MESA AZ 85208-3116

CASILLAS JESUS AND
CASILLAS TERESA
32721 E COLFAX AVE
WATKINS CO 80137-8700

CITY OF AURORA
15151 E ALAMEDA PARKWAY 5TH FLOOR
AURORA CO 80012

CORDER CASPER I AND
CORDER MARTHA F
1980 CLAY ST
WATKINS CO 80137

CORDER CASPER L AND
CORDER MARTHA F
1980 CLAY ST
WATKINS CO 80137-6817

CORDER CASPER L AND
CORDER MARTHA F
1980 CLAY ST
WATKINS CO 80137

DAVIS HAROLD K AND
DAVIS SHARON A
135 ANDERSON ST
WATKINS CO 80137

ELDRIDGE CLEBERNE D
1595 S TENNYSON ST
DENVER CO 80219-4431

ELRICK DONALD G AND
ELRICK JANICE D
1935 ANDERSON ST
WATKINS CO 80137-6818

GALLEGOS DANIEL J
PO BOX 1366
CHEYENNE WY 82003-1366

GALLEGOS DANIEL J AND
GALLEGOS MARCIA J
PO BOX 1366
CHEYENNE WY 82003-1366

HAWTHORNE FAMILY LIMITED
PARTNERSHIP LTD
2126 CO RD S
WIGGINS CO 80654-9010

HEIN DUSTON
12991 N SIERRA CIR
PARKER CO 80138-8731

LARATO URSULA ELEANOR
96 LOOKOUT MOUNTAIN RD
GOLDEN CO 80401-9517

MK LLLP
1600 N HUDSON RD
WATKINS CO 80137-6800

MOENCH RONALD F AND
MOENCH KELLY M
32555 FRONT ST N
WATKINS CO 80137-6711

NICHOLS JULIETTE
C/O TRUST DIVISION UNITED
PO BOX 1059
CLARKSDALE MS 38614-1059

O NEILL CATHY
45700 US HIGHWAY 36
BENNETT CO 80102-8629

O NEILL PHILIP AND
O NEILL CATHY
PO BOX 486
WATKINS CO 80137-0486

POWELL PROFESSIONAL PARTNERSHIP
2759 CASTLE CREST DRIVE
CASTLE ROCK CO 80104

PRAIRIE VIEW PROPERTY
OWNERS ASSOCIATION
PO BOX 96
WATKINS CO 80137-0096

PRICE THOMAS R J ET ALS
770 IOWA AVE
STRATTON CO 80836-1327

PROSPER FARMS INVESTMENTS LLC
5641 BROADWAY
DENVER CO 80216-1021

RANDALL INVESTMENTS
9888 WHISTLING ELK DRIVE
LITTLETON CO 80127

SALAS JUAN M AND
TELLEZ JAILENE
1950 GILMORE ST
WATKINS CO 80137-6811

SCHAT DENNIS
1950 DENVER RD
WATKINS CO 80137

SUN DEVELOPMENT LP
C/O PETROLEUM WHLSALE /JENNIFER ARNOLD
PO BOX 4456
HOUSTON TX 77210

SUNGWOO INC
32691 E COLFAX AVE
WATKINS CO 80137-8727

WATKINS ELEVATOR INC
PO BOX 72
WATKINS CO 80137

WATKINS HOSPITALITY LLC
10 E 120TH AVE
NORTHGLENN CO 80233-1002

WESTERN TRANSPORT LLC UND 58.76% AND TREE TO
P LP AND
LP UND 21.24% AND COLORADO MAVERICK COMPANY
LLC UND 20%
625 E MAIN ST STE 1028-303
ASPEN CO 81611-1935

WHITE FAMILY REVOCABLE TRUST
C/O CORNELIA M WHITE
615 E PLATTE AVE
FORT MORGAN CO 80701-3338

WILSON ELIZABETH
PO BOX 268
WATKINS CO 80137-0268

WILSON ELIZABETH A
PO BOX 268
WATKINS CO 80137-0268

WINDER TALLON
1931 GILMORE ST
WATKINS CO 80137-6811

WRIGHT THOMAS W JR AND
WRIGHT LAWRENCE D
2030 WATKINS ROAD
WATKINS CO 80137

YOUNG FREDRIC WATSON
C/O CORNELIA M WHITE
615 E PLATTE AVE
FORT MORGAN CO 80701-3338

WINDER TALLON
OR CURRENT RESIDENT
1931 GILMORE ST
WATKINS CO 80137-6811

YOUNG WILLIAM A/MADELINE S AS
TRUSTEES OF W A YOUNG FAM TRS
615 E PLATTE AVE
FORT MORGAN CO 80701

CURRENT RESIDENT
33355 E COLFAX AVE
WATKINS CO 80137-6732

CASILLAS JESUS AND
CASILLAS TERESA
OR CURRENT RESIDENT
32721 E COLFAX AVE
WATKINS CO 80137-8700

CURRENT RESIDENT
32845 E COLFAX AVE
WATKINS CO 80137-6736

ELRICK DONALD AND
ELRICK JANICE
OR CURRENT RESIDENT
1935 ANDERSON ST
WATKINS CO 80137-6818

CURRENT RESIDENT
2030 N WATKINS RD
WATKINS CO 80137-6810

FERRELL JAMES E AND
FERRELL FRANCES LYNN
OR CURRENT RESIDENT
1980 GILMORE ST
WATKINS CO 80137-6811

CURRENT RESIDENT
1965 ANDERSON ST
WATKINS CO 80137-6818

MC CARTHY PATRICK J AND
MC CARTHY GLORIA J
OR CURRENT RESIDENT
31815 E 2ND COURT
WATKINS CO 80137

CURRENT RESIDENT
32555 E FRONT ST N
WATKINS CO 80137-6819

NUNEZ ABEL AND
NUNEZ VERONICA
OR CURRENT RESIDENT
2100 N WATKINS RD
WATKINS CO 80137-6804

CURRENT RESIDENT
32820 E FRONT ST S
WATKINS CO 80137-7178

SALAS JUAN M AND
TELLEZ JAILENE
OR CURRENT RESIDENT
1950 GILMORE ST
WATKINS CO 80137-6811

CURRENT RESIDENT
1800 N WATKINS RD
WATKINS CO 80137-7182

SUGAR MARK L AND SUGAR TRACY B
OR CURRENT RESIDENT
1991 GILMORE ST
WATKINS CO 80137-6811

CURRENT RESIDENT
32781 E COLFAX AVE
WATKINS CO 80137-8700

SUNGWOO INC
OR CURRENT RESIDENT
32691 E COLFAX AVE
WATKINS CO 80137-8727

CURRENT RESIDENT
32681 E COLFAX AVE
WATKINS CO 80137-8727

CERTIFICATE OF POSTING

I, J. Gregory Barnes do hereby certify that Adams County staff posted the property at subject property on June 25, 2019 in accordance with the requirements of the Adams County Zoning Regulations.

J. Gregory Barnes

Jamaso Pipeline

RCU2018-00032

August 6, 2019

Board of County Commissioners Public Hearing

Community and Economic Development Department

Case Manager: Greg Barnes

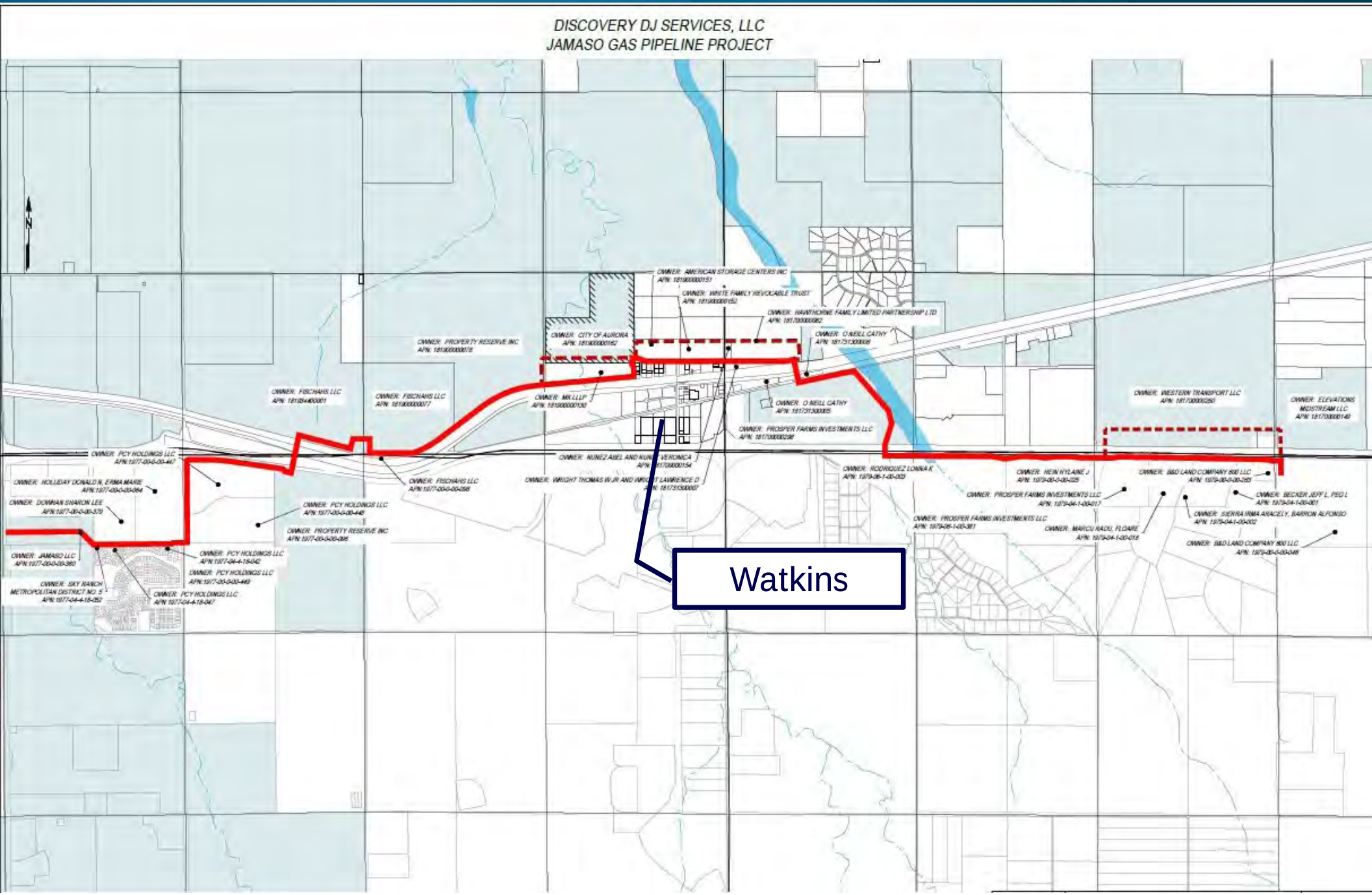
Requests

- A conditional use permit to allow portions of the following pipelines:
  - 24” natural gas
  - 24” crude oil
  - 24” wastewater
  - 24” fresh water
  - 6” electrical power line
- Development Agreement

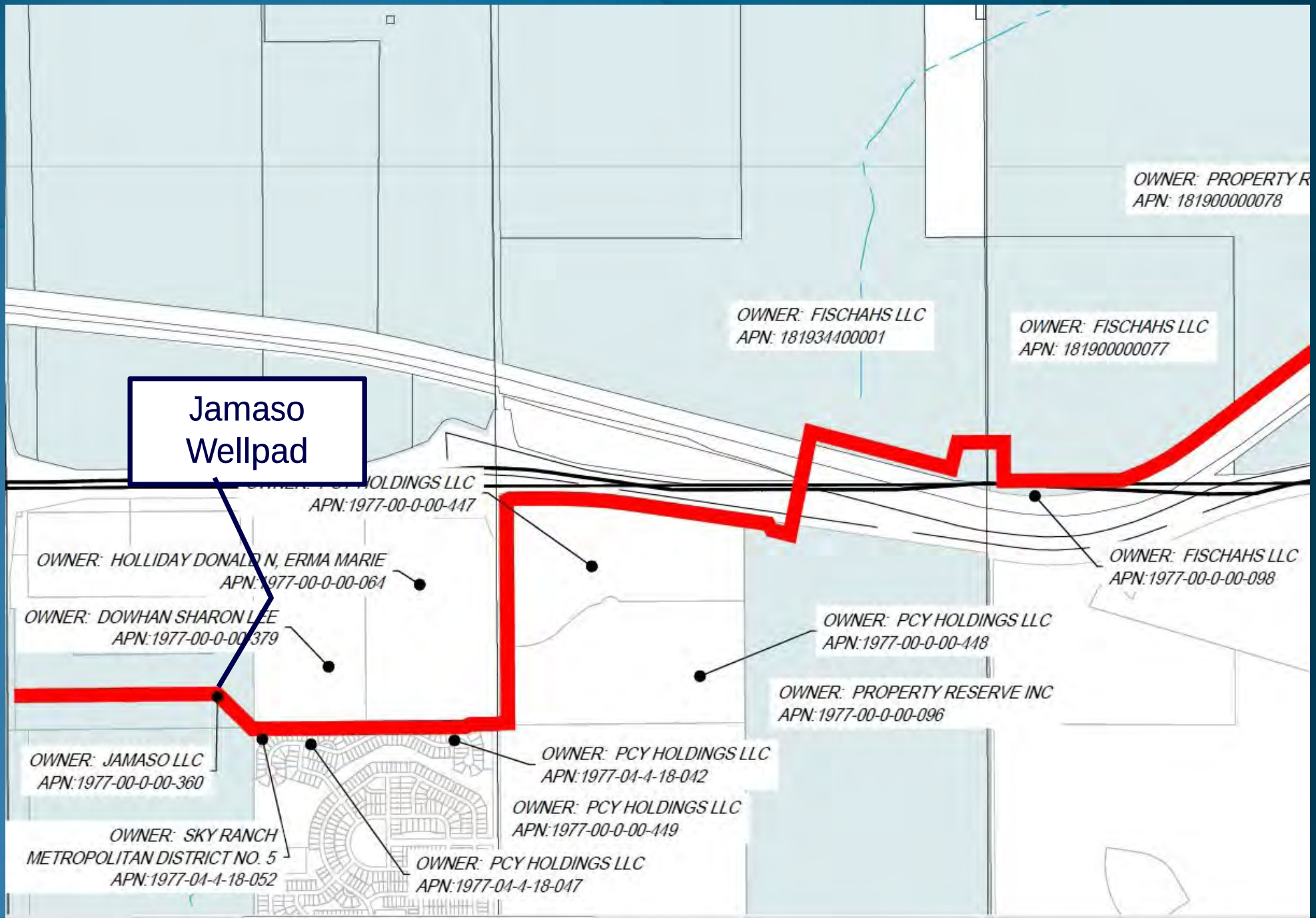
Background

- Increase in oil and gas production throughout State
- Lack of infrastructure (pipelines) to support new wellpads
- Existing infrastructure nearing or at capacity
- Pipelines reduce truck transportation from wellpads to refineries

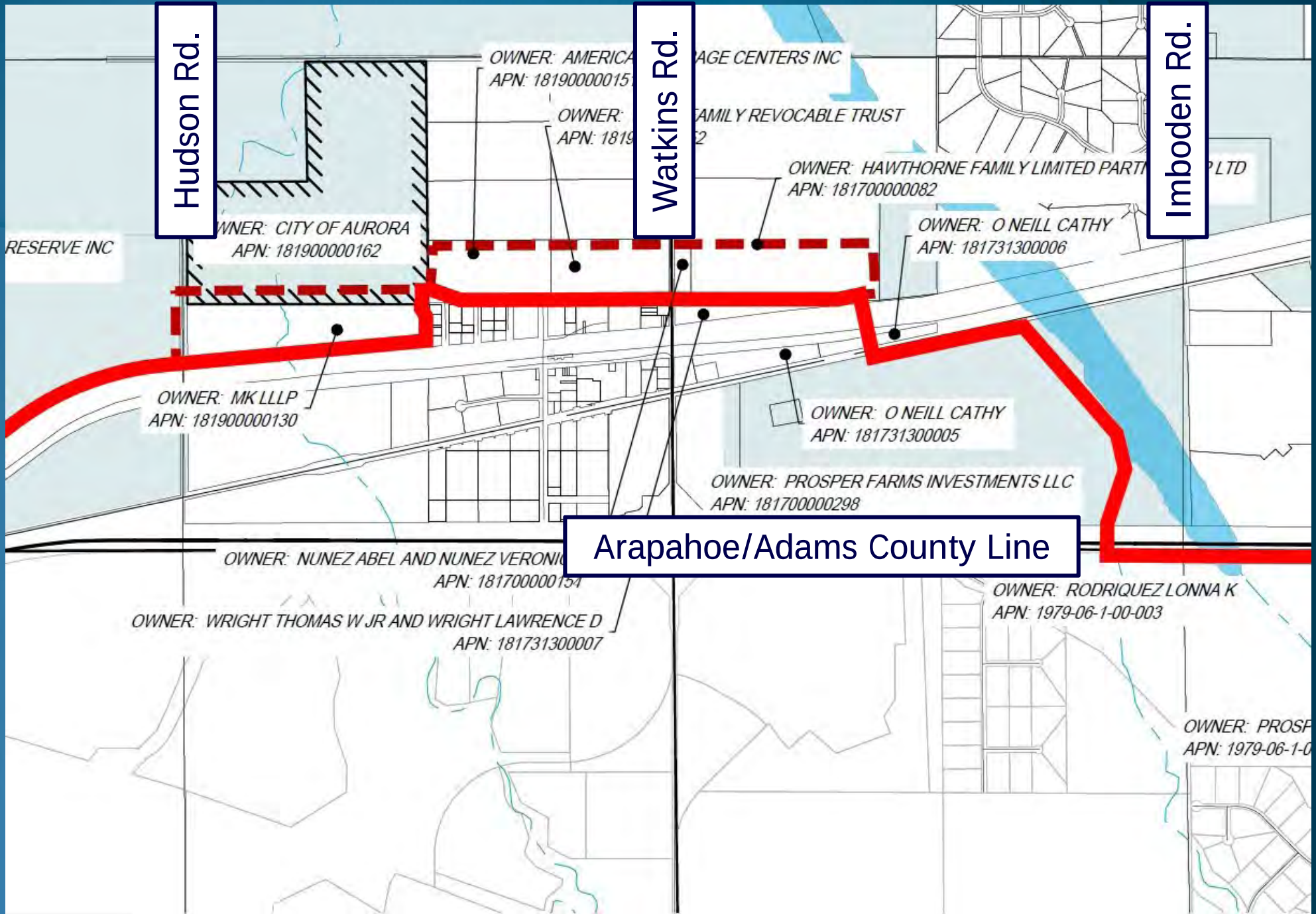
Pipeline Route



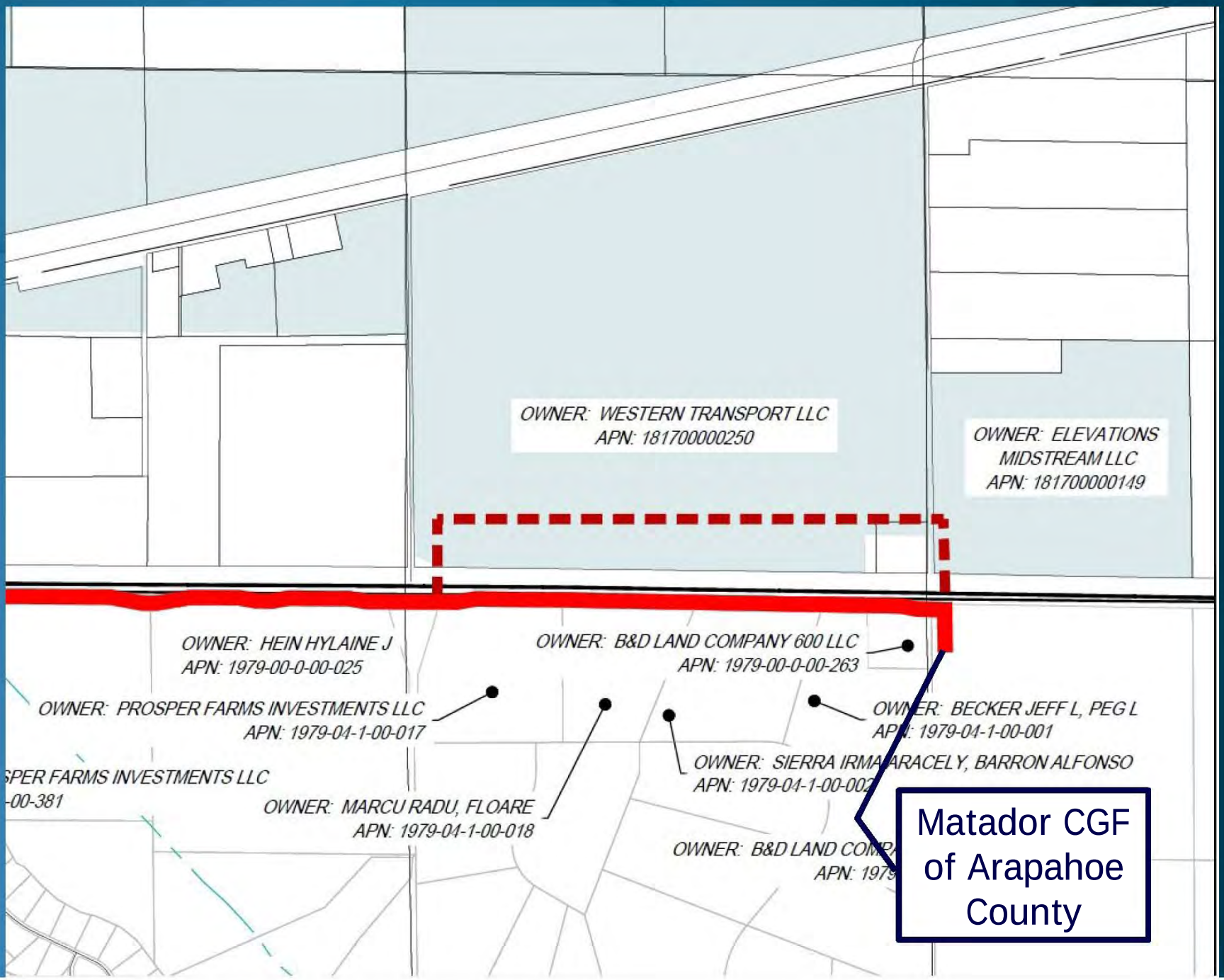
Pipeline Route



Pipeline Route



Pipeline Route



Criteria for Conditional Use

Section 2-02-08-06

1. Permitted in zone district
2. Consistent with regulations
3. Comply with performance standards
4. Harmonious & compatible
5. Addressed all off-site impacts
6. Site suitable for use
7. Site plan adequate for use
8. Adequate services

Areas and Activities of State Interest

Section 6-07-02

- The project, including at least 3 alternatives
- Property rights, permits, and other approvals
- Financial feasibility of the project
- Land use
- Recreational opportunities
- Environmental impact analysis

Development Agreement

- Pre-Construction:
  - Submit plans for review and approval
  - Stormwater BMPs
  - Traffic control plans
- Construction:
  - 6 AM to 6 PM Monday through Saturday
  - Responsible for roadway cleanliness adjacent to project
  - Comply with Tri-County recommendations
- Post-Construction:
  - Restore any disturbed lands
  - Submit “as-built” plans within 120 days
  - Submit emergency response plan

Other Information

- Easement Width:
  - 30’ Temporary
  - 50’ Permanent
- Pipeline Depth:
  - Varies from 3-10’
- Unincorporated Adams County Right-of-Way Crossings:
  - Only Watkins Road

Referral Comments

- Comments:
  - CDOT: permit for construction in state-maintained rights-of-way
  - Tri-County: identify all wells and septic areas
  - Xcel: transmission lines
- No concerns:
  - Union Pacific Railroad
- Property Owners and Residents within 1,000 ft:

Notifications Sent	Comments Received
60	0

Summary of Analysis

- Harmonious & compatible
- Addressed all off-site impacts
- Site suitable for use
- Not detrimental to health, safety, welfare
- Best alternative to minimize impacts
- Minimal noise, odor, dust, traffic

Planning Commission Update

Public Hearing: July 11, 2019

No members of the public testified

Recommendation

RCU2018-00032 Jamaso Pipeline

Approval based on 33 Findings-of- Fact and 1 condition.

Recommended Condition

1. The applicant shall comply with all terms and conditions of the Development Agreement between Rocky Mountain Midstream, LLC and Adams County.