Board of County Commissioners

Eva J. Henry - District #1
Charles "Chaz" Tedesco - District #2
Erik Hansen - 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
July 17, 2018
9:30 AM

1. **ROLL CALL**

2. **PLEDGE OF ALLEGIANCE**

3. **MOTION TO APPROVE AGENDA**

4. **AWARDS AND PRESENTATIONS**

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 2-6, 2018

   B. Minutes of the Commissioners' Proceedings from July 10, 2018

   C. Resolution Approving the Agreement Regarding Final Design, Right-of-Way Acquisition, and Construction of Drainage and Flood Control Improvements for Clear Creek at BNSF Crossing between Pecos and Federal Boulevard Adams County (Agreement No. 18-04.06) between Adams County and Urban Drainage Flood Control District
   (File approved by ELT)

D. Resolution Approving the Agreement between Adams County and Adams 12 Five Star Schools to Provide Health First Colorado Application Processing at Adams 12 Five Star Schools
(File approved by ELT)

E. Resolution Approving the Adams County Head Start Year Four of Five Continuation Grant Application for 2018 - 2019
(File approved by ELT)

F. Resolution Approving the 2018 Community Services Block Grant Subgrantee Contract Amendment between Adams County and Almost Home
(File approved by ELT)

G. Resolution Approving the 2018 Community Services Block Grant Subgrantee Contract Amendment between Adams County and Project Angel Heart
(File approved by ELT)

H. Resolution Approving Amendment No. 4 to the Unum Life Insurance Policy
(File approved by ELT)

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

J. Resolution Approving Amendments to Adams County's Contracts with United Healthcare Services, Inc.
(File approved by ELT)

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

7. NEW BUSINESS

A. COUNTY MANAGER

1. Resolution Approving Amendment One to the Agreement between Adams County and W.L. Contractors Inc., to Provide Traffic Signal Maintenance and Emergency Repair Services
(File approved by ELT)

B. COUNTY ATTORNEY

8. Motion to Adjourn into Executive Session Pursuant to C.R.S. 24-6-402(4)(b) for the Purpose of Receiving Legal Advice Regarding Unauthorized Inhabitation of Public and Private Spaces

9. LAND USE HEARINGS

A. Cases to be Heard

1. PLT2017-00019 Comanche Vista Estates, Filing 5
(File approved by ELT)

2. RCU2017-00042 Verizon Hailstorm Tower
(File approved by ELT)

10. ADJOURNMENT

AND SUCH OTHER MATTERS OF PUBLIC BUSINESS WHICH MAY ARISE

County of Adams

Net Warrant by Fund Summary

Fund Number	Fund Description	Amount
1	General Fund	825,800.95
5	Golf Course Enterprise Fund	13,906.77
6	Equipment Service Fund	89,832.72
7	Stormwater Utility Fund	3,268.73
13	Road & Bridge Fund	12,251.22
19	Insurance Fund	11,005.75
30	Community Dev Block Grant Fund	23.08
31	Head Start Fund	3,236.55
35	Workforce & Business Center	40.00
43	Front Range Airport	775.38
50	FLATROCK Facility Fund	1,430.24
94	Sheriff Payables	14,790.50
		976,361.89

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725386	91631	ADAMSON POLICE PRODUCTS	07/03/18	4,454.35
00725387	33944	B C INTERIORS	07/03/18	40.00
00725388	624135	BOWMAN LORI	07/03/18	59.95
00725390	28303	CENTURA HEALTH	07/03/18	600.00
00725392	327914	CESCO LINGUISTIC SERVICE INC	07/03/18	1,122.48
00725394	7612	COLO SUPREME COURT	07/03/18	50.00
00725395	252174	COLORADO COMMUNITY MEDIA	07/03/18	20.48
00725397	4258	CONNOLLY'S TOWING	07/03/18	175.00
00725398	561841	DOUGLASS TAYLER	07/03/18	32.05
00725399	248103	DS WATERS OF AMERICA INC	07/03/18	1,547.63
00725400	13136	EMPLOYERS COUNCIL SERVICES INC	07/03/18	130.00
00725401	346534	FIRST CHOICE COFFEE SERVICES	07/03/18	291.85
00725402	12689	GALLS LLC	07/03/18	3,985.54
00725403	32276	INSIGHT PUBLIC SECTOR	07/03/18	129,652.66
00725404	62147	LAUGHERY PATSY	07/03/18	11.34
00725405	36861	LEXIS NEXIS MATTHEW BENDER	07/03/18	2,072.99
00725406	514476	LOPILATO REGINA	07/03/18	155.00
00725407	488944	MAIL MASTERS OF COLORADO	07/03/18	2,475.67
00725409	506542	MLADENOV INNA	07/03/18	78.53
00725411	725603	MURPHY DUFFY D	07/03/18	80.52
00725412	38079	PASQUALI AIDA E	07/03/18	14.28
00725413	176327	PITNEY BOWES	07/03/18	1,308.09
00725414	20607	ROBERTS LISA D	07/03/18	47.93
00725416	37110	SB PORTA BOWL RESTROOMS INC	07/03/18	165.00
00725417	13538	SHRED IT USA LLC	07/03/18	218.40
00725419	618144	T&G PECOS LLC	07/03/18	1,800.00
00725420	725336	US CORRECTIONS LLC	07/03/18	782.00
00725421	272242	WESTERN STATES PROJECT	07/03/18	250.00
00725422	24560	WIRELESS ADVANCED COMMUNICATIO	07/03/18	160.00
00725423	579705	WROBLEWSKI GREG	07/03/18	216.00
00725487	4936	ADAMS COUNTY ECONOMIC DEVELOP	07/05/18	131,516.00
00725488	334777	ALLEN DEBRA JEAN	07/05/18	133.53
00725489	689589	ALPHA INSULATION & WATERPROOFI	07/05/18	19,488.00
00725490	725689	ALVAREZ ROBERT DANIEL	07/05/18	19.00
00725491	725690	ATTORNEY GENERAL OF SOUTH DAKO	07/05/18	19.00
00725492	304120	BACA GREG	07/05/18	209.00

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725493	725692	BONINA AND BONINA	07/05/18	19.00
00725494	725696	BRUNS MICHELLE	07/05/18	19.00
00725495	725697	BUTLER ROSEMARY	07/05/18	19.00
00725496	725804	CANO MARTIN	07/05/18	400.00
00725500	40398	CINTAS CORPORATION #66	07/05/18	141.80
00725501	625677	CODE 4 SECURITY SERVICES LLC	07/05/18	160.00
00725502	612089	COMMERCIAL CLEANING SYSTEMS	07/05/18	3,297.65
00725504	725698	CRITELLI JOSEPH S	07/05/18	19.00
00725505	725699	DAVI NAILS SALON AND SPA	07/05/18	19.00
00725506	725700	DENALI LAW FIRM	07/05/18	38.00
00725507	519505	DENOVO VENTURES LLC	07/05/18	1,487.50
00725508	13377	DENVER REGIONAL COUNCIL OF	07/05/18	54,700.00
00725511	248103	DS WATERS OF AMERICA INC	07/05/18	84.10
00725512	725701	ELIAS LAW	07/05/18	19.00
00725513	703433	EZ MESSENGER	07/05/18	38.00
00725514	725739	EZ MESSENGER	07/05/18	5.00
00725515	24524	E470 PUBLIC HIGHWAY AUTHORITY	07/05/18	232.80
00725517	346534	FIRST CHOICE COFFEE SERVICES	07/05/18	31.70
00725519	725702	FORTNA VALERIE ANNETTE	07/05/18	19.00
00725520	725607	FUENTES ALEJANDRA	07/05/18	981.00
00725521	289637	GENERAL NETWORKS	07/05/18	74.10
00725522	725703	GREGORIO TROY	07/05/18	19.00
00725523	725704	HALSTEAD LAW	07/05/18	74.00
00725524	725705	HARTWICK DANIEL E	07/05/18	19.00
00725525	699829	HILL'S PET NUTRITION SALES INC	07/05/18	330.00
00725526	79260	IDEXX DISTRIBUTION INC	07/05/18	188.85
00725527	725706	ISMAIL HANDRIN SALAH	07/05/18	19.00
00725528	725707	JOYCE CHRISTAN N	07/05/18	19.00
00725529	39055	JUNDA GRAPHICS	07/05/18	400.00
00725530	725709	KLINE CHRISTIANA	07/05/18	19.00
00725531	725710	LAND NATALIE	07/05/18	19.00
00725532	40843	LANGUAGE LINE SERVICES	07/05/18	574.82
00725533	725711	LAW OFFICE OF LEEANNE QUATTRUC	07/05/18	19.00
00725534	238225	LINKEDIN.COM	07/05/18	3,543.75
00725535	725798	LY JENIFER	07/05/18	400.00
00725536	725712	MANHATTAN FUND XXI LLC	07/05/18	66.00

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725537	725713	MARTINEZ BREANNA	07/05/18	19.00
00725538	725714	MARTINEZ BREANNA JENAE	07/05/18	19.00
00725539	13688	METRONORTH CHAMBER OF COMMERCE	07/05/18	1,250.00
00725540	13591	MWI VETERINARY SUPPLY CO	07/05/18	3,546.87
00725541	725715	NAJERA GENEVIEVE RENEE	07/05/18	19.00
00725542	725716	NELSON PAMELA SALAPICH	07/05/18	19.00
00725543	725717	NEWBOLD CHAPMAN AND GEYER	07/05/18	19.00
00725545	13422	NORTHGLENN AMBULANCE	07/05/18	627.90
00725547	725718	OLIMON BERUMEN ARGENTINA	07/05/18	19.00
00725549	282112	ORACLE AMERICA INC	07/05/18	38,297.40
00725550	725720	PACHECO ROBERT	07/05/18	19.00
00725551	725721	PALACIOS LEOBARDO PRADO ERIKA	07/05/18	19.00
00725552	669732	PATTERSON VETERINARY SUPPLY IN	07/05/18	902.00
00725553	725722	PIPPIN SLATE ALEXANDER	07/05/18	41.16
00725554	725723	PORTALES ROBERTO E C	07/05/18	147.00
00725556	378028	PROCESS SERVICE OF WYOMING INC	07/05/18	57.00
00725557	16377	PROFESSIONAL FINANCE CO	07/05/18	19.00
00725559	308437	RANDSTAD US LP	07/05/18	1,394.04
00725560	725794	REID KIMBERLY	07/05/18	400.00
00725561	726282	ROCCO LEON	07/05/18	10.00
00725562	725725	ROMERO AMY LYN	07/05/18	19.00
00725564	145355	SANITY SOLUTIONS INC	07/05/18	49,853.70
00725566	13538	SHRED IT USA LLC	07/05/18	299.41
00725568	243343	STENGER AND STENGER	07/05/18	57.00
00725569	226116	STUTZMAN DEBORAH	07/05/18	47.60
00725570	76394	SYMBOL ARTS	07/05/18	810.00
00725571	620851	TERAN KELLY	07/05/18	150.00
00725572	725802	THAO SHOUA	07/05/18	400.00
00725573	41127	THYSSENKRUPP ELEVATOR CORP	07/05/18	6,514.25
00725575	37005	TOSHIBA BUSINESS SOLUTIONS	07/05/18	1,925.66
00725586	725803	VILLALOBOS KARINA	07/05/18	400.00
00725587	1574	WEST ADAMS SOIL CONSERVATION	07/05/18	400.00
00725588	18645	WILBUR-ELLIS COMPANY LLC	07/05/18	4,572.20
00725590	725797	XIONG CATALINA	07/05/18	650.00
00725591	91631	ADAMSON POLICE PRODUCTS	07/06/18	605.00
00725592	45983	AGREN BLANDO COURT REPORTING	07/06/18	1,148.10

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725593	383698	ALLIED UNIVERSAL SECURITY SERV	07/06/18	20,430.46
00725594	630098	BUA RICHARD	07/06/18	56.57
00725595	323020	BULLOCK RACHEL	07/06/18	50.90
00725596	40398	CINTAS CORPORATION #66	07/06/18	142.23
00725597	612089	COMMERCIAL CLEANING SYSTEMS	07/06/18	75,808.43
00725598	61609	DAVIS GRAHAM & STUBBS LLP	07/06/18	1,852.50
00725599	38011	DERBY INDUSTRIES	07/06/18	3,956.62
00725600	671123	FOUND MY KEYS	07/06/18	980.00
00725601	48462	G-DERBY PROMOTIONS	07/06/18	8,400.00
00725602	48462	G-DERBY PROMOTIONS	07/06/18	25,000.00
00725603	726561	GALLEGOS JESSICA	07/06/18	24.20
00725604	12689	GALLS LLC	07/06/18	16,199.15
00725605	726557	HALL KRISTEN J	07/06/18	28.50
00725606	79260	IDEXX DISTRIBUTION INC	07/06/18	1,885.23
00725607	5814	I70 SCOUT THE	07/06/18	14.40
00725608	5814	I70 SCOUT THE	07/06/18	15.36
00725609	62528	JEFFERSON COUNTY SHERIFF'S CIV	07/06/18	43.50
00725610	726880	KANE SUE	07/06/18	541.42
00725611	77611	KD SERVICE GROUP	07/06/18	386.12
00725613	597186	MICHELSON FOUND ANIMALS FOUNDA	07/06/18	1,759.16
00725614	93018	MURPHY RICK	07/06/18	3,664.92
00725615	13591	MWI VETERINARY SUPPLY CO	07/06/18	2,379.43
00725616	276363	OKADA DAVID	07/06/18	177.34
00725617	720230	PHILLIPS PET FOOD & SUPPLIES	07/06/18	359.00
00725618	48059	RADIO RESOURCE INC	07/06/18	78.00
00725619	26297	SENIORS RESOURCE CENTER INC	07/06/18	175,116.03
00725620	369655	TORGERSEN BETH	07/06/18	212.55
00725621	666214	TYGRETT DEBRA R	07/06/18	188.00
00725628	338508	WRIGHTWAY INDUSTRIES INC	07/06/18	457.30
			Fund Total	**825,800.95**

5 Golf Course Enterprise Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725622	1007	UNITED POWER (UNION REA)	07/06/18	41.32
00725623	1007	UNITED POWER (UNION REA)	07/06/18	1,043.26
00725624	1007	UNITED POWER (UNION REA)	07/06/18	339.43
00725625	1007	UNITED POWER (UNION REA)	07/06/18	4,001.29
00725626	1007	UNITED POWER (UNION REA)	07/06/18	7,968.84
00725629	13822	XCEL ENERGY	07/06/18	125.01
00725630	13822	XCEL ENERGY	07/06/18	387.62
			Fund Total	**13,906.77**

6 Equipment Service Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725485	11657	A & E TIRE INC	07/05/18	4,770.63
00725486	295403	ABRA AUTO BODY & GLASS	07/05/18	1,821.20
00725509	37242	DIETRICH HERMAN A	07/05/18	277.73
00725516	346750	FACTORY MOTOR PARTS	07/05/18	7,526.00
00725544	7983	NORSTAR INDUSTRIES	07/05/18	44,565.00
00725555	324769	PRECISE MRM LLC	07/05/18	5,208.00
00725563	16237	SAM HILL OIL INC	07/05/18	22,694.78
00725567	714682	SMITH JAVON D	07/05/18	354.39
00725627	350373	WEX BANK	07/06/18	2,614.99
			Fund Total	**89,832.72**

7 Stormwater Utility Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725359	403701	ANDERSON JENNIFER	07/02/18	49.41
00725360	393743	BEACH KEITH L AND	07/02/18	40.37
00725361	394780	BEDNAR KENNETH L	07/02/18	63.86
00725362	388387	BLEA MILDRED L AND	07/02/18	58.59
00725363	394180	BRUNEMEIER KENNETH E AND	07/02/18	10.00
00725364	392566	DELEON ALFRED J	07/02/18	83.00
00725365	401810	ESTRADA IRIGOYEN RUBEN AND	07/02/18	58.12
00725366	479696	FOSTER REGAN M AND	07/02/18	70.08
00725367	693392	GALLEGOS REINALDO E AND GALLEG	07/02/18	83.00
00725368	403457	GENDRON PHILLIP A	07/02/18	25.25
00725369	394499	HOLLOWAY ROBERT J	07/02/18	34.15
00725370	389530	JIRON JOHN D AND	07/02/18	27.16
00725371	397217	KING TIMOTHY C	07/02/18	10.00
00725372	393185	LEMMERMAN MABEL RAYNELL	07/02/18	72.25
00725373	403118	LUCERO TRACY L AND	07/02/18	21.42
00725374	480754	MARES GREGORY T AND	07/02/18	34.06
00725375	410256	MARTINEZ EPIFENIO AND	07/02/18	278.99
00725376	691372	MIDTOWN RESIDENTIAL LLC	07/02/18	51.19
00725377	691461	MIDTOWN RESIDENTIAL LLC	07/02/18	117.93
00725378	394470	MIRESKANDARI ANDY	07/02/18	1,805.16
00725379	586136	NGO DIEU AND TRAN BINH AND	07/02/18	19.51
00725380	691487	PECOS PLACE BUILDERS LLC	07/02/18	77.04
00725381	481190	PEREZ-GUTIERREZ JUAN	07/02/18	10.00
00725382	395199	RICHARDS LARRY A AND	07/02/18	15.77
00725383	409832	RODRIGUEZ FLORENCIO SAENZ AND	07/02/18	42.13
00725384	692164	URIBE ANTONIO AND	07/02/18	83.00
00725385	408174	WILLIS EUGENE A AND	07/02/18	27.29
			Fund Total	**3,268.73**

13 Road & Bridge Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725358	725691	HARICK INC	07/02/18	2,006.00
00725410	688102	MOSKOWITZ MARK	07/03/18	17.60
00725418	725771	STALEY BRIAN	07/03/18	135.00
00725510	128693	DREXEL BARRELL & CO	07/05/18	6,647.84
00725576	1007	UNITED POWER (UNION REA)	07/05/18	23.16
00725577	1007	UNITED POWER (UNION REA)	07/05/18	48.84
00725578	1007	UNITED POWER (UNION REA)	07/05/18	34.00
00725579	1007	UNITED POWER (UNION REA)	07/05/18	78.12
00725580	1007	UNITED POWER (UNION REA)	07/05/18	36.00
00725581	1007	UNITED POWER (UNION REA)	07/05/18	102.69
00725582	1007	UNITED POWER (UNION REA)	07/05/18	34.46
00725583	1007	UNITED POWER (UNION REA)	07/05/18	135.12
00725584	1007	UNITED POWER (UNION REA)	07/05/18	16.50
00725585	1007	UNITED POWER (UNION REA)	07/05/18	48.84
00725589	13822	XCEL ENERGY	07/05/18	45.05
00725612	51500	MERRICK & COMPANY	07/06/18	2,842.00
			Fund Total	**12,251.22**

19 Insurance Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725408	725770	MEDINA MAXINE	07/03/18	1,170.75
00725518	182042	FIT SOLDIERS FITNESS BOOT CAMP	07/05/18	4,165.00
00725565	255505	SHERMAN & HOWARD LLC	07/05/18	5,670.00
			Fund Total	**11,005.75**

30 Community Dev Block Grant Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725396	252174	COLORADO COMMUNITY MEDIA	07/03/18	23.08
			Fund Total	**23.08**

31 Head Start Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725497	37266	CENTURY LINK	07/05/18	352.09
00725498	37266	CENTURY LINK	07/05/18	96.96
00725499	152461	CENTURYLINK	07/05/18	10.86
00725546	55021	NULINX INTERNATIONAL	07/05/18	2,385.00
00725548	371505	OLIVER LESLIE	07/05/18	96.64
00725558	129209	RAMIREZ SUSANA	07/05/18	295.00
			Fund Total	**3,236.55**

35 Workforce & Business Center

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725389	591794	BREEDLOVE XAVIER	07/03/18	40.00
			Fund Total	**40.00**

43 Front Range Airport

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725391	80257	CENTURYLINK	07/03/18	315.38
00725415	366395	RUPPEL DAVID	07/03/18	160.00
00725574	41127	THYSSENKRUPP ELEVATOR CORP	07/05/18	300.00
			Fund Total	**775.38**

50 FLATROCK Facility Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725503	612089	COMMERCIAL CLEANING SYSTEMS	07/05/18	1,430.24
			Fund Total	**1,430.24**

94 **Sheriff Payables**

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00725393	33480	COLO BUREAU OF INVESTIGATION	07/03/18	14,790.50
			Fund Total	**14,790.50**

Grand Total	**976,361.89**

4302	Airport Administration	Fund	Voucher	Batch No	GL Date	Amount
	Telephone					
	CENTURYLINK	00043	930055	311157	06/29/18	47.40
					Account Total	47.40
	Travel & Transportation					
	RUPPEL DAVID	00043	930021	311119	06/29/18	160.00
					Account Total	160.00
					Department Total	207.40

4308	Airport ATCT	Fund	Voucher	Batch No	GL Date	Amount
	Telephone					
	CENTURYLINK	00043	930055	311157	06/29/18	49.79
	CENTURYLINK	00043	930055	311157	06/29/18	120.51
					Account Total	170.30
					Department Total	170.30

4303	Airport FBO	Fund	Voucher	Batch No	GL Date	Amount
	Telephone					
	CENTURYLINK	00043	930055	311157	06/29/18	49.98
					Account Total	49.98
					Department Total	49.98

2051	ANS - Administration	Fund	Voucher	Batch No	GL Date	Amount
	Animal Control/Shelter					
	ROCCO LEON	00001	930288	311428	07/03/18	10.00
					Account Total	10.00
					Department Total	10.00

1011	Board of County Commissioners	Fund	Voucher	Batch No	GL Date	Amount
	Legal Notices					
	COLORADO COMMUNITY MEDIA	00001	930064	311172	06/29/18	20.48
					Account Total	20.48
					Department Total	20.48

3064	Building Safety	Fund	Voucher	Batch No	GL Date	Amount
	Travel & Transportation					
	LOPILATO REGINA	00001	930022	311119	06/29/18	155.00
	WROBLEWSKI GREG	00001	930020	311119	06/29/18	216.00
					Account Total	371.00
					Department Total	371.00

9275	Community Corrections	Fund	Voucher	Batch No	GL Date	Amount
	Mileage Reimbursements					
	BULLOCK RACHEL	00001	930473	311685	07/06/18	50.90
	STUTZMAN DEBORAH	00001	930291	311428	07/03/18	47.60
	TORGERSEN BETH	00001	930472	311685	07/06/18	212.55
					Account Total	311.05
					Department Total	311.05

1033	Community Transit	Fund	Voucher	Batch No	GL Date	Amount
	Community Transit Services					
	SENIORS RESOURCE CENTER INC	00001	930467	311685	07/06/18	39,332.81
	SENIORS RESOURCE CENTER INC	00001	930468	311685	07/06/18	43,013.94
	SENIORS RESOURCE CENTER INC	00001	930470	311685	07/06/18	47,036.47
	SENIORS RESOURCE CENTER INC	00001	930471	311685	07/06/18	45,732.81
					Account Total	175,116.03
					Department Total	175,116.03

1041	County Assessor	Fund	Voucher	Batch No	GL Date	Amount
	Printing External					
	MAIL MASTERS OF COLORADO	00001	930025	311142	06/29/18	2,475.67
					Account Total	2,475.67
	Special Events					
	ROBERTS LISA D	00001	930026	311142	06/29/18	47.93
					Account Total	47.93
					Department Total	2,523.60

1013	County Attorney	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	AGREN BLANDO COURT REPORTING	00001	930166	311228	06/29/18	684.60
	AGREN BLANDO COURT REPORTING	00001	930167	311228	06/29/18	463.50
	I70 SCOUT THE	00001	930169	311228	06/29/18	14.40
	I70 SCOUT THE	00001	930170	311228	06/29/18	15.36
	JEFFERSON COUNTY SHERIFF'S CIV	00001	930168	311228	06/29/18	43.50
					Account Total	1,221.36
					Department Total	1,221.36

1052	Criminal Justice Coord Council	Fund	Voucher	Batch No	GL Date	Amount
	Mileage Reimbursements					
	ALLEN DEBRA JEAN	00001	929917	311008	06/28/18	133.53
					Account Total	133.53
					Department Total	133.53

941017	CDBG 2017/2018	Fund	Voucher	Batch No	GL Date	Amount
	Legal Notices					
	COLORADO COMMUNITY MEDIA	00030	930157	311226	06/29/18	23.08
					Account Total	23.08
					Department Total	23.08

1023	CLK Motor Vehicle	Fund	Voucher	Batch No	GL Date	Amount
	Mileage Reimbursements					
	DOUGLASS TAYLER	00001	930171	311233	06/29/18	32.05
	GALLEGOS JESSICA	00001	930406	311620	07/05/18	24.20
	HALL KRISTEN J	00001	930404	311620	07/05/18	11.99
	HALL KRISTEN J	00001	930405	311620	07/05/18	16.51
	MLADENOV INNA	00001	930172	311233	06/29/18	51.01
	MLADENOV INNA	00001	930173	311233	06/29/18	27.52
	PASQUALI AIDA E	00001	930174	311233	06/29/18	14.28
					Account Total	177.56
					Department Total	177.56

1051	District Attorney	Fund	Voucher	Batch No	GL Date	Amount
	Education & Training					
	COLO SUPREME COURT	00001	930016	311122	06/29/18	50.00
					Account Total	50.00
					Department Total	50.00

7041	Economic Development Center	Fund	Voucher	Batch No	GL Date	Amount
	Grants to Other Instit					
	ADAMS COUNTY ECONOMIC DEVELOP	00001	930289	311428	07/03/18	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					
	A & E TIRE INC	00006	930306	311441	07/03/18	2,148.18
	A & E TIRE INC	00006	930308	311441	07/03/18	422.35
	A & E TIRE INC	00006	930309	311441	07/03/18	40.00
	A & E TIRE INC	00006	930310	311441	07/03/18	27.50
	A & E TIRE INC	00006	930311	311441	07/03/18	1,202.13
	A & E TIRE INC	00006	930379	311570	07/05/18	529.76
	A & E TIRE INC	00006	930394	311441	07/05/18	400.71
	ABRA AUTO BODY & GLASS	00006	930294	311441	07/03/18	308.62
	ABRA AUTO BODY & GLASS	00006	930295	311441	07/03/18	182.58
	ABRA AUTO BODY & GLASS	00006	930296	311441	07/03/18	160.00
	ABRA AUTO BODY & GLASS	00006	930297	311441	07/03/18	160.00
	ABRA AUTO BODY & GLASS	00006	930298	311441	07/03/18	25.00
	ABRA AUTO BODY & GLASS	00006	930299	311441	07/03/18	160.00
	ABRA AUTO BODY & GLASS	00006	930300	311441	07/03/18	25.00
	ABRA AUTO BODY & GLASS	00006	930301	311441	07/03/18	160.00
	ABRA AUTO BODY & GLASS	00006	930302	311441	07/03/18	160.00
	ABRA AUTO BODY & GLASS	00006	930303	311441	07/03/18	160.00
	ABRA AUTO BODY & GLASS	00006	930304	311441	07/03/18	160.00
	ABRA AUTO BODY & GLASS	00006	930377	311570	07/05/18	160.00
	FACTORY MOTOR PARTS	00006	930375	311570	07/05/18	7,526.00
	NORSTAR INDUSTRIES	00006	930384	311570	07/05/18	44,565.00
	PRECISE MRM LLC	00006	930381	311570	07/05/18	5,208.00
	SAM HILL OIL INC	00006	930349	311570	07/05/18	8,035.05
	SAM HILL OIL INC	00006	930350	311570	07/05/18	14,659.73
	WEX BANK	00006	930480	311690	07/06/18	2,614.99
					Account Total	89,200.60
					Department Total	89,200.60

9114	Fleet- Commerce	Fund	Voucher	Batch No	GL Date	Amount
	Tools Reimbursement					
	SMITH JAVON D	00006	930273	311324	07/02/18	354.39
					Account Total	354.39
	Travel & Transportation					
	DIETRICH HERMAN A	00006	929625	310828	06/25/18	226.46
	DIETRICH HERMAN A	00006	929626	310828	06/25/18	51.27
					Account Total	277.73
					Department Total	632.12

43	Front Range Airport	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	THYSSENKRUPP ELEVATOR CORP	00043	930351	311570	07/05/18	300.00
					Account Total	300.00
					Department Total	300.00

50	FLATROCK Facility Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	COMMERCIAL CLEANING SYSTEMS	00050	930313	311441	07/03/18	59.62
	COMMERCIAL CLEANING SYSTEMS	00050	930314	311441	07/03/18	1,370.62
					Account Total	1,430.24
					Department Total	1,430.24

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	ADAMSON POLICE PRODUCTS	00001	929580	310808	06/27/18	249.60
	ADAMSON POLICE PRODUCTS	00001	930006	311048	06/28/18	4,204.75
	ADAMSON POLICE PRODUCTS	00001	930024	311145	06/29/18	605.00
	ALLIED UNIVERSAL SECURITY SERV	00001	930027	311145	06/29/18	20,430.46
	ALPHA INSULATION & WATERPROOFI	00001	930365	311570	07/05/18	19,488.00
	CINTAS CORPORATION #66	00001	930312	311441	07/03/18	141.80
	CINTAS CORPORATION #66	00001	930481	311690	07/06/18	142.23
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	286.48
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	176.50
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	18.29
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	29.75
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	30.04
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	18.37
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	126.66
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	57.67
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	790.21
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	25.18
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	34.76
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	1,140.47
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	71.08
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	34.41
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	184.46
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	18.24
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	67.58
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	160.54
	COMMERCIAL CLEANING SYSTEMS	00001	930315	311441	07/03/18	26.96
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	6,585.68
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	4,057.47
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	420.54
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	683.85
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	690.68
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	422.40
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	2,911.76
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	1,325.76
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	18,165.84

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	578.85
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	799.02
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	26,217.65
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	1,634.09
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	791.14
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	4,240.43
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	419.31
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	1,553.67
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	3,690.57
	COMMERCIAL CLEANING SYSTEMS	00001	930478	311690	07/06/18	619.72
	DENOVO VENTURES LLC	00001	930319	311441	07/03/18	1,487.50
	DERBY INDUSTRIES	00001	930028	311145	06/29/18	3,956.62
	FOUND MY KEYS	00001	930029	311145	06/29/18	980.00
	G-DERBY PROMOTIONS	00001	930475	311690	07/06/18	8,400.00
	G-DERBY PROMOTIONS	00001	930476	311690	07/06/18	25,000.00
	GALLS LLC	00001	929581	310808	06/27/18	99.90
	GALLS LLC	00001	929582	310808	06/27/18	805.00
	GALLS LLC	00001	929583	310808	06/27/18	146.85
	GALLS LLC	00001	929584	310808	06/27/18	289.47
	GALLS LLC	00001	929585	310808	06/27/18	308.37
	GALLS LLC	00001	929586	310808	06/27/18	293.04
	GALLS LLC	00001	929587	310808	06/27/18	485.84
	GALLS LLC	00001	929588	310808	06/27/18	294.95
	GALLS LLC	00001	929589	310808	06/27/18	60.95
	GALLS LLC	00001	929589	310808	06/27/18	209.00
	GALLS LLC	00001	929590	310808	06/27/18	97.90
	GALLS LLC	00001	929591	310808	06/27/18	7.54
	GALLS LLC	00001	929591	310808	06/27/18	115.35
	GALLS LLC	00001	929592	310808	06/27/18	176.35
	GALLS LLC	00001	929593	310808	06/27/18	350.57
	GALLS LLC	00001	929593	310808	06/27/18	119.33
	GALLS LLC	00001	930007	311048	06/28/18	121.14
	GALLS LLC	00001	930008	311048	06/28/18	3.99
	GALLS LLC	00001	930030	311145	06/29/18	97.90
	GALLS LLC	00001	930032	311145	06/29/18	146.85
	GALLS LLC	00001	930034	311145	06/29/18	756.40

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	GALLS LLC	00001	930035	311145	06/29/18	258.75
	GALLS LLC	00001	930037	311145	06/29/18	482.84
	GALLS LLC	00001	930038	311145	06/29/18	97.90
	GALLS LLC	00001	930039	311145	06/29/18	267.99
	GALLS LLC	00001	930040	311145	06/29/18	274.96
	GALLS LLC	00001	930041	311145	06/29/18	2,718.00
	GALLS LLC	00001	930042	311145	06/29/18	121.14
	GALLS LLC	00001	930043	311145	06/29/18	73.95
	GALLS LLC	00001	930044	311145	06/29/18	56.95
	GALLS LLC	00001	930047	311145	06/29/18	33.95
	GALLS LLC	00001	930112	311145	06/29/18	206.79
	GALLS LLC	00001	930113	311145	06/29/18	56.95
	GALLS LLC	00001	930114	311145	06/29/18	95.90
	GALLS LLC	00001	930115	311145	06/29/18	190.84
	GALLS LLC	00001	930116	311145	06/29/18	590.89
	GALLS LLC	00001	930117	311145	06/29/18	146.85
	GALLS LLC	00001	930118	311145	06/29/18	314.03
	GALLS LLC	00001	930119	311145	06/29/18	1,549.96
	GALLS LLC	00001	930120	311145	06/29/18	335.90
	GALLS LLC	00001	930121	311145	06/29/18	95.33
	GALLS LLC	00001	930122	311145	06/29/18	558.80
	GALLS LLC	00001	930123	311145	06/29/18	366.61
	GALLS LLC	00001	930124	311145	06/29/18	146.85
	GALLS LLC	00001	930125	311145	06/29/18	15.20
	GALLS LLC	00001	930126	311145	06/29/18	168.90
	GALLS LLC	00001	930127	311145	06/29/18	267.99
	GALLS LLC	00001	930128	311145	06/29/18	267.99
	GALLS LLC	00001	930129	311145	06/29/18	267.99
	GALLS LLC	00001	930130	311145	06/29/18	53.95
	GALLS LLC	00001	930131	311145	06/29/18	169.99
	GALLS LLC	00001	930132	311145	06/29/18	7.68
	GALLS LLC	00001	930133	311145	06/29/18	1,736.50
	GALLS LLC	00001	930134	311145	06/29/18	999.00
	GALLS LLC	00001	930135	311145	06/29/18	170.09
	GALLS LLC	00001	930136	311145	06/29/18	262.80
	GALLS LLC	00001	930137	311145	06/29/18	35.95

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	GALLS LLC	00001	930138	311145	06/29/18	164.98
	GALLS LLC	00001	930139	311145	06/29/18	162.00
	GALLS LLC	00001	930194	311145	06/29/18	590.37
	GALLS LLC	00001	930195	311145	06/29/18	230.85
	GALLS LLC	00001	930196	311145	06/29/18	169.99
	GALLS LLC	00001	930197	311145	06/29/18	293.70
	GALLS LLC	00001	930198	311145	06/29/18	119.95
	GENERAL NETWORKS	00001	930321	311441	07/03/18	74.10
	HILL'S PET NUTRITION SALES INC	00001	930322	311441	07/03/18	330.00
	IDEXX DISTRIBUTION INC	00001	930323	311441	07/03/18	188.85
	IDEXX DISTRIBUTION INC	00001	930482	311690	07/06/18	1,885.23
	INSIGHT PUBLIC SECTOR	00001	929594	310808	06/27/18	105,512.88
	INSIGHT PUBLIC SECTOR	00001	929594	310808	06/27/18	24,139.78
	JUNDA GRAPHICS	00001	930293	311434	07/03/18	400.00
	KD SERVICE GROUP	00001	930140	311145	06/29/18	386.12
	LEXIS NEXIS MATTHEW BENDER	00001	929595	310808	06/27/18	2,072.99
	LINKEDIN.COM	00001	930325	311441	07/03/18	3,543.75
	MICHELSON FOUND ANIMALS FOUNDA	00001	930483	311690	07/06/18	1,759.16
	MURPHY RICK	00001	930141	311145	06/29/18	3,664.92
	MWI VETERINARY SUPPLY CO	00001	930339	311570	07/05/18	69.32
	MWI VETERINARY SUPPLY CO	00001	930340	311570	07/05/18	124.75
	MWI VETERINARY SUPPLY CO	00001	930341	311570	07/05/18	294.04
	MWI VETERINARY SUPPLY CO	00001	930342	311570	07/05/18	19.75
	MWI VETERINARY SUPPLY CO	00001	930343	311570	07/05/18	64.45
	MWI VETERINARY SUPPLY CO	00001	930343	311570	07/05/18	60.30
	MWI VETERINARY SUPPLY CO	00001	930334	311570	07/05/18	373.02
	MWI VETERINARY SUPPLY CO	00001	930335	311570	07/05/18	1,415.78
	MWI VETERINARY SUPPLY CO	00001	930335	311570	07/05/18	24.92
	MWI VETERINARY SUPPLY CO	00001	930336	311570	07/05/18	224.71
	MWI VETERINARY SUPPLY CO	00001	930337	311570	07/05/18	222.02
	MWI VETERINARY SUPPLY CO	00001	930338	311570	07/05/18	653.81
	MWI VETERINARY SUPPLY CO	00001	930484	311690	07/06/18	45.97
	MWI VETERINARY SUPPLY CO	00001	930485	311690	07/06/18	146.18
	MWI VETERINARY SUPPLY CO	00001	930486	311690	07/06/18	2,187.28
	ORACLE AMERICA INC	00001	930344	311570	07/05/18	38,297.40
	PATTERSON VETERINARY SUPPLY IN	00001	930345	311570	07/05/18	902.00

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	PHILLIPS PET FOOD & SUPPLIES	00001	930487	311690	07/06/18	359.00
	PITNEY BOWES	00001	930009	311048	06/28/18	1,308.09
	RADIO RESOURCE INC	00001	930477	311690	07/06/18	78.00
	RANDSTAD US LP	00001	930346	311570	07/05/18	786.38
	RANDSTAD US LP	00001	930347	311570	07/05/18	607.66
	SANITY SOLUTIONS INC	00001	930348	311570	07/05/18	49,853.70
	T&G PECOS LLC	00001	929596	310808	06/27/18	1,800.00
	THYSSENKRUPP ELEVATOR CORP	00001	930352	311570	07/05/18	1,182.04
	THYSSENKRUPP ELEVATOR CORP	00001	930352	311570	07/05/18	125.00
	THYSSENKRUPP ELEVATOR CORP	00001	930352	311570	07/05/18	2,575.00
	THYSSENKRUPP ELEVATOR CORP	00001	930352	311570	07/05/18	91.21
	THYSSENKRUPP ELEVATOR CORP	00001	930352	311570	07/05/18	791.00
	THYSSENKRUPP ELEVATOR CORP	00001	930352	311570	07/05/18	250.00
	THYSSENKRUPP ELEVATOR CORP	00001	930352	311570	07/05/18	250.00
	THYSSENKRUPP ELEVATOR CORP	00001	930352	311570	07/05/18	325.00
	THYSSENKRUPP ELEVATOR CORP	00001	930352	311570	07/05/18	675.00
	THYSSENKRUPP ELEVATOR CORP	00001	930352	311570	07/05/18	250.00
	TYGRETT DEBRA R	00001	930199	311145	06/29/18	188.00
	US CORRECTIONS LLC	00001	930010	311048	06/28/18	782.00
	WILBUR-ELLIS COMPANY LLC	00001	930354	311570	07/05/18	1,593.60
	WILBUR-ELLIS COMPANY LLC	00001	930356	311570	07/05/18	1,593.60
	WILBUR-ELLIS COMPANY LLC	00001	930359	311570	07/05/18	1,385.00
	WIRELESS ADVANCED COMMUNICATIO	00001	929597	310808	06/27/18	160.00
	WRIGHTWAY INDUSTRIES INC	00001	930488	311690	07/06/18	457.30
					Account Total	440,926.79
					Department Total	440,926.79

5026	Golf Course- Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	UNITED POWER (UNION REA)	00005	930500	311701	07/06/18	1,043.26
	UNITED POWER (UNION REA)	00005	930501	311701	07/06/18	339.43
	UNITED POWER (UNION REA)	00005	930502	311701	07/06/18	4,001.29
	UNITED POWER (UNION REA)	00005	930504	311701	07/06/18	4,603.57
	UNITED POWER (UNION REA)	00005	930504	311701	07/06/18	30.65
	XCEL ENERGY	00005	930503	311701	07/06/18	125.01
	XCEL ENERGY	00005	930505	311701	07/06/18	50.08
					Account Total	10,193.29
					Department Total	10,193.29

5021	Golf Course- Pro Shop	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	UNITED POWER (UNION REA)	00005	930499	311701	07/06/18	41.32
	UNITED POWER (UNION REA)	00005	930504	311701	07/06/18	3,334.62
	XCEL ENERGY	00005	930505	311701	07/06/18	337.54
					Account Total	3,713.48
					Department Total	3,713.48

9252	GF- Admin/Org Support	Fund	Voucher	Batch No	GL Date	Amount
	Membership Dues					
	DENVER REGIONAL COUNCIL OF	00001	930290	311428	07/03/18	54,700.00
					Account Total	54,700.00
	Other Professional Serv					
	DAVIS GRAHAM & STUBBS LLP	00001	930165	311228	06/29/18	1,852.50
					Account Total	1,852.50
					Department Total	56,552.50

1015	Human Resources- Admin	Fund	Voucher	Batch No	GL Date	Amount
	Mileage Reimbursements					
	LAUGHERY PATSY	00001	929923	311009	06/28/18	5.89
	LAUGHERY PATSY	00001	929924	311009	06/28/18	5.45
					Account Total	11.34
	Travel & Transportation					
	KANE SUE	00001	930474	311688	07/06/18	541.42
					Account Total	541.42
					Department Total	552.76

935118	HHS Grant	Fund	Voucher	Batch No	GL Date	Amount
	Education & Training					
	OLIVER LESLIE	00031	930217	311295	07/02/18	70.97
	RAMIREZ SUSANA	00031	930219	311295	07/02/18	295.00
					Account Total	365.97
	Mileage Reimbursements					
	OLIVER LESLIE	00031	930220	311298	07/02/18	25.67
					Account Total	25.67
	Subscrip/Publications					
	NULINX INTERNATIONAL	00031	930214	311295	07/02/18	675.75
	NULINX INTERNATIONAL	00031	930214	311295	07/02/18	119.25
	NULINX INTERNATIONAL	00031	930215	311295	07/02/18	675.75
	NULINX INTERNATIONAL	00031	930215	311295	07/02/18	119.25
	NULINX INTERNATIONAL	00031	930216	311295	07/02/18	675.75
	NULINX INTERNATIONAL	00031	930216	311295	07/02/18	119.25
					Account Total	2,385.00
	Telephone					
	CENTURY LINK	00031	930211	311295	07/02/18	352.09
	CENTURY LINK	00031	930212	311295	07/02/18	96.96
	CENTURYLINK	00031	930213	311295	07/02/18	10.86
					Account Total	459.91
					Department Total	3,236.55

19	Insurance Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	FIT SOLDIERS FITNESS BOOT CAMP	00019	930362	311570	07/05/18	4,165.00
	SHERMAN & HOWARD LLC	00019	930371	311570	07/05/18	5,670.00
					Account Total	9,835.00
					Department Total	9,835.00

8611	Insurance- Property/Casualty	Fund	Voucher	Batch No	GL Date	Amount
	Prop Claims-Under Deduct					
	MEDINA MAXINE	00019	930014	311119	06/29/18	1,170.75
					Account Total	1,170.75
					Department Total	1,170.75

1055	IT GIS	Fund	Voucher	Batch No	GL Date	Amount
	Travel & Transportation					
	BACA GREG	00001	930292	311428	07/03/18	209.00
					Account Total	209.00
					Department Total	209.00

1056	IT Help Desk & Servers	Fund	Voucher	Batch No	GL Date	Amount
	Mileage Reimbursements					
	OKADA DAVID	00001	930469	311685	07/06/18	177.34
					Account Total	177.34
					Department Total	177.34

5011	PKS- Administration	Fund	Voucher	Batch No	GL Date	Amount
	Operating Supplies					
	WEST ADAMS SOIL CONSERVATION	00001	930083	311177	06/29/18	400.00
					Account Total	400.00
	Other Professional Serv					
	CODE 4 SECURITY SERVICES LLC	00001	930075	311177	06/29/18	160.00
					Account Total	160.00
					Department Total	560.00

5010	PKS- Fair & Special Events	Fund	Voucher	Batch No	GL Date	Amount
	Liquor Sales					
	FUENTES ALEJANDRA	00001	930077	311177	06/29/18	756.00
					Account Total	756.00
	Regional Park Rentals					
	CANO MARTIN	00001	930073	311177	06/29/18	400.00
	FUENTES ALEJANDRA	00001	930076	311177	06/29/18	225.00
	LY JENIFER	00001	930078	311177	06/29/18	400.00
	REID KIMBERLY	00001	930079	311177	06/29/18	400.00
	TERAN KELLY	00001	930080	311177	06/29/18	150.00
	THAO SHOUA	00001	930081	311177	06/29/18	400.00
	VILLALOBOS KARINA	00001	930082	311177	06/29/18	400.00
	XIONG CATALINA	00001	930074	311177	06/29/18	650.00
					Account Total	3,025.00
					Department Total	3,781.00

1082	PLN- Development Review	Fund	Voucher	Batch No	GL Date	Amount
	Education & Training					
	WESTERN STATES PROJECT	00001	930023	311119	06/29/18	250.00
					Account Total	250.00
					Department Total	250.00

13	Road & Bridge Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	DREXEL BARRELL & CO	00013	930320	311441	07/03/18	6,647.84
	MERRICK & COMPANY	00013	930479	311690	07/06/18	1,800.00
	MERRICK & COMPANY	00013	930479	311690	07/06/18	1,042.00
					Account Total	9,489.84
					Department Total	9,489.84

94	Sheriff Payables	Fund	Voucher	Batch No	GL Date	Amount
	Fingerprint Cards - CBI					
	COLO BUREAU OF INVESTIGATION	00094	930013	311054	06/28/18	14,790.50
	MURPHY DUFFY D	00094	929648	310814	06/27/18	13.00
					Account Total	14,803.50
					Department Total	14,803.50

2004	Sheriff Training	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	930005	311008	06/28/18	199.55
					Account Total	199.55
	Other Professional Serv					
	SHRED IT USA LLC	00001	930004	311008	06/28/18	85.95
					Account Total	85.95
					Department Total	285.50

2008	SHF - Training Academy	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	930005	311008	06/28/18	26.89
					Account Total	26.89
	Other Professional Serv					
	SHRED IT USA LLC	00001	930004	311008	06/28/18	85.96
					Account Total	85.96
					Department Total	112.85

2011	SHF- Admin Services Division	Fund	Voucher	Batch No	GL Date	Amount
	Concealed Handgun Permit Fees					
	MURPHY DUFFY D	00001	929648	310814	06/27/18	50.00
	MURPHY DUFFY D	00001	929648	310814	06/27/18	15.00
					Account Total	65.00
	Education & Training					
	EMPLOYERS COUNCIL SERVICES INC	00001	929616	310814	06/27/18	130.00
					Account Total	130.00
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	930005	311008	06/28/18	193.89
	TOSHIBA BUSINESS SOLUTIONS	00001	930005	311008	06/28/18	80.76
					Account Total	274.65
	Operating Supplies					
	B C INTERIORS	00001	929658	310814	06/27/18	40.00
	E470 PUBLIC HIGHWAY AUTHORITY	00001	930001	311008	06/28/18	35.10
	MURPHY DUFFY D	00001	929648	310814	06/27/18	2.52
					Account Total	77.62
	Other Professional Serv					
	SHRED IT USA LLC	00001	929619	310814	06/27/18	150.00
					Account Total	150.00
	Public Relations					
	METRONORTH CHAMBER OF COMMERCE	00001	929920	311008	06/28/18	1,250.00
					Account Total	1,250.00
	Uniforms & Cleaning					
	SYMBOL ARTS	00001	929922	311008	06/28/18	810.00
					Account Total	810.00
					Department Total	2,757.27

2015	SHF- Civil Section	Fund	Voucher	Batch No	GL Date	Amount
	Sheriff's Fees					
	ALVAREZ ROBERT DANIEL	00001	929965	311014	06/28/18	19.00
	ATTORNEY GENERAL OF SOUTH DAKO	00001	929966	311014	06/28/18	19.00
	BONINA AND BONINA	00001	929967	311014	06/28/18	19.00
	BRUNS MICHELLE	00001	929968	311014	06/28/18	19.00
	BUTLER ROSEMARY	00001	929969	311014	06/28/18	19.00
	CRITELLI JOSEPH S	00001	929970	311014	06/28/18	19.00
	DAVI NAILS SALON AND SPA	00001	929971	311014	06/28/18	19.00
	DENALI LAW FIRM	00001	929972	311014	06/28/18	19.00
	DENALI LAW FIRM	00001	929973	311014	06/28/18	19.00
	ELIAS LAW	00001	929974	311014	06/28/18	19.00
	EZ MESSENGER	00001	929996	311014	06/28/18	19.00
	EZ MESSENGER	00001	929997	311014	06/28/18	19.00
	EZ MESSENGER	00001	929998	311014	06/28/18	5.00
	FORTNA VALERIE ANNETTE	00001	929975	311014	06/28/18	19.00
	GREGORIO TROY	00001	929976	311014	06/28/18	19.00
	HALSTEAD LAW	00001	929977	311014	06/28/18	74.00
	HARTWICK DANIEL E	00001	929978	311014	06/28/18	19.00
	ISMAIL HANDRIN SALAH	00001	929979	311014	06/28/18	19.00
	JOYCE CHRISTAN N	00001	929980	311014	06/28/18	19.00
	KLINE CHRISTIANA	00001	929981	311014	06/28/18	19.00
	LAND NATALIE	00001	929982	311014	06/28/18	19.00
	LAW OFFICE OF LEEANNE QUATTRUC	00001	929983	311014	06/28/18	19.00
	MANHATTAN FUND XXI LLC	00001	929984	311014	06/28/18	66.00
	MARTINEZ BREANNA	00001	929985	311014	06/28/18	19.00
	MARTINEZ BREANNA JENAE	00001	929986	311014	06/28/18	19.00
	NAJERA GENEVIEVE RENEE	00001	929987	311014	06/28/18	19.00
	NELSON PAMELA SALAPICH	00001	929988	311014	06/28/18	19.00
	NEWBOLD CHAPMAN AND GEYER	00001	929989	311014	06/28/18	19.00
	OLIMON BERUMEN ARGENTINA	00001	929990	311014	06/28/18	19.00
	PACHECO ROBERT	00001	929991	311014	06/28/18	19.00
	PALACIOS LEOBARDO PRADO ERIKA	00001	929992	311014	06/28/18	19.00
	PIPPIN SLATE ALEXANDER	00001	929993	311014	06/28/18	41.16
	PORTALES ROBERTO E C	00001	929994	311014	06/28/18	147.00
	PROCESS SERVICE OF WYOMING INC	00001	929940	311014	06/28/18	19.00
	PROCESS SERVICE OF WYOMING INC	00001	929941	311014	06/28/18	19.00

2015	SHF- Civil Section	Fund	Voucher	Batch No	GL Date	Amount
	PROCESS SERVICE OF WYOMING INC	00001	929942	311014	06/28/18	19.00
	PROFESSIONAL FINANCE CO	00001	929943	311014	06/28/18	19.00
	ROMERO AMY LYN	00001	929995	311014	06/28/18	19.00
	STENGER AND STENGER	00001	929944	311014	06/28/18	19.00
	STENGER AND STENGER	00001	929945	311014	06/28/18	19.00
	STENGER AND STENGER	00001	929946	311014	06/28/18	19.00
					Account Total	1,017.16
					Department Total	1,017.16

2075	SHF- Commissary Fund	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	930005	311008	06/28/18	116.17
					Account Total	116.17
	Other Professional Serv					
	CESCO LINGUISTIC SERVICE INC	00001	929609	310814	06/27/18	380.34
	CESCO LINGUISTIC SERVICE INC	00001	929610	310814	06/27/18	742.14
					Account Total	1,122.48
					Department Total	1,238.65

2016	SHF- Detective Division	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	930005	311008	06/28/18	145.68
					Account Total	145.68
	Interpreting Services					
	LANGUAGE LINE SERVICES	00001	930002	311008	06/28/18	124.64
					Account Total	124.64
	Medical Services					
	CENTURA HEALTH	00001	929608	310814	06/27/18	600.00
					Account Total	600.00
	Operating Supplies					
	DS WATERS OF AMERICA INC	00001	929612	310814	06/27/18	448.10
	E470 PUBLIC HIGHWAY AUTHORITY	00001	930001	311008	06/28/18	3.90
					Account Total	452.00
	Other Professional Serv					
	CONNOLLY'S TOWING	00001	929611	310814	06/27/18	175.00
	SHRED IT USA LLC	00001	929618	310814	06/27/18	34.20
					Account Total	209.20
					Department Total	1,531.52

2071	SHF- Detention Facility	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	930005	311008	06/28/18	665.81
	TOSHIBA BUSINESS SOLUTIONS	00001	930005	311008	06/28/18	242.27
					Account Total	908.08
	Interpreting Services					
	LANGUAGE LINE SERVICES	00001	930002	311008	06/28/18	329.64
					Account Total	329.64
	Mileage Reimbursements					
	BOWMAN LORI	00001	930011	311050	06/28/18	59.95
					Account Total	59.95
	Operating Supplies					
	DS WATERS OF AMERICA INC	00001	929613	310814	06/27/18	83.89
	DS WATERS OF AMERICA INC	00001	929614	310814	06/27/18	81.47
	DS WATERS OF AMERICA INC	00001	929615	310814	06/27/18	624.70
	E470 PUBLIC HIGHWAY AUTHORITY	00001	930001	311008	06/28/18	101.40
	E470 PUBLIC HIGHWAY AUTHORITY	00001	930001	311008	06/28/18	30.00
					Account Total	921.46
					Department Total	2,219.13

2017	SHF- Patrol Division	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	930005	311008	06/28/18	88.06
					Account Total	88.06
	Interpreting Services					
	LANGUAGE LINE SERVICES	00001	930002	311008	06/28/18	111.52
					Account Total	111.52
	Operating Supplies					
	DS WATERS OF AMERICA INC	00001	929650	310814	06/27/18	309.47
	E470 PUBLIC HIGHWAY AUTHORITY	00001	930001	311008	06/28/18	62.40
					Account Total	371.87
	Other Professional Serv					
	SHRED IT USA LLC	00001	929618	310814	06/27/18	34.20
					Account Total	34.20
					Department Total	605.65

2018	SHF- Records/Warrants Section	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	TOSHIBA BUSINESS SOLUTIONS	00001	930005	311008	06/28/18	142.30
					Account Total	142.30
	Interpreting Services					
	LANGUAGE LINE SERVICES	00001	930002	311008	06/28/18	9.02
					Account Total	9.02
	Operating Supplies					
	DS WATERS OF AMERICA INC	00001	929918	311008	06/28/18	84.10
	FIRST CHOICE COFFEE SERVICES	00001	929617	310814	06/27/18	140.20
	FIRST CHOICE COFFEE SERVICES	00001	929659	310814	06/27/18	151.65
	FIRST CHOICE COFFEE SERVICES	00001	929919	311008	06/28/18	31.70
					Account Total	407.65
	Other Professional Serv					
	SHRED IT USA LLC	00001	929921	311008	06/28/18	127.50
					Account Total	127.50
					Department Total	686.47

2005	SHF- TAC Section	Fund	Voucher	Batch No	GL Date	Amount
	Equipment Rental					
	SB PORTA BOWL RESTROOMS INC	00001	929649	310814	06/27/18	165.00
	TOSHIBA BUSINESS SOLUTIONS	00001	930005	311008	06/28/18	24.28
					Account Total	189.28
	Other Professional Serv					
	NORTHGLENN AMBULANCE	00001	930003	311008	06/28/18	627.90
					Account Total	627.90
					Department Total	817.18

2024	SHF- Volunteer Program	Fund	Voucher	Batch No	GL Date	Amount
	Mileage Reimbursements					
	BUA RICHARD	00001	930200	311238	06/29/18	56.57
					Account Total	56.57
					Department Total	56.57

3011	Transportation Administration	Fund	Voucher	Batch No	GL Date	Amount
	Mileage Reimbursements					
	MOSKOWITZ MARK	00013	930018	311119	06/29/18	8.28
	MOSKOWITZ MARK	00013	930019	311119	06/29/18	9.32
					Account Total	17.60
					Department Total	17.60

3056	Transportation CIP	Fund	Voucher	Batch No	GL Date	Amount
	Land					
	HARICK INC	00013	930210	311291	07/02/18	600.00
					Account Total	600.00
	Road & Streets					
	HARICK INC	00013	930209	311291	07/02/18	1,406.00
					Account Total	1,406.00
					Department Total	2,006.00

3061	Transportation Engineering	Fund	Voucher	Batch No	GL Date	Amount
	Travel & Transportation					
	STALEY BRIAN	00001	930015	311119	06/29/18	135.00
					Account Total	135.00
					Department Total	135.00

3055	Transportation Streets Program	Fund	Voucher	Batch No	GL Date	Amount
	Gas & Electricity					
	UNITED POWER (UNION REA)	00013	930033	311150	06/29/18	23.16
	UNITED POWER (UNION REA)	00013	930036	311150	06/29/18	48.84
	UNITED POWER (UNION REA)	00013	930045	311150	06/29/18	34.00
	UNITED POWER (UNION REA)	00013	930046	311150	06/29/18	78.12
	UNITED POWER (UNION REA)	00013	930048	311150	06/29/18	36.00
	UNITED POWER (UNION REA)	00013	930049	311150	06/29/18	102.69
	UNITED POWER (UNION REA)	00013	930050	311150	06/29/18	34.46
	UNITED POWER (UNION REA)	00013	930051	311150	06/29/18	135.12
	UNITED POWER (UNION REA)	00013	930052	311150	06/29/18	16.50
	UNITED POWER (UNION REA)	00013	930053	311150	06/29/18	48.84
	XCEL ENERGY	00013	930031	311150	06/29/18	45.05
					Account Total	602.78
					Department Total	602.78

4316	Wastewater Treatment Plant	Fund	Voucher	Batch No	GL Date	Amount
	Telephone					
	CENTURYLINK	00043	930055	311157	06/29/18	47.70
					Account Total	47.70
					Department Total	47.70

97500	WIOA YOUTH OLDER	Fund	Voucher	Batch No	GL Date	Amount
	Supp Svcs-Incentives					
	BREEDLOVE XAVIER	00035	930221	311305	07/02/18	40.00
					Account Total	40.00
					Department Total	40.00

Grand Total	**973,093.16**

MINUTES OF COMMISSIONERS' PROCEEDINGS FOR TUESDAY, JULY 10, 2018

1. ROLL CALL
   Present: Commissioner Henry Commissioner O'Dorisio Commissioner Hodge
   Excused: Commissioner Tedesco Commissioner Hansen

2. PLEDGE OF ALLEGIANCE

3. MOTION TO APPROVE AGENDA (09:32 AM)
   Motion to Approve 3. MOTION TO APPROVE AGENDA Moved by Eva J. Henry, seconded by Steve O'Dorisio, unanimously carried.

4. AWARDS AND PRESENTATIONS (09:32 AM)
   A. 18-643 Employees of the Season Awards Presentation (09:32 AM)

5. PUBLIC COMMENT (10:08 AM)

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 (10:08 AM)

6. CONSENT CALENDAR (10:09 AM)
   A. 18-632 List of Expenditures Under the Dates of June 25-29, 2018
   B. 18-642 Minutes of the Commissioners' Proceedings from July 3, 2018
   C. 18-612 Adams County Treasurer's Summary May 1-31, 2018
   D. 18-542 Resolution for Final Acceptance of Public Improvements Constructed at the Bartley Subdivision, Phase IV, Case No PLT2015-00048 and SUB2017-00001 (File approved by ELT)
   E. 18-611 Resolution Approving Agreement Regarding Funding of Major Drainageway Planning and Flood Hazard Area Delineation for Brantner Gulch and Tributaries (File approved by ELT)
   F. 18-620 Resolution Approving Land Lease Agreement between Adams County and Direct Transportation, LLC, dba Western Shuttles (File approved by ELT)
   G. 18-622 Resolution Approving Consent to Assignment and Assignment of Lease with Ronald C. Webster to Ronald C. Webster Revocable Living Trust U-A, Dated April 18, 2012 (File approved by ELT)
   H. 18-623 Resolution Approving Consent to Assignment and Assignment of Lease with Ronald C. Webster to Ronald C. Webster Revocable Living Trust U-A, Dated April 18, 2012 (File approved by ELT)
   I. 18-624 Resolution for Final Acceptance of Public Improvements Constructed at the Mapleton Industrial Development, HUB 25, Subdivision Project Case Number PLN2016-00012 and INF2016-00043 (File approved by ELT)
   J. 18-627 Resolution Approving Consent to Assignment and Assignment Among Adams

County, Jeffrey E. Schetgen, and D & G Aviation, LLC (File approved by ELT)

K. 18-647 Resolution Approving Amendments to the Adams County Code of Ethics (File approved by ELT)

Motion to Approve 6. CONSENT CALENDAR Moved by Eva J. Henry, seconded by Steve O'Dorisio, unanimously carried.

7. NEW BUSINESS (10:09 AM)

A. COUNTY MANAGER (10:09 AM)

1. 18-376 Resolution Approving a Purchase Order between Adams County and Atlantic Machinery, Inc., for Street Sweepers (File approved by ELT) (10:09 AM)
   Motion to Approve 1. 18-376 Resolution Approving a Purchase Order between Adams County and Atlantic Machinery, Inc., for Street Sweepers
   (File approved by ELT) Moved by Eva J. Henry, seconded by Steve O'Dorisio, unanimously carried.
2. 18-595 Resolution Approving Amendment Two to the Agreement between Adams County and EON Enterprises, Inc., (dba EON Office) for General Office Supplies, Paper, and Toner (File approved by ELT) (10:13 AM)
   Motion to Approve 2. 18-595 Resolution Approving Amendment Two to the Agreement between Adams County and EON Enterprises, Inc., (dba EON Office) for General Office Supplies, Paper, and Toner
   (File approved by ELT) Moved by Eva J. Henry, seconded by Steve O'Dorisio, unanimously carried.
3. 18-626 Resolution Approving the Agreement between Adams County and RockSol Consulting Group, Inc., for Professional Roadway Engineering Services (File approved by ELT) (10:15 AM)
   Motion to Approve 3. 18-626 Resolution Approving the Agreement between Adams County and RockSol Consulting Group, Inc., for Professional Roadway Engineering Services
   (File approved by ELT) Moved by Steve O'Dorisio, seconded by Eva J. Henry, unanimously carried.
4. 18-628 Resolution Approving the Agreement between Adams County and Whitestone Construction Services, Inc., for General Contractor (GC) Services (File approved by ELT) (10:15 AM)
   Motion to Approve 4. 18-628 Resolution Approving the Agreement between Adams County and Whitestone Construction Services, Inc., for General Contractor (GC) Services
   (File approved by ELT) Moved by Steve O'Dorisio, seconded by Eva J. Henry, unanimously carried.

B. COUNTY ATTORNEY (10:18 AM)

8. LAND USE HEARINGS (10:18 AM)

A. Cases to be Heard (10:18 AM)

1. 18-633 RCU2017-00035 Channing Self-Storage (File approved by ELT) (10:18 AM)
   Motion to Approve 1. 18-633 RCU2017-00035 Channing Self-Storage
   (File approved by ELT) Moved by Eva J. Henry, seconded by Steve O'Dorisio, unanimously carried.
2. 18-634 PLN2018-00011 Balanced Housing Plan (File approved by ELT) (10:51 AM)
   Motion to Approve 2. 18-634 PLN2018-00011 Balanced Housing Plan
   (File approved by ELT) Moved by Steve O'Dorisio, seconded by Eva J. Henry, unanimously carried.

9. ADJOURNMENT (11:07 AM)

AND SUCH OTHER MATTERS OF PUBLIC BUSINESS WHICH MAY ARISE

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: July 17, 2018	
SUBJECT:	Agreement Regarding Final Design, Right-Of-Way Acquisition, And Construction Of Drainage And Flood Control Improvements For Clear Creek At BNSF Crossing Between Pecos And Federal Boulevard Adams County (Agreement No. 18-04.06)
FROM:	Jeffery A. Maxwell, PE, PTOE, Director of Public Works
AGENCY/DEPARTMENT: Public Works	
HEARD AT STUDY SESSION ON: February 6, 2018 and March 20, 2018	
AUTHORIZATION TO MOVE FORWARD: ☐ **YES** ☐ **NO**	
RECOMMENDED ACTION:	That the Board of County Commissioners approve Agreement Regarding Final Design, Right-Of-Way Acquisition, And Construction Of Drainage And Flood Control Improvements For Clear Creek At BNSF Crossing Between Pecos And Federal Boulevard Adams County (Agreement No. 18-04.06)

BACKGROUND:

This project has two significant components: drainage improvements to Clear Creek; and the installation of the Clear Creek Trail under the Regional Transportation District (RTD) and the Burlington Northern and Santa Fe Railroad (BNSF) bridges over Clear Creek.

Drainage Improvements

In 2016, due to significant repairs needed on the BNSF drop structure in Clear Creek, BNSF staff met with representatives from the County and the Urban Drainage and Flood Control District (UDFCD) to discuss the possibility of a joint project to relocate the drop structure off BNSF property to a mutually acceptable location. BNSF representatives agreed to provide a maximum of $60,000 toward a preliminary design study, which recommended relocating the drop structure upstream of the BNSF property. The study identified a $2.25M cost to remove and replace in-kind the BNSF drop structure. BNSF representatives are in the process of drafting up an agreement to fund $2.25M of this project. Public Works presented this information at the February 6, 2018 Study Session and received Board support to revise the capital improvement projects priorities schedule of the Stormwater Utility (SWU). The schedule identified $750,000 of SWU funds for this Project.

County and UDFCD staff are working with BNSF on date(s) their funding will be available to the Project.

The attached agreement portions the $750,000 (County contribution) into the following elements of effort: Final Design ($200,000), Right-of-way ($250,000), Construction ($250,000), and Contingency ($50,000). This breakdown is for estimating purposes only, actual costs may vary.

Clear Creek Trail

The Clear Creek Trail is a "Key Multi-Use Trail" (or major regional trail) that provides recreational benefits to the region (ref: 2035 Metro Vision Regional Transportation Plan "Plan"). The Plan emphasizes that major regional trails should follow waterways and railroad corridors. In anticipation of the Trail crossing under the BNSF bridge and the RTD bridge, County staff required the substructures of both bridges be designed to accommodate the lower elevation needed for the trail and channel. Additionally, County staff informed BNSF that a trail underpass was a condition the County will require with the project. Knowing that additional excavation is needed to achieve adequate clearance for the trail, the Parks and Open Space staff (Parks) presented their funding plan to the Board at the March 20, 2018 Study Session. Parks' plan was to apply for $1,500,000 of Open Space funds, with $750,000 being the required 30% shareback. Parks staff clarified the uncertainty of being awarded any of the requested Open Space funds. The Board acknowledged that the Project may require up to $2,250,000 for the construction of the recreational amenities for this project.

A condition of BNSF providing their funding is to have construction complete prior to spring 2020. The Parties acknowledge that sufficient funding must be available prior to any construction, or pre-construction activities.

This agreement will initiate a separate account at the UDFCD for this project.

This IGA has been reviewed by our Deputy County Attorney.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Urban Drainage and Flood Control District; Public Works; Parks and Open Space, County Attorney's Office

ATTACHED DOCUMENTS:

- Intergovernmental Agreement
- Draft Resolution

FISCAL IMPACT:

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

Fund: 7

Cost Center: 3704

	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:	9105	TBD	$750,000
Total Expenditures:			**$750,000**

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

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

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING THE AGREEMENT REGARDING FINAL DESIGN, RIGHT-OF-WAY ACQUISITION, AND CONSTRUCTION OF DRAINAGE AND FLOOD CONTROL IMPROVEMENTS FOR CLEAR CREEK AT BNSF CROSSING BETWEEN PECOS AND FEDERAL BOULEVARD ADAMS COUNTY (AGREEMENT NO. 18-04.06) BETWEEN ADAMS COUNTY AND URBAN DRAINAGE AND FLOOD CONTROL DISTRICT

Resolution 2018-XXX

WHEREAS, Adams County ("County")and Urban Drainage and Flood Control District ("District"), collectively known as "Parties," wish to enter into Agreement Regarding Final Design, Right-Of-Way Acquisition, and Construction of Drainage and Flood Control Improvements for Clear Creek at BNSF Crossing Between Pecos and Federal Boulevard Adams County (Agreement No. 18-04.06) ("Agreement"); and,

WHEREAS, by means of the attached Agreement, the Parties wish to fund the Clear Creek Trail and Drop Structure Partnership with BNSF Project("Project"); and,

WHEREAS, pursuant to the Agreement the County will provide the initial funding of $750,000 in order to initiate the Project.

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, State of Colorado, that the Agreement Regarding Final Design, Right-Of-Way Acquisition, and Construction of Drainage and Flood Control Improvements for Clear Creek at BNSF Crossing Between Pecos and Federal Boulevard Adams County (Agreement No. 18-04.06) between Adams County and Urban Drainage and Flood Control District, a copy of which is attached hereto and incorporated by this reference, be approved.

BE IT FURTHER RESOLVED that the Chair is authorized to execute said Agreement on behalf of Adams County.

AGREEMENT REGARDING
FINAL DESIGN, RIGHT-OF-WAY ACQUISITION, AND CONSTRUCTION
OF DRAINAGE AND FLOOD CONTROL IMPROVEMENTS FOR
CLEAR CREEK AT BNSF CROSSING BETWEEN PECOS AND FEDERAL BOULEVARD
ADAMS COUNTY

Agreement No. 18-04.06
Project No. 106259

THIS AGREEMENT, by and between URBAN DRAINAGE AND FLOOD CONTROL DISTRICT (hereinafter called "DISTRICT") and ADAMS COUNTY (hereinafter called "COUNTY") and collectively known as "PARTIES";

WITNESSETH:

WHEREAS, DISTRICT, in a policy statement previously adopted (Resolution No. 14, Series of 1970 and Resolution No. 11, Series of 1973) expressed an intent to assist public bodies which have heretofore enacted floodplain regulation measures; and

WHEREAS, PARTIES participated in a joint planning study titled "Major Drainageway Planning, Phase B Conceptual Preliminary Design for Clear Creek" by ICON Engineering, Inc., dated February 2008 (hereinafter called "PLAN"); and

WHEREAS, PARTIES now desire to proceed with the design, right-of-way acquisition and construction of drainage and flood control improvements for Clear Creek at BNSF Crossing between Pecos and Federal Boulevard (hereinafter called "PROJECT"); and

WHEREAS, the County Commissioners of COUNTY have authorized, by appropriation or resolution, all of PROJECT costs of the respective PARTIES.

NOW, THEREFORE, in consideration of the mutual promises contained herein, PARTIES hereto agree as follows:

1. SCOPE OF THIS AGREEMENT

   This Agreement defines the responsibilities and financial commitments of PARTIES with respect to PROJECT.

2. SCOPE OF PROJECT

   A. Final Design. PROJECT shall include the final design of improvements in accordance with the recommendations defined in PLAN. Specifically, the final design of facilities shall extend from approximately 200 feet downstream of the BNSF Railroad tracks to approximately 1,200 feet upstream of the BNSF Railroad tracks, as shown on Exhibit A.

   B. Right-of-Way Delineation and Acquisition. Right-of-way for the improvements as set forth in the final design and an estimate of costs for acquisition shall be determined. Maps, parcel descriptions, and parcel plats shall also be prepared.

   C. Construction. PROJECT shall include construction by DISTRICT of the drainage and flood control improvements as set forth in the final design and vegetation establishment.

3. PUBLIC NECESSITY

PARTIES agree that the work performed pursuant to this Agreement is necessary for the health, safety, comfort, convenience, and welfare of all the people of the State, and is of particular benefit to the inhabitants of PARTIES and to their property therein.

4. PROJECT COSTS AND ALLOCATION OF COSTS

A. PARTIES agree that for the purposes of this Agreement PROJECT costs shall consist of and be limited to the following:

1. Final design services;
2. Delineation, description and acquisition of required rights-of-way/easements;
3. Construction of improvements;
4. Contingencies mutually agreeable to PARTIES.

B. It is understood that PROJECT costs as defined above are not to exceed $750,000 without amendment to this Agreement.

PROJECT costs for the various elements of the effort are estimated as follows:

	ITEM		AMOUNT
1.	Final Design	$	200,000
2.	Right-of-way	$	250,000
3.	Construction	$	250,000
4.	Contingency	$	50,000
	Grand Total	$	750,000

This breakdown of costs is for estimating purposes only. Costs may vary between the various elements of the effort without amendment to this Agreement provided the total expenditures do not exceed the maximum contribution by all PARTIES plus accrued interest, if applicable.

C. Based on total PROJECT costs, the maximum percent and dollar contribution by each party shall be:

	Percentage Share	Maximum Contribution
DISTRICT	0.00%	$ -0-
COUNTY	100.00%	$750,000
TOTAL	100.00%	$750,000

5. MANAGEMENT OF FINANCES

As set forth in DISTRICT policy (Resolution No. 11, Series of 1973, Resolution No. 49, Series of 1977, and Resolution No. 37, Series of 2009), the funding of a local body's one-half share may come from its own revenue sources or from funds received from state, federal, or other sources of funding without limitation and without prior DISTRICT approval.

Payment of each party's full share (COUNTY - $750,000; DISTRICT - $-0-) shall be made to DISTRICT subsequent to execution of this Agreement and within 30 days of request for payment

by DISTRICT. The payments by PARTIES shall be held by DISTRICT in a special fund to pay for increments of PROJECT as authorized by PARTIES, and as defined herein. DISTRICT shall provide a periodic accounting of PROJECT funds as well as a periodic notification to COUNTY of any unpaid obligations. Any interest earned by the monies contributed by PARTIES shall be accrued to the special fund established by DISTRICT for PROJECT and such interest shall be used only for PROJECT upon approval by the contracting officers (Paragraph 13).

Within one year of completion of PROJECT if there are monies including interest earned remaining which are not committed, obligated, or disbursed, each party shall receive a share of such monies, which shares shall be computed as were the original shares; or, at COUNTY request, COUNTY share of remaining monies shall be transferred to another special fund held by DISTRICT.

6. FINAL DESIGN

The contracting officers for PARTIES, as defined under Paragraph 13 of this Agreement, shall select an engineer mutually agreeable to both PARTIES. DISTRICT shall contract with selected engineer and shall supervise and coordinate the final design including right-of-way delineation subject to approval of the contracting officer for COUNTY. Payment for final design services shall be made by DISTRICT as the work progresses from the PROJECT fund established as set forth above.

Final design services shall consist of, but not be limited to, the following:

A. Preparation of a work plan schedule identifying the timing of major elements in the design;
B. Delineation of required right-of-way/easements;
C. Preparation of detailed construction plans and specifications;
D. Preparation of an estimate of probable construction costs of the work covered by the plans and specifications;
E. Preparation of an appropriate construction schedule.

DISTRICT shall provide any written work product by the engineer to COUNTY.

7. RIGHT-OF-WAY

COUNTY, with DISTRICT assistance, shall be responsible for acquiring, subject to approval of DISTRICT, such land or interests in land needed to implement construction of the drainage and flood control improvements as defined herein. The cost to be shared by PARTIES for right-of-way acquisition may include relocation costs of existing occupants. Appraisal costs and costs associated with condemnation (including outside legal costs) will also be considered a PROJECT cost. Right-of-way acquisition by negotiation and / or the exercise of eminent domain shall be in full compliance with the laws of the State of Colorado. In addition, the right-of-way acquired shall be in the name of COUNTY and the conveyancing document shall be promptly recorded in the records of the Clerk and Recorder of COUNTY. DISTRICT shall serve as the paying agency.

A. Coordination of Right-of-Way Acquisition. Cost sharing by PARTIES will be based on supporting documentation such as formal appraisals, reasonable relocation cost settlements,

legal description of the property, and other information deemed appropriate to the acquisition. Furthermore, cost sharing will be only for the properties, or portions thereof, approved by PARTIES to be needed for the drainage and flood control portions of PROJECT. Request for such approval shall include appraisals of property, legal description of the property, and other information deemed appropriate to the acquisition by PARTIES to this Agreement. COUNTY shall purchase the right-of-way only after receiving prior approval of DISTRICT, and such purchases shall be made with PROJECT funds.

B. Payment for Right-of-Way Acquisition. Following purchase or receipt of executed memorandum of agreement between COUNTY and property owner for the needed right-of-way that commits the property owner to sell property to COUNTY at a price certain and on a date certain, COUNTY shall so advise DISTRICT and request payment as provided above. DISTRICT shall make payment within 30 days of receipt of request accompanied by the information set forth above.

C. Ownership of Property and Limitation of Use. COUNTY shall own the property either in fee or non-revocable easement and shall be responsible for same. It is specifically understood that the right-of-way is being used for drainage and flood control purposes. The properties upon which PROJECT is constructed shall not be used for any purpose that will diminish or preclude its use for drainage and flood control purposes. COUNTY may not dispose of or change the use of the properties without approval of DISTRICT. If, in the future, COUNTY disposes of any portion of or all of the properties acquired upon which PROJECT is constructed pursuant to this Agreement; changes the use of any portion or all of the properties upon which PROJECT is constructed pursuant to this Agreement; or modifies any of the improvements located on any portion of the properties upon which PROJECT is constructed pursuant to this Agreement; and COUNTY has not obtained the written approval of DISTRICT prior to such action, COUNTY shall take any and all action necessary to reverse said unauthorized activity and return the properties and improvements thereon, acquired and constructed pursuant to this Agreement, to the ownership and condition they were in immediately prior to the unauthorized activity at COUNTY's sole expense. In the event COUNTY breaches the terms and provisions of this Paragraph 7.C and does not voluntarily cure as set forth above, DISTRICT shall have the right to pursue a claim against COUNTY for specific performance of this portion of the Agreement.

DISTRICT may, subsequent to the recording by COUNTY of any document transferring title or another interest to property acquired pursuant to this Agreement to COUNTY, record a memorandum of this Agreement (Exhibit B), specifically a verbatim transcript of Paragraph 7.C. Ownership of Property and Limitation of Use except for this sub-paragraph which shall not be contained in the memorandum. The memorandum shall reference by legal description the property being acquired by COUNTY and shall be recorded in the records of the Clerk and Recorder of Adams County immediately following the recording of

the document transferring title or another interest to COUNTY. COUNTY authorizes the recording of that memorandum and acknowledges that the same is meant to encumber the property with its restrictions.

8. MANAGEMENT OF CONSTRUCTION

A. Costs. Construction costs shall consist of those costs as incurred by the most qualified contractor(s) including detour costs, licenses and permits, utility relocations, and construction related engineering services as defined in Paragraph 4 of this Agreement.

B. Construction Management and Payment

1. DISTRICT, with the concurrence of COUNTY, shall administer and coordinate the construction-related work as provided herein.
2. DISTRICT, with concurrence of COUNTY, shall select and award construction contract(s).
3. DISTRICT shall require the contractor to provide adequate liability insurance that includes COUNTY. The contractor shall be required to indemnify COUNTY. Copies of the insurance coverage shall be provided to COUNTY.
4. DISTRICT, with assistance of COUNTY, shall coordinate field surveying; staking; inspection; testing; acquisition of right-of-way; and engineering as required to construct PROJECT. DISTRICT, with assistance of COUNTY, shall assure that construction is performed in accordance with the construction contract documents including approved plans and specifications and shall accurately record the quantities and costs relative thereto. Copies of all inspection reports shall be furnished to COUNTY on a weekly basis. DISTRICT shall retain an engineer to perform all or a part of these duties.
5. DISTRICT, with concurrence of COUNTY, shall contract with and provide the services of the design engineer for basic engineering construction services to include addendum preparation; survey control points; explanatory sketches; revisions of contract plans; shop drawing review; as-built plans; weekly inspection of work; and final inspection.
6. PARTIES shall have access to the site during construction at all times to observe the progress of work and conformance to construction contract documents including plans and specifications.
7. DISTRICT shall review and approve contractor billings.. DISTRICT shall remit payment to contractor based on billings.
8. DISTRICT, with concurrence of COUNTY, shall prepare and issue all written change or work orders to the contract documents.
9. PARTIES shall jointly conduct a final inspection and accept or reject the completed PROJECT in accordance with the contract documents.
10. DISTRICT shall provide COUNTY a set of reproducible "as-built" plans.

C. Construction Change Orders. In the event that it becomes necessary and advisable to change the scope or detail of the work to be performed under the contract(s), such changes shall be rejected or approved in writing by the contracting officers. No change orders shall be approved that increase the costs beyond the funds available in the PROJECT fund, including interest earned on those funds, unless and until the additional funds needed to pay for the added costs are committed by all PARTIES.

9. MAINTENANCE

PARTIES agree that COUNTY shall own and be responsible for maintenance of the completed and accepted PROJECT. PARTIES further agree that DISTRICT, at COUNTY's request, shall assist COUNTY with the maintenance of all facilities constructed or modified by virtue of this Agreement to the extent possible depending on availability of DISTRICT funds. Such maintenance assistance shall be limited to drainage and flood control features of PROJECT. Maintenance assistance may include activities such as keeping flow areas free and clear of debris and silt, keeping culverts free of debris and sediment, repairing drainage and flood control structures such as drop structures and energy dissipaters, and clean-up measures after periods of heavy runoff. The specific nature of the maintenance assistance shall be set forth in a memorandum of understanding from DISTRICT to COUNTY, upon acceptance of DISTRICT's annual Maintenance Work Program.

DISTRICT shall have right-of-access to right-of-way and storm drainage improvements at all times for observation of flood control facility conditions and for maintenance when funds are available.

10. FLOODPLAIN REGULATION

COUNTY agrees to regulate and control the floodplain of Clear Creek within COUNTY in the manner prescribed by the National Flood Insurance Program and prescribed regulations thereto as a minimum.

PARTIES understand and agree, however, that COUNTY cannot obligate itself by contract to exercise its police powers. If COUNTY fails to regulate the floodplain of Clear Creek within COUNTY in the manner prescribed by the National Flood Insurance Program and prescribed regulations thereto as a minimum, DISTRICT may exercise its power to do so and COUNTY shall cooperate fully.

11. TERM OF AGREEMENT

Despite the date that this Agreement is signed by PARTIES, the term of this Agreement shall commence upon the earlier of the date of final execution by all PARTIES or December 31 of the year that it is tendered to COUNTY for execution and shall terminate three (3) years after the final payment is made to the construction contractor and the final accounting of funds on deposit at DISTRICT is provided to all PARTIES pursuant to Paragraph 5 herein, except for Paragraph 10. FLOODPLAIN REGULATION, Paragraph 7.C. Ownership of Property and Limitation of Use, and Paragraph 9. MAINTENANCE, which shall run in perpetuity.

12. LIABILITY

Each party hereto shall be responsible for any suits, demands, costs or actions at law resulting from its own acts or omissions and may insure against such possibilities as appropriate.

13. CONTRACTING OFFICERS

A. The contracting officer for COUNTY shall be the Engineering Manager, 4430 South Adams County Parkway, Suite 2000B, Brighton, Colorado 80601

B. The contracting officer for DISTRICT shall be the Executive Director, 2480 West 26th Avenue, Suite 156B, Denver, Colorado 80211.

C. The contracting officers for PARTIES each agree to designate and assign a PROJECT representative to act on the behalf of said PARTIES in all matters related to PROJECT undertaken pursuant to this Agreement. Each representative shall coordinate all PROJECT-related issues between PARTIES, shall attend all progress meetings, and shall be responsible for providing all available PROJECT-related file information to the engineer upon request by DISTRICT or COUNTY. Said representatives shall have the authority for all approvals, authorizations, notices or concurrences required under this Agreement. However, in regard to any amendments or addenda to this Agreement, said representative shall be responsible to promptly obtain the approval of the proper authority.

14. RESPONSIBILITIES OF PARTIES

DISTRICT shall be responsible for coordinating with COUNTY the information developed by the various consultants hired by DISTRICT and for obtaining all concurrences from COUNTY needed to complete PROJECT in a timely manner. COUNTY agrees to review all concept plans, preliminary design plans, and final plans and specifications; and to provide comments within 21 calendar days after the drafts have been provided by DISTRICT to COUNTY.

15. AMENDMENTS

This Agreement contains all of the terms agreed upon by and among PARTIES. Any amendments to this Agreement shall be in writing and executed by PARTIES hereto to be valid and binding.

16. SEVERABILITY

If any clause or provision herein contained shall be adjudged to be invalid or unenforceable by a court of competent jurisdiction or by operation of any applicable law, such invalid or unenforceable clause or provision shall not affect the validity of the Agreement as a whole and all other clauses or provisions shall be given full force and effect.

17. APPLICABLE LAWS

This Agreement shall be governed by and construed in accordance with the laws of the State of Colorado. Jurisdiction for any and all legal actions regarding this Agreement shall be in the State of Colorado and venue for the same shall lie in the county where PROJECT is located.

18. ASSIGNABILITY

No party to this Agreement shall assign or transfer any of its rights or obligations hereunder without the prior written consent of the nonassigning party or parties to this Agreement.

19. BINDING EFFECT

The provisions of this Agreement shall bind and shall inure to the benefit of PARTIES hereto and to their respective successors and permitted assigns.

20. ENFORCEABILITY

PARTIES hereto agree and acknowledge that this Agreement may be enforced in law or in equity, by decree of specific performance or damages, or such other legal or equitable relief as may be available subject to the provisions of the laws of the State of Colorado.

21. TERMINATION OF AGREEMENT

This Agreement may be terminated upon thirty (30) days' written notice by any party to this Agreement, but only if there are no contingent, outstanding contracts. If there are contingent, outstanding contracts, this Agreement may only be terminated upon the cancellation of all contingent, outstanding contracts. All costs associated with the cancellation of the contingent contracts shall be shared between PARTIES in the same ratio(s) as were their contributions.

22. PUBLIC RELATIONS

It shall be at COUNTY's sole discretion to initiate and to carry out any public relations program to inform the residents in PROJECT area as to the purpose of PROJECT and what impact it may have on them. Technical information shall be presented to the public by the selected engineer. In any event DISTRICT shall have no responsibility for a public relations program, but shall assist COUNTY as needed and appropriate.

23. NO DISCRIMINATION IN EMPLOYMENT

In connection with the performance of work under this Agreement, PARTIES agree not to refuse to hire, discharge, promote or demote, or to discriminate in matters of compensation against any person otherwise qualified because of race, color, ancestry, creed, religion, national origin, gender, age, military status, sexual orientation, marital status, or physical or mental disability and further agree to insert the foregoing provision in all subcontracts hereunder.

24. APPROPRIATIONS

Notwithstanding any other term, condition, or provision herein, each and every obligation of COUNTY and/or DISTRICT stated in this Agreement is subject to the requirement of a prior appropriation of funds therefore by the appropriate governing body of COUNTY and/or DISTRICT.

25. NO THIRD PARTY BENEFICIARIES

It is expressly understood and agreed that enforcement of the terms and conditions of this Agreement, and all rights of action relating to such enforcement, shall be strictly reserved to PARTIES, and nothing contained in this Agreement shall give or allow any such claim or right of action by any other or third person on such Agreement. It is the express intention of PARTIES that any person or party other than any one of PARTIES receiving services or benefits under this Agreement shall be deemed to be an incidental beneficiary only.

26. ILLEGAL ALIENS

PARTIES agree that any public contract for services executed as a result of this intergovernmental agreement shall prohibit the employment of illegal aliens in compliance with §8-17.5-101 C.R.S. *et seq*. The following language shall be included in any contract for public services:

A. At the time of execution of this Agreement, CONTRACTOR does not knowingly employ or contract with an illegal alien who will perform work under this Agreement.

B. CONTRACTOR shall participate in the E-Verify Program, as defined in § 8 17.5-101(3.7), C.R.S., to confirm the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement.

C. CONTRACTOR shall not knowingly employ or contract with an illegal alien to perform work under this Agreement.

D. CONTRACTOR shall not enter into a contractor with a subconsultant or subcontractor that fails to certify to CONTRACTOR that it shall not knowingly employ or contact with an illegal alien to perform work under this Agreement.

E. CONTRACTOR shall confirm the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement through participation in the E-Verify Program.

F. CONTRACTOR is prohibited from using the E-Verify Program procedures to undertake pre-employment screening of job applicants while performing its obligation under this Agreement, and that otherwise requires CONTRACTOR to comply with any and all federal requirements related to use of the E-Verify Program including, by way of example, all program requirements related to employee notification and preservation of employee rights.

G. If CONTRACTOR obtains actual knowledge that a subconsultant or subcontracctor performing work under this Agreement knowingly employs or contract with an illegal alien, it will notify such subconsultant or subcontractor and PARTIES within three (3) days. CONTRACTOR shall also then terminate such subconsultant or subcontractor if within three (3) days after such notice the subconsultant or subcontractor does not stop employing or contracting with the illegal alien, unless during such three (3) day period the subconsultant or subcontractor provides information to establish that the subconsultant or subcontractor has not knowingly employed or contracted with an illegal alien.

H. CONTRACTOR shall comply with any reasonable request made in the course of an investigation by the Colorado Department of Labor and Employment under authority of § 8-17.5-102(5), C.R.S.

I. CONTRACTOR shall, within twenty days after hiring an employee who is newly hired for employment to perform work under this Agreement, affirms that it has examined the legal work status of such employees, retained file copies of the documents required by 8 U.S.C. Section 1324a, and not altered or falsified the identification documents for such employees. CONTRACTOR shall provide a written, notarized copy of the affirmation to PARTIES.

27. GOVERNMENTAL IMMUNITIES

PARTIES hereto intend that nothing herein shall be deemed or construed as a waiver by any party of any rights, limitations, or protections afforded to them under the Colorado Governmental Immunity Act (§ 24-10-101, *et seq*., C.R.S.) as now or hereafter amended or otherwise available at law or equity.

28. INTENT OF AGREEMENT

Except as otherwise stated herein, this Agreement is intended to describe the rights and responsibilities of and between PARTIES and is not intended to and shall not be deemed to confer rights upon any person or entities not named as PARTIES, nor to limit in any way the powers and responsibilities of the COUNTY, the DISTRICT or any other entity not a party hereto.

29. EXECUTION IN COUNTERPARTS – ELECTRONIC SIGNATURES

This Agreement, and all subsequent documents requiring the signatures of PARTIES to this Agreement, may be executed in two or more counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument. PARTIES approve the use of electronic signatures for execution of this Agreement, and all subsequent documents requiring the signatures of PARTIES to this Agreement. Only the following two forms of electronic signatures shall be permitted to bind PARTIES to this Agreement, and all subsequent documents requiring the signatures of PARTIES to this Agreement.

A. Electronic or facsimile delivery of a fully executed copy of a signature page; or

B. The image of the signature of an authorized signer inserted onto PDF format documents.

Documents requiring notarization may also be notarized by electronic signature, as provided above. All use of electronic signatures shall be governed by the Uniform Electronic Transactions Act, CRS §§ 24-71.3-101 to -121.

WHEREFORE, PARTIES hereto have caused this instrument to be executed by properly authorized signatories as of the date and year written below.

URBAN DRAINAGE AND
FLOOD CONTROL DISTRICT

By_____

Name Ken A. MacKenzie

Title Executive Director

Date_____

_____
Checked By

ADAMS COUNTY

By_____

Name_____

Title_____

Date_____

A AGREEMENT REGARDING
FINAL DESIGN, RIGHT-OF-WAY ACQUISITION, AND CONSTRUCTION
OF DRAINAGE AND FLOOD CONTROL IMPROVEMENTS FOR
CLEAR CREEK AT BNSF CROSSING BETWEEN PECOS AND FEDERAL BOULEVARD
ADAMS COUNTY

Agreement No. 18-04.06
Project No. 106259

Exhibit A

SAMPLE

AGREEMENT REGARDING
FINAL DESIGN, RIGHT-OF-WAY ACQUISITION, AND CONSTRUCTION
OF DRAINAGE AND FLOOD CONTROL IMPROVEMENTS FOR
CLEAR CREEK AT BNSF CROSSING BETWEEN PECOS AND FEDERAL BOULEVARD
ADAMS COUNTY

Agreement No. 18-04.06
Project No. 106259

Exhibit B

MEMORANDUM

This MEMORANDUM is entered into this _____ day of _____, 20__ by and between URBAN DRAINAGE AND FLOOD CONTROL DISTRICT, a quasi-governmental entity, whose address is 2480 West 26th Avenue, Suite 156-B, Denver, Colorado 80211 (hereinafter called "DISTRICT") and _____, a governmental entity, whose address is _____ (hereinafter called "COUNTY") and collectively known as "PARTIES";

WHEREAS, PARTIES entered into "Agreement Regarding Final Design, Right-of-Way Acquisition and Construction of Drainage and Flood Control Improvements for _____," Agreement No. _____ on or about _____, 20__, (hereinafter called "AGREEMENT"); and

WHEREAS, AGREEMENT is unrecorded, however PARTIES have agreed in AGREEMENT to record this MEMORANDUM in the records of the Clerk and Recorder of _____, State of Colorado, in order to put all who inquire on notice of AGREEMENT and in particular Paragraph 7.C of AGREEMENT; and

WHEREAS, in AGREEMENT, PARTIES agreed to participate equally (up to a maximum of $_____ each) in the cost of the construction of drainage and flood control improvements for _____ within COUNTY boundaries which include _____ (hereinafter called "PROJECT"); and

WHEREAS, construction of PROJECT may require the acquisition by COUNTY of real property; and

WHEREAS, AGREEMENT further provides that COUNTY will own all real property required to construct the improvements and that COUNTY ownership of that real property shall be subject to the terms and conditions of AGREEMENT and in particular Paragraph 7.C of AGREEMENT; and

WHEREAS, Paragraph 7.C of AGREEMENT provides in appropriate part as follows:

"7.C. Ownership of Property and Limitation of Use. COUNTY shall own the property either in fee or non-revocable easement and shall be responsible for same. It is specifically understood that the right-of-way is being used for drainage and flood control purposes. The properties upon which PROJECT is constructed shall not be used for any purpose that will diminish or preclude its use for drainage and flood control purposes. COUNTY may not dispose of or change the use of the properties without approval of DISTRICT. If, in the future, COUNTY disposes of any portion of or all of the properties acquired upon which PROJECT is constructed pursuant to this Agreement, changes the use of any portion or all of the properties upon which PROJECT is constructed pursuant to this Agreement, or modifies any of the improvements located on any portion of the properties upon which PROJECT is constructed pursuant to this Agreement, and COUNTY has not obtained the written approval of DISTRICT, prior to such action, COUNTY shall take any and all action necessary to reverse said unauthorized activity and return the properties and improvements thereon, acquired and constructed pursuant to this Agreement, to the ownership and condition they were in immediately prior to the unauthorized activity at COUNTY's sole expense. In the event COUNTY breaches the terms and provisions of this Paragraph 7.C and does not voluntarily cure as set forth above, DISTRICT shall have the right to pursue a claim against COUNTY for specific performance of this portion of the Agreement."; and

WHEREAS, COUNTY has just acquired the real property described in Exhibit Z attached hereto and incorporated herein by reference, as if set forth verbatim herein, pursuant to the terms and conditions of AGREEMENT for the construction of PROJECT; and

WHEREAS, PARTIES intend that the terms and provisions of AGREEMENT, including but not limited to Paragraph 7.C of AGREEMENT set forth verbatim above, shall apply to and control the real property described in Exhibit Z.

IT HAS BEEN AGREED previously in AGREEMENT by and between PARTIES that the terms and provisions of AGREEMENT, including but not limited to Paragraph 7.C of AGREEMENT set forth verbatim above shall apply to and control the real property described in Exhibit Z, now owned by COUNTY and that this MEMORANDUM be placed of record for the purposes of encumbering the real property described in Exhibit Z with the limitations and restrictions set forth in this MEMORANDUM.

This MEMORANDUM is not a complete summary of AGREEMENT. Provisions in this MEMORANDUM shall not be used in interpreting AGREEMENT's provision. In the event of conflict between this MEMORANDUM and the unrecorded AGREEMENT, the unrecorded AGREEMENT shall control.

URBAN DRAINAGE AND
FLOOD CONTROL DISTRICT

(SEAL)

By_____

ATTEST: Title Executive Director

_____ Date_____

STATE OF COLORADO)

) ss.

COUNTY OF _____)

Subscribed and sworn to before me this _____ day of _____, 20__, by _____.

WITNESS my hand and official seal.

(SEAL) _____

Notary Public

My Commission Expires _____.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: July 17, 2018
SUBJECT: Adams 12 Five Star Schools
FROM: Chris Kline, Director
AGENCY/DEPARTMENT: Human Services Department
HEARD AT STUDY SESSION ON
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 and community resource programs to quickly and accurately process medical assistance applications on behalf of their clients. Adams County hires Community Support Specialists who are designated to expedite the medical assistance applications submitted by clients of each of these organizations. Funding for the salary and benefits of the Adams County employee who works under the Adams 12 Five Star Schools contract is as follows:

Twenty five percent (25%) of the salary and benefits for the Adams County employee who works with Adams 12 Five Star School is funded by Adams 12 Five Star School, and the other seventy five percent (75%) is reimbursed with federal Medicaid funds. In addition, Adams 12 pays $100 per month toward administrative costs as well as $520 per month toward supervisory costs.

Renewal of this contract will enable timely processing of Health First Colorado applications. This contract is intended to prevent a negative impact on the delivery of medical services to needy families and will ensure each partner receives timely medical assistance payments for the services rendered to these families.

This position is 100% reimbursed, there is no cost to 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 12 Five Star Schools

ATTACHED DOCUMENTS:

Resolution
Contract between Adams County and Adams 12 Five Star Schools
Agency Letter Number: 15-006

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**

RESOLUTION APPROVING THE AGREEMENT BETWEEN ADAMS COUNTY AND ADAMS 12 FIVE STAR SCHOOLS TO PROVIDE HEALTH FIRST COLORADO APPLICATION PROCESSING AT ADAMS 12 FIVE STAR SCHOOLS

WHEREAS, Adams 12 Five Star Schools (Adams 12) requested to reimburse the Adams County Human Services Department (ACHSD) to employ a Community Support Specialist to process Health First Colorado applications; and,

WHEREAS, the current Community Support 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 financial counselors would have to transport application forms to ACHSD, which would delay Health First Colorado eligibility determinations, provision of medical services to needy families, and timely payment for services; and,

WHEREAS, twenty-five percent (25%) of the salary and benefits for the Community Support Specialist will be funded by Adams 12 and seventy-five percent (75%) will be funded by Colorado Department of Health Care Policy and Financing.

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 Health First Colorado Application Processing at Adams 12 Five Star Schools, be 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 HEALTH FIRST COLORADO APPLICATION PROCESSING AT ADAMS 12 FIVE STAR SCHOOLS

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 "the district".

WITNESSETH:

WHEREAS, the district accepts Health First Colorado applications each month from Adams County residents; and

WHEREAS, currently the district 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 Health First Colorado eligibility determination, provision of medical services to needy individuals and families, and timely payment for those services to the district; and

WHEREAS, the district sometimes provides medical services to indigent patients prior to Health First Colorado eligibility determination, thus risking non-payment for those services if treated patients are later deemed ineligible; and

WHEREAS, the district is willing to pay twenty five percent (25%) the salary and benefits and provide a working space and appropriate office equipment for a Community Support Specialist; and

WHEREAS, ACHSD has agreed to allow one Community Support Specialist, employed by Adams County, to process the district's, Health First Colorado 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 ACHSD shall be assigned to work at the district's facility at the Student and Family Resource Center, Northglenn Facility. The Community Support Specialist shall be responsible for determining eligibility for Health First Colorado 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 applications per month, will also be responsible for adding "Needy Newborns" and "pregnant women" to ongoing Health First Colorado cases, and assisting the district staff with Health First Colorado eligibility issues as related to this agreement, including billing back dates as time allows. The Community Support Specialist through the district 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 Health First Colorado applications processed by the district 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 district's policies to the extent that such policies and regulations are not in conflict with those of the ACHSD 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. The Districts Financial Responsibility. Twenty-five percent [1]of the average salary costs, employer taxes, retirement contribution, health insurance, and other applicable benefits for the Community Support Specialist in accordance with rates specified by ACHSD, shall be paid to ACHSD effective upon the start date of the Community Support Specialist. ACHSD estimates that 25% of the average salary and benefits range for the Community Support Specialist will be between $11,250 and $15,000 annually. 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 $520 per month effective the Community Support Specialists start date and adjusted annually thereafter shall be paid by the district. 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 the district within the first quarter of each year.

[1] CMS has approved a waiver allowing ACHSD to charge seventy-five percent of these costs to Medicaid, with the remaining twenty-five percent chargeable to the contracting entity.

Notwithstanding the Term (Section J) of this Agreement, financial responsibility for payments owed by the district for salary 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 Health First Colorado eligibility function, and if mutually agreed to, the full cost of the Community Support Specialist will be borne by the district 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.

The district shall reimburse ACHSD for administrative costs, at a fixed rate of One Hundred Dollars, ($100) per month, incurred by the Community Support Specialist and supervisory staff in carrying out the functions of the Community Support Specialist, such as mileage, continuing education, training and other required meetings. The $100 administrative cost will be submitted on the monthly invoice to the district.

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 the district's facility. To ensure timely payment by the district, ACHSD shall strive to submit all invoices to the district within the first five (5) business days of the month.

The district will be responsible for all costs associated with the Community Support Specialist's and Supervisor's parking at the district.

E. Coverage for Long-Term Absences. ACHSD shall attempt to provide an on-site replacement staff for the district 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, the district 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. The district shall provide working space such as an office or cubicle, office equipment and supplies, a desktop computer, and a locking file cabinet for the Community Support Specialist. ACHSD, with the cooperation of the information technology staff of the district, 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 district 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. The district 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 the district shall exchange evidence of insurance showing general liability coverage for the district, 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 the district 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, 2018, for a term of twelve (12) months ending on June 30, 2019. Additionally, this agreement may be terminated without cause by either ACHSD or the district upon thirty (30) days written advance notice, and in the event of such termination, the district monthly financial obligation shall cease for all subsequent months.

K. Confidentiality. The Community Support Specialist shall comply with the district 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 the district.

L. Evaluation Plan. ACHSD and the district 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 the district 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 the district.

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 the district 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, the district reputation, property, or the district operations, the district must immediately report such information to an ACHSD Superior 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:
STAN MARTIN
CLERK AND RECORDER

APPROVED AS TO FORM:

_____
Adams County Attorney's Office

_____
Deputy Clerk

CONTRACTOR:

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

Subscribed and sworn to before me this _____ day of _____ 2018, by _____.

_____
Notary Public

My commission expires: _____

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

AGENCY LETTER

AGENCY LETTER NUMBER: 15-006
SUPRECEDES NUMBER: NA
DIVISION OR OFFICE: Finance Office
SUBJECT AREA: County Finance
SUBJECT: Enhanced Match Funding Information
TYPE: I
APPROVED BY: John Bartholomew

HCPF Agency Letters can be accessed online: www.colorado.gov/hcpf
>>Partners & Researchers >> County and Medical Assistance Site >> Agency Letters

Purpose:

The purpose of this agency letter is to provide guidance to counties Human Services financial staff in regards to what administrative expenses qualify for the federal enhanced match provided by the implementation of the Affordable Care Act (ACA).

Background:

Effective October 2013, states have been eligible for a 75% federal match on certain Affordable Care Act (ACA) activities related to eligibility processing and determination activities which were previously eligible for a 50% federal match. Centers for Medicare and Medicaid Services (CMS) examined practices under Medicaid Management Information Systems (MMIS) rules for approval of 75% federal match for maintenance and operations in the context of eligibility determinations and confirmed that certain eligibility determination-related costs for specific activities are eligible for 75% federal financial participation (FFP) on an ongoing basis. The Department evaluated historical data of county worker activities and cost pool data in the County Financial Management System (CFMS) and based on this information, the Department worked with counties and Department of Human Services (DHS) to enable codes and modify cost pools within CFMS to allow counties to receive enhanced federal match for certain activities provided in Table 1.1.

HCPF Agency Letter Number HCPF 15-006

Table 1.1

Eligible for 75/25 Application, On-going Case Maintenance and Renewal*	Eligible for 50/50 Policy, Outreach and Post-eligibility
• Intake - Application/data receipt(i) • Acceptance- Edits, verification and resolution of inconsistencies(ii) • Eligibility determination (iii) • Outputs-Issuance of eligibility notices to customer, file updates and transactions to partners(iv) • On-going case maintenance activities, including intake activities related to renewals(v) • Customer service, including call center activities (vi) and out-stationed eligibility worker activities (vii) related to eligibility determination. • Maintenance and Routine Updates, including routine system maintenance, security updates, and other routine maintenance activities related to the Eligibility Determination System.	• Outreach and Marketing – General public outreach, beneficiary education and outreach, including explanation of eligibility policies, program and benefits. • Policy development and research even if related to eligibility determination standards and methodologies • Staff development and training even if related to eligibility determination, except for Operational Readiness training as defined in the response to question 3 below. • Community-based application assistance • Program integrity, including auditing efforts • Appeals of final eligibility system determinations • On-going case maintenance activities, including plan choice/counseling and enrollment • Customer service, including call center activities and out-stationed eligibility worker activities, related to beneficiary education, benefits, plan choice/enrollment, and civil rights complaints.

*Includes line staff, supervisory staff and support staff for the activities listed.
i. Activities related to receipt of the application or data related to applications.
ii. Manual and automated edits and verification of data.
iii. Activities related to assisting the automated eligibility determination system in the evaluation of the edited, verified data to make an eligibility determination.
iv. Includes the issuance of the eligibility notice to the beneficiary, file updates and all activities related to notification to partners of the decision (e.g. Federally-facilitated Marketplace, SBMs, MCOs, POS, etc.).
v. Includes receipt of data related to the ongoing-eligibility and maintenance of a beneficiary's eligibility, such as annual renewals, address changes, income changes, household composition changes, etc. and the related steps as described in notes i, ii, iii & iv above.
vi. Costs of call center staff should be allocated based on the portion of staff time spent performing functions eligible at the 75 percent versus 50 percent FFP levels. Those call center functions related to benefits, general beneficiary education, plan choice and enrollment would only be eligible at the 50 percent FFP level.
vii. Costs of out-stationed eligibility workers entering eligibility application data also would be eligible for 75 percent FFP. Costs of workers conducting consumer assistance would only be eligible for 50 percent FFP.

The Department has received questions from counties regarding the enhanced match and the purpose of this letter is to provide written guidance to answer those questions.

Procedure or Information:

The following frequently asked questions (FAQ) is to provide additional guidance to county finance human services staff as to what Medicaid administrative costs are/are not eligible for the enhanced funding.

Are salary expenses for staff performing the following activities for Medicaid eligibility allowed to be submitted for the enhanced match?

- Processing applications
- Ongoing case maintenance
- Eligibility renewal

Yes. These activities are eligible for the enhanced match. In situations where staff work on more than one federal program; all costs must be distributed to the appropriate programs by use of 100% time reporting or through random moment sampling based on the use of designated cost pools. Reports must reflect an after the fact distribution of actual activities performed. Time reporting must be completed at least monthly and account for the total activity for which the employee is compensated. This is identified in the Affordable Care Act: State Resources FAQ dated April 25, 2013.

Are salary expenses for staff performing customer service related to Medicaid eligibility allowed to be submitted for the enhanced match?

It depends. Customer service, including call center activities and out-stationed eligibility worker activities related to eligibility determination are eligible for enhanced match.

However, customer service, including call center activities and out-stationed eligibility worker activities, related to beneficiary education, benefits, plan choice/enrollment, and civil rights complaints are eligible for the 50% match.

Does postage, office supplies, and outreach or marketing expenses related to new Medicaid client enrollment incurred by the county qualify?

No. Postage, office supplies, and marketing outreach materials are eligible for a 50% match only. This is identified in the State Medicaid Manual (SMM) Section 1100 in accordance with Section 1903 (A)(3)(b) of the Social Security Act.

Is the required training (CBMS or other training), and associated expenses (travel, meals, hotel, etc.) that staff must take eligible for the enhanced match?

No. Hours for staff development and training, even if related to eligibility determination, cannot be claimed for the enhanced match. All associated expenses with that training are also not

eligible for the enhanced match. These expenses are eligible for the 50% match. This is identified in the Affordable Care Act: State Resources FAQ dated April 25, 2013.

Is travel that the county worker does between remote locations to perform eligibility tasks eligible for the enhanced match?

No. Travel costs are eligible for the 50% match. This is addressed in 42 CFR Part 432 Subpart C at 432.50(b) (6).

Does office equipment such as new phones, computers, and office furniture for staff hired to process Medicaid eligibility qualify for the enhanced match?

No. Supplies and equipment used at the County offices are included in an indirect cost pool covering the administration of Medicaid as well as other public programs delivered at these offices. The State Medicaid Manual (SMM) Section 11276.9 states these costs are matched at 50%. You can access the State Medicaid Manual at:

https://www.colorado.gov/pacific/hcpf/colorado-medicaid-state-plan

Are eligibility reviews conducted by supervisors at the counties eligible for enhanced match?

Supervisory staff performing verification post eligibility, and that are part of the normally initiated part of a sampling approach, are considered to be program integrity activities and are not eligible for the enhanced match. The State Medicaid Manual (SMM) Section 11276.9 states these costs are part of the Medicaid Eligibility Quality Control program and are matched at 50%.

Supervisor's performing application/data receipt, eligibility determination, on-going case maintenance and renewal activities are eligible for the enhanced match. This is identified in the Affordable Care Act: State Resources FAQ dated April 25, 2013.

If a county has a contract with an external company to digitize case files or a county has purchased a file retention software package, does that qualify for the enhanced match?

No. This is not a direct cost. Other public programs will be covered with the use of these types of services and are not eligible for the enhanced match. Supplies and equipment used at the County offices, and not defined any more specifically, are included in an indirect cost pool covering the administration of Medicaid as well as the other public programs delivered at these offices. The State Medicaid Manual (SMM) Section 11276.9 states that these costs are matched at 50%.

I have a question that is not covered by this FAQ.

Please send any questions regarding enhanced match funding to HCPFaudit@hcpf.state.co.us.

HCPF Agency Letter Number HCPF 15-006
Effective Date:

July 1, 2015

Contact:

hcpfaudit@hcpf.state.co.us

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: July 17, 2018
SUBJECT: Adams County Head Start Year Four of Five Continuation Grant application for 2018-2019
FROM: Chris Kline, Director of Human Services Departmen
AGENCY/DEPARTMENT: Human Services Department
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners Approves the resolution approving the Adams County Head Start Year Four of Five Continuation Grant application for 2018-2019

BACKGROUND:

Adams County Head Start (ACHS) is submitting a Year Four of Five Continuation Grant application for November 1, 2018 - October 31, 2019. The Grant amount is $4,122,510. These funds are being made available through the U.S. Department of Health and Human Services, Administration for Children and Families (ACF). This grant requires Adams County Head Start to provide a 20% match of in-kind totaling $1,030,628 which will be obtained through volunteer time, state and private funding, and donated goods and services. The total amount is $5,153,138. The grant application is due to the Administration for Children and Families on July 26, 2018.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Human Services Department Head Start and the U.S. Department of Health and Human Services

ATTACHED DOCUMENTS:

Resolution attached
Office of Head Start Letter
Grant Application
Adams County Head Start Self Assessment Action Plan

FISCAL IMPACT:

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

Fund:	31
Cost Center:	935119

	Object Account	Subledger	Amount
Current Budgeted Revenue:	5230		$4,122,510
Additional Revenue not included in Current Budget:			
Total Revenues:			$4,122,510

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:	7000.9999		$4,122,510
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			$4,122,510

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

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

Additional Note:

RESOLUTION APPROVING THE ADAMS COUNTY HEAD START YEAR FOUR OF FIVE CONTINUATION GRANT APPLICATION FOR 2018 - 2019

WHEREAS, Adams County has a five year federal grant from the U. S. Department of Health and Human Services, Administration for Children and Families ("ACF") for the Adams County Head Start Program; and,

WHEREAS, by means of the attached application Adams County Head Start wishes to apply for the Year Four of Five Continuation Grant; and,

WHEREAS, the grant funds will continue to be used to support the Adams County Head Start Program.

NOW THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the Adams County Head Start Year Four of Five Continuation Grant application be approved.

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

ADAMS COUNTY HEAD START
TABLE OF CONTENTS

Section I. PROGRAM DESIGN AND APPROACH TO SERVICE DELIVERY

SUB-SECTION A: Goals

PROGRAM GOALS: MEASURABLE OBJECTIVES, EXPECTED OUTCOMES, CHALLENGES, AND REVISIONS

Due to the decrease in number of children now served not all outcomes can be compared to previous years. Adams County Head Start has 256 slots, 193 less than years 1-2 of the grant. This change impacted the baselines for some of the program objectives.

***Program Goal 1*: Adams County Head Start (ACHS) will enhance comprehensive services to maximize children's potential to enter kindergarten with a successful academic and social emotional foundation.**

***Objective 1*: Providing professional development for teaching staff to increase instructional support in their teaching practices will result in 64% of our teachers demonstrating a positive increase in their CLASS scores from fall to spring annually.**

Overall, the program rated at or above the national average scores in the areas of Emotional and Instructional Support; however, a .67 decrease in Classroom Organization was identified in this year's CLASS scores compared to the national average scores. When this year's scores were compared to last year's, a decrease of .36 was observed.

The program did not meet the anticipated 64% increase; only 47% of the teachers demonstrated growth from their CLASS pre to post scores in at least one of the domains. Scores from five teachers were not included; two left the program, two started later in the year, and one was a substitute teacher.

Three teachers scored lower on their CLASS scores averaging a .42 decrease. CLASS outcomes for this year reflect the need for supplementary training in the Classroom Organization and Instructional Support domains. Factors potentially impacting the outcome were the need for

additional observation and scoring training for education supervisors to ensure consistency of scores with fidelity.

A plan to reach the 64% benchmark was developed and is to be implemented next year. CLASS observers will be trained to enhance fidelity of the tool and teachers will receive CLASS training to increase knowledge in all domains. Additionally, the program will utilize a peer coaching approach to support teachers who need additional guidance. Staff who scored the lowest will receive additional support from the education coach.

<u>Objective 2:</u> Increase exposure to family literacy by participating in the Families and Fathers Reading Every Day (FFRED) program resulting in determining the baseline in year one of five; from year two through five, the program will experience: a 10% increase on # of reading hours at home; a 5 % increase in # of books given to families by Head Start; and a 10% increase in the # of families reading to their children at home.

Objectives two and three were merged in 2015-2016. See outcomes under objective three.

<u>Objective 3:</u> Promote the importance of parent involvement in building their child's literacy and vocabulary skills. Parent participation data from the first grant year in literacy and vocabulary knowledge will be used to identify a baseline of our HS family community. The parent participation baseline will increase by 3% annually.

Family participation was significant this year. Adams County Head Start served two hundred and eighty families. One thousand five hundred and seventy-eight family members participated in reading time with their children, generating 2,250 hours. Participants received one book per week, with a total of 741 Fathers and Families Reading Every Day (FFRED) books distributed. This year's parent participation increased by 91%; hours of reading time by 93%; and books given to families by 119%.

This year's Cultural Literacy Festival took place in May with 342 adults and children attending. Children engaged in a myriad of activities that focused on book themes to enhance

early childhood literacy. Families also had the opportunity to participate in a book swap. The activities were a big success in promoting literacy as evidenced by the number of participants.

Three thousand six hundred and three books were checked out by families who participated in the Lending Library program. Approximately 790 hours of adult reading with children were generated and 727 family members participated this year. As mentioned earlier the program moved to an all full day model which decreased our enrollment slots by 193; even with this decrease, participation only decreased by two parents.

The Family Connection program continued the promotion of early literacy at home. Each family in the program received nine books this year, 3% more than last year. Teachers introduced the books through classroom activities and they also presented the same books to the parents at parent cafés while demonstrating how parents can engage their child while reading. Throughout the year families had the opportunity to participate in five extension activities related to the book. These activities were completed in the home by the parent and child. Four hundred and thirty-six individuals read to a student at home, generating 602 reading hours; almost double compared to last year.

***Objective 4*: The health and nutrition area will strengthen the follow-up process in place for children who have been identified at high risk for health/nutritional needs as evidenced by initiating the follow-up process through the following steps: Provide screening form with necessary follow-up to parent day of screening; Create a COPA referral for that child within 5 business days after screening; Case note all communication with family regarding necessary follow-up; If amenable with family, establish a FPA goal based on referral and necessary follow-up if necessary appointment with referred specialist is not complete within one month of referral notification; and Expecting a 5% annual increase in the completion of hearing, vision and dental referrals from baseline established 2015-2016.**

All children needing a referral received one within five days after their screening. The total

number of referrals made, for both sensory and dental treatment, was 146 and 100 of these were completed by June 2018. This is a 20% increase for completed referrals from 2017. Based on the referral process areas needing improvement last year, the goal of a 10% annual increase was achieved. All referrals that remain in progress are for children expected to return for their second year at ACHS.

This year dental screenings began in early September and only two centers had their second six month dental screenings during the first week of May. This allowed more families the months of May and June to receive follow-up care from their dental homes. Additionally, the health team was able to work with the Family Service Specialists (FSS) at two centers in order to develop family partnership agreements with two families who were referred for dental and vision needs. Both families were able to verbalize barriers and develop a plan for their children to receive the recommended follow-up care based on the screening referral. In both cases, each child received the recommended oral health care. In addition, one child also received the prescription glasses needed for vision correction.

The health team continues to contact families as file audits take place during the remainder of June and July to provide support for any necessary care, including returning children who will still be receiving care next year. The health specialist (HS) will determine whether a family goal is amenable for the parent/guardian to successfully support and meet the family where they are at in this process. Families who developed health goals this year felt supported. They understood the importance of the early screening process and of receiving the necessary follow-up care.

Reasons for incomplete referrals mirror similar reasons as previous years: the child dropping

out of the program or transitioning to kindergarten; medical/dental providers not having appointment times available that corresponded to the schedule of the family's availability; the appointment needing to be scheduled at a much later time after the referral was given to the parents; and some parents choosing not to follow up on the referral even after receiving support and guidance regarding the timeliness surrounding their child's medical/dental care.

Objective 5: Provide parents with a minimum of three annual group based parent education sessions on developmental and social-emotional topics. The baseline for parent attendance will be established in year one and a 3% annual growth is expected.

Six successful parent education sessions on social emotional and development topics were offered this year. There was a 16% annual growth in parent attendance, vastly surpassing the anticipated 3% increase. Last year, a total of 82 parents participated in at least one of the three parent workshops. This year 95 attended at least one of the six workshops. There is only a difference of 13 parents in attendance from last year. Considering the reduction in program slots by almost half compared to last year, the percentage of parents participating is definitely higher this year.

Various educational opportunities were offered this year. In November and March the mental health consultants presented topics related to managing challenging behaviors and social emotional development during the transition to kindergarten process at all parent cafes.

In October and April parents had the opportunity to connect and relax with their children through creative movements, songs, stories, and games in the Family Yoga workshop offered by a licensed pre-school yoga teacher. Parents learned about the benefits of mindfulness and yoga practice including how it helps increase focus, self regulation, emotional expression, and the

enhancement of the connection of feeling the body and connections with others. Eleven parents participated in these activities. Additionally, a workshop on special education law was offered in December and one parent attended. The January's workshop on Advocacy did not have any participants.

In addition to the workshops, ACHS continued providing therapeutic services with the support from Denver Children's Advocacy Center. Seven families, facing multiple barriers accessing mental health treatment, received onsite therapy free of charge to them and to ACHS. These services were made possible through a grant from the Rose Foundation secured by the Denver Children Advocacy Center to ensure vulnerable children are able and ready to learn no matter their circumstance.

Objective 6: Identify teaching staff needs related to mental health and special education. The education and support areas will work closely to coordinate training for staff.

To support children experiencing learning/behavioral challenges the collaborative team composed of the education supervisor, teachers, special education school district personnel, mental health consultant, and the special education and support services program supervisor attended monthly collaborative meetings. Based on several sources professional development needs for the education staff were identified by the special education and support services program supervisor. The sources included the Teaching Pyramid Observational Tool (TPOT), teachers' feedback gathered in monthly collaborative meetings, and teacher surveys. After identifying staff professional development needs, the special education and support services program supervisor and education manager incorporated trainings.

The Special Education and Support Services department provided 16 trainings/educational

opportunities on mental health and special education topics for the teaching staff. They received seven trainings on classroom management. These were Proactive Teaching, Building Positive Relationships with Students, Motivating Students through Incentives, Decreasing Inappropriate Behaviors through Ignoring and Redirecting, Teaching and Promoting Social Skills and Problem Solving, Managing Anger, Utilizing Friendship Skills and Understanding, and Communicating Feelings. Two other trainings were offered by the mental health consultant on Trauma in the Classroom and Its Impact on Development, Learning, Behavior, and Classroom Dynamics; along with Compassion Fatigue and Self-Care for Long Term Health.

Six additional educational opportunities were provided through a Resilient Educators group where education staff had the opportunity to explore topics related to compassion fatigue, secondary stress, self-care and resiliency, and learned about basic mindfulness practices to incorporate in the classroom and their personal life. Participation was a success, as 100% of the teaching staff attended at least one Resilient Educators group meeting.

***Objective 7*: Align professional development needs with each area to maximize ACHS's quality of services.**

Adams County Head Start paid tuition for teachers pursuing educational advancement. This year seven education staff successfully completed college classes/degrees. By the end of the school year, one staff received a Child Development Associate, four are working towards an AA/AS, and two are working towards a BA/BS.

Family services staff received two special education and mental health trainings. The first was on How to Navigate through the Mental Health and Special Education Process in ACHS. The second was on The Trauma-Informed Approach and Self-Care. All FSSs have the Family

Development Credential and the family service leadership team received a Reflective Leadership training to align leadership practices with the Family Development Credential. Family Services Specialists will receive a refresher course in August.

In September the health and nutrition services manager became a certified asthma educator. The health team was trained on Managing Challenging Behaviors and How to Navigate through the Mental Health and Special Education Process. This year members of the health team were invited to present at the NHSA Conference held in Austin, Texas on unique processes used by the program to work with families and on cultivating medical provider partnerships. The nutrition leadership team attended trainings on updated CACFP menu requirements which were implemented this year.

Adams County provides numerous trainings for employees at no cost to the program. For example, a detailed training on Cultural Humility was provided for employees in an all day session. In addition, certificate programs are offered for Organizational Professionalism and Organizational Leadership. Other classes on skill building, cultural awareness and wellness trainings are also offered. The county also implemented the "LEAD Reads" which helps staff expand their learning through books.

***Objective 8*: Enhance case management efforts across the program through the implementation of motivational interviewing and stages of change frameworks in addition to improving the current case management process. The program will develop an action plan with timelines to track and measure progress and identify necessary changes.**

The program continues to use case management and Motivational Interviewing (MI) as fundamental philosophies to identify family needs, their priorities, and meeting the family where they are to help them achieve their goals. In 2017-2018, the family services team participated in

a one day advanced MI training hosted by the Human Services Network of Colorado. All eight FSSs and their supervisor attended and were trained on advanced concepts of communication and change talk, motivational stages, principles of MI, and the benefits of MI. With this knowledge and skills, the FSSs have been able to provide effective case management for families. The program is working to schedule a MI refresher training for the family services staff next year. As a way to ensure and track that MI is being used the area has adopted a new case note technique called DAP (Data, Assessment, Plan) which staff were trained on. Brief DAP refreshers have taken place during Family Services team meetings. Since the implementation of DAP, a case note audit was completed by the quality assurance manager. During the audit 3 files from each FSS caseload and 2 files from family services supervisor were assessed to identify whether DAP was being implemented in case notes. The results indicated that 11 files had the appropriate format and 15 did not. Three FSS's and their supervisor demonstrated an understanding of its implementation and five FSSs appeared to need further training. Going forward the Family Services team will receive another training on DAP in August and will have frequent refreshers to ensure proper use of the technique. If staff continues to struggle, their supervisor will work with them on an individual basis. The Family Services leadership will conduct DAP audits for proper use and consistency.

This year the health team attended a one day Advanced Motivational Interview conference provided by the University of Denver School of Nursing. The conference was specifically designed for healthcare professionals working directly with clients on health issues related to readiness, barriers, and motivation to change. This advanced course will also help serve future

efforts to build a robust tobacco cessation initiative for families in ACHS.

The health team continues case noting as a mechanism to measure the health specialist's ability to utilize MI skills. The expectation is that HSs use case noting to align subjective, objective, assessment and plan (SOAP) information. This includes indicating families' barriers and the support provided by the HS for the family to receive necessary medical/dental care. Additionally, the team is also expected to accurately describe the family's willingness toward the behavioral change(s) and document the support provided to the parent/guardian working on completing the recommended follow-up.

The health and nutrition manager (HNM) conducted a random audit of 50% of all incomplete referrals measuring the team's use of the new case note guidelines and to receive an equitable measure amongst all HS. Audit outcomes indicated that 43 referrals were incomplete as of mid-June. Twenty-two of these referrals were randomly selected to assess if case notes had the necessary information to understand why the child did not receive the needed care. The results were as follows: 32% of them did not address the parent/guardian's barriers/reasons why the follow-up could not be completed within the year. Fifty-nine percent of the twenty-two referrals had case notes that included what the HS did to support the family. Sometimes support provided was to contact a medical/dental provider for the family, or to explain why the referral was provided and continue to encourage the parent to receive the care necessary for their child. Sixty-four percent of the twenty-two referrals indicated the parent's willingness to follow through with scheduling an appointment and receiving the care necessary with either a future appointment date noted, or a verbalization that the parent was going to call their provider to schedule an

appointment that week. Out of the fifteen barriers noted, the top three barriers were time to schedule and bring their child to a follow-up appointment, forgot to schedule an appointment, or the parent simply did not understand the process.

The HNM will continue to work with each health specialist to fine tune their MI practices as well as their case noting during the next year. Case note audits will continue throughout the year to help identify the team's strengths and weaknesses so the program can effectively advocate for families and help the parents become their child's best role model in preventive care.

***Program Goal 2**: Adams County Head Start will strengthen the transition process to the local school system for children and families so that Head Start children succeed in kindergarten and beyond. Goal 2 Expected Outcome: Parents know how to navigate the school system to ensure their children's needs are shared with the local school system and addressed.*

***Objective 1**: 100% of families will understand their child's developmental progress throughout the school year and will be informed of the progress their child has made to meet expectations set for children starting kindergarten. The content shared with families includes developmental progress discussions, sharing of portfolios, and TS GOLD information; parents will receive information of the school district's general entry to kindergarten developmental expectations; families will receive developmentally appropriate activities that help maintain and strengthen children's developmental skills during the summer months before entering kindergarten.*

Parents received information on their child's developmental progress throughout the school year through several venues, such as parent teacher conferences, home visits, and one-on-one discussions. Per the self-assessment, the anticipated outcome was achieved. One-hundred percent of families who participated in a second parent teacher conference or last home visit received their child's TS GOLD outcomes. During the May home visits families were given kindergarten transition guides that included information about kindergarten readiness, resources for families, and contact information for all public schools in Adams County. They also received

activities to help their child maintain and strengthen academic skills over the summer months.

Objective 2: ***HS parents will learn about the school options available to them including their home school and other options. A 10% increase on the following is expected by year five of the grant. The baseline being the outcomes generated from the previous year's data; Number of parents attending the Kinder Transition parent cafe; Number of parents who selected a school for their child before the program year ends; Number of transition packets given to parents containing information about the school and an identified point of contact for future questions.***

Kindergarten transition was the focus of the January parent café at each center with 49 parents attending; which was a 44% increase in attendance from last year. Parents learned about the school districts' guidelines on what their child needs to know to be ready for kindergarten as well as the options offered by the school districts' Choice program. Choice is an event that provides a window of time where school districts offer families the opportunity to register their child at a school other than their designated school.

Out of 295 children enrolled 204 are of age to transition to kindergarten. Out of these, 34 left the program prior to the end of the school year and 170 completed the year. Ninety-nine percent of the 170 selected an elementary school prior to the school year ending.

Objective 3: ***In collaboration with the school districts the education leadership will establish kindergarten developmental expectations. After year one, these meetings will take place annually and an annual debriefing meeting at the end of each program year will be held to identify how the process can be strengthened by the collaboration.***

This objective was omitted before the start of the 2016-2017 program year and its omission was reported in last year's grant application.

Objective 4: ***The receiving school is aware of the child's needs and the parent has the necessary health/nutritional documentation in place before school starts. This successful transition will be measured by Establishing a relationship with school district RNs/Health Clerks; Number of parents with children who have health/nutritional needs contacted by the Health Specialist to provide guidance and support through the transition process will***

increase by 5% annually where baseline is established 2015-2016; and The number of parent contacts, case management support provided by the health team, and number of children who left the program with the necessary documentation needed by the school to address their health/nutritional needs will be 85% annually.

In 2017-2018 the program supported families on how to collaborate with the chosen school district health and nutrition teams in order to aid them in the kindergarten transition process for their child's medical/dietary needs. There were 27 children with health/nutrition needs throughout the year. Eighteen families chose schools and only four of the 27 children dropped from the program. Additionally, one health care plan was no longer needed as the child grew out of the allergy.

By mid-May three families were still unsure of which school their child will attend in August. Last year 10 families successfully made contact with the chosen school. This year five out of the 20 families (25%) had chosen a school and successfully made contact with the appropriate health or nutrition office in the school by mid-June. The three families, who are still undecided on a school at this time, plan on contacting the school in August. Although this is a 15% decrease of families who made contact with their health and/or nutrition departments last school year, the health team successfully provided guidance and advisement. The team also gave families the paperwork needed to provide their chosen school prior to their child starting. The packet contained their chosen school's health and nutrition contact information, blank health care and special diet forms, as well as other necessary medical information. This information was provided to 100% of families (23) whose children remained in the program until the end of the year. Based on last year, the anticipated outcome was 85% of families were to receive guidance and advisement this year and we exceeded this goal.

In June the health team attempted to follow-up with parents in regard to contacting the health and nutrition department(s) of their chosen school. Eleven parents were unavailable for various reasons: voice mail was full, no email available, phone disconnected, etc. We successfully left messages or sent emails to seven out of the 11 parents (64%) to determine if further support was needed and if they contacted their chosen school. Follow-up will continue until the end of June.

The program continued guiding families on how to advocate for their child's special dietary needs (religious restrictions surrounding specific foods, etc.) without a required Health Care Plan. The process included giving parents the public school forms in English and other languages as needed.

<u>Objective 5</u>: HS children with special developmental and/or mental health needs successfully transition to the receiving school(s) as measured by an annual increase of 3% of parents making at least one contact with school personnel to discuss their child's individual needs after the baseline number is set in year one of five.

Based on criteria set by ACHS, 20 out of 23 students with special education and/or mental health needs successfully transitioned to kindergarten this year; surpassing the anticipated 3% annual increase from the 66% baseline. Eighty-seven percent of students with IEPs successfully transitioned.

The criteria used to identify a successful transition were:

- formal enrollment took place
- receiving school obtained a copy of the IEP paperwork
- parent/guardian knew the school district and their child's home school
- a school was selected
- parent had the opportunity to contact/meet a representative of the school

- parent expressed feeling confident that the transition to kindergarten was successful

<u>Objective 6</u>: Provide the professional development necessary and implement monitoring processes to assess the transition efforts. The process will be monitored by the Area Implementation Action Plan quarterly.

The family services area received kindergarten transition information at FSS staff meetings beginning in September when the area's timeline for kindergarten transition was reviewed with the team. Throughout the year monthly transition tasks were reviewed at each meeting. In February the family services area received training on kindergarten transition covering the Head Start Performance Standards (HSPS), the kindergarten process, and forms to ensure compliance and completeness. The outcome is measured by the number of kindergarten transition packets distributed to families; one hundred percent of the families who completed the school year who are transitioning to kindergarten received these packets.

The health area received kindergarten transition process training in November and monthly supervision meetings were held with each team member to review this process for transitioning children. The HNM provided a universal template at the beginning of the year to track transitioning families with dietary needs and health care plans (HCPs). The health area put a plan in place that resulted in 85% of families transitioning. The team provided families with guidance, tools to advocate for their child's health and nutrition needs while in public schools, and appropriate support on how to manage this process so their child receives appropriate health care while attending their chosen school district. Additionally, they continued to educate families on school lunch policies and provided blank HCP forms for families to follow the selected school's process.

This year the program was unsuccessful in identifying any training that solely encompassed the principles of the teach-back method. Instead, the team was trained in August on proper case noting methods using the SOAP noting format to capture details of any guidance or parent advocacy provided by the health team. Additionally, the HS attended an advanced motivational interviewing (MI) conference, which included principles on paraphrasing and teach-back techniques within the MI framework.

The special education and support services program supervisor provided an orientation in August for the education, family services, and health staff to discuss the importance of working as a team in supporting the students and families with IEPs for a successful transition to kindergarten. The orientation included staff roles and responsibilities throughout the transition process. During collaborative meetings in March and April the team gathered required documentation and information. Transition meetings were also scheduled in these months. The team provided appropriate guidance and support to families on how to advocate for their child with special education needs. The program prepares the necessary paperwork for parents to enroll their child at the selected school. Parents also receive support to connect with a special education representative from the chosen school. The plan for next year is to continue strengthening the process in place.

Program Goal 3: ***Enhance family wellbeing through individualized support by meeting families where they are. Goal 3 Expected Outcome: By focusing on being more family-centered , ACHS will provide individualized, culturally responsive, and relevant services for the family that will maximize the assistance ACHS can provide for each family's needs in support of self-reliance beyond HS.***

Objective 1: ***Gather more information about families during the enrollment process and throughout the program year that will be used in collaboration with all ACHS areas to***

adequately support families. In year one, all ACHS areas will develop an integrated process and pilot the coordination of the multi-disciplinary team's roles and responsibilities in the development of family goals. The implementation and enhancement of the process will take full effect starting year two.

This year the Special Education and Support Services department implemented pre and post surveys to assess parent knowledge on their child's IEP process. The survey focused on parent knowledge at entry into the program and at the end of the school year after receiving support from the Special Education and Support Services area. Twenty-nine parents participated and outcomes indicate that most parents learned more about this process by the post survey time. The survey also asked families what topics they wanted to learn more about and most were related to how to support their child with an IEP at home; including the resources available for them and the desire to have one-on-one meetings with the department to learn more about their child's specific needs.

The family goal planning process was restructured this year to provide support to the Health and Special Education and Support Services areas. The initial contact with the family is done by the Family Services team to determine if the family wants to establish a health or special education and support services goal. When a need is identified the family services specialist contacts the appropriate team member who meets with the family to develop a goal and supports them in the process of meeting it.

The Family Strengths and Priorities Assessment and the Family Referral forms are reviewed annually and updated as needed. The updates help staff better assess family needs and provide insight on how they can be supported with their family partnership agreements (FPAs). The area continued utilizing a pre and post survey as a family assessment tool. Pre-assessment questions

were completed by families at enrollment and the post-assessment in April and May. Outcomes indicated the need to enhance reliability measures. The program plans to provide staff with a refresher on effective case management and MI. Adams County Head Start focused on and emphasized the importance of parent involvement this program year and saw significant growth within the FFRED program as well as the participation at the Cultural Literacy Festival and Policy Council (PC).

Program Goals - Challenges and Revisions: No changes in this section.

School Readiness Goals (SRGs)

No changes were made to the ACHS School Readiness Goals during the year. The goals and outcomes are outlined in the table below.

Adams County Head Start School Readiness Goals			
Social and Emotional Development Children will: • Engage in and maintain positive adult-child relationships and interactions. • Engage in and maintain positive peer relationships and interactions • Display levels of attention, emotional regulations, and behavior in the classroom that are appropriate to the situation and the supports available • Learn and internalize (follow) classroom rules, routines, and directions • Develop and display a sense of self, confidence in their abilities, and a strong identity that is rooted in their family and culture.	**Language and Literacy** Children will: • Use and comprehend increasingly complex and varied vocabulary: • Use and comprehend oral language for conversation and communication: • Identify and discriminate the sounds within words as separate from the word itself. • Use and understand print as a system of visible marks that represent the sounds within words and words themselves • Engage with literature in developmentally appropriate ways. • Children who are Dual Language Learners will demonstrate increased competency in their home language while developing proficiency in English.	**Cognition and Mathematics** • Children will use math regularly and in everyday routines to count, compare, relate, identify patters and problem solve.	**Physical Well-Being and Motor Development** Children will: • Demonstrate control of large muscles for movement, navigation, and balance • Demonstrate control of small muscles for such purposes as using utensils, self-care, building, writing, and manipulation. • Identify and practice healthy and safe habits.

Children's Progress in Achieving School Readiness in the 2017-2018 School Year for 4 Year Olds		
Developmental Domains	Program Outcome Percent	Met Widely Held Expectations
Social-Emotional	99%	Yes
Physical	100%	Yes
Language	95%	Yes
Cognitive	97%	Yes
Literacy	96%	Yes
Math	92%	No

School readiness outcomes reflect a 95% or higher score based on the TS Gold widely held expectations (WHE) in five developmental domains. Math was the lowest TS Gold score this year. Data reflects the need to focus on strengthening math in the curriculum being used so that teachers can increase focus on math concepts.

A plan that includes training and ongoing monitoring has been implemented for the next program year and will improve data fidelity. All teachers are to receive training on TS GOLD objectives and outcomes to ensure data fidelity. The program has decided to utilize the Creative Curriculum's online resources to simplify and streamline the data gathering and lesson planning process. An increase in TS GOLD outcomes is expected as the fidelity of data improves with the implementation of teacher trainings, ongoing monitoring, and additional resources.

During the year parents provided input on the existing SRGs through discussions with teachers during home visits and parent teacher conferences. Key questions were asked to elicit feedback on what parents need to know about kindergarten, what preparation is required for kindergarten, and how ACHS can help their child prepare for school. The SRGs were also presented to parents at parent cafés. Policy Council and the Board of County Commissioners (BOCC) also received the current SRGs. In the September education staff meeting, the team reviewed SRGs, the Early Learning Framework (ELF), and provided input. Information shared

and analyzed resulted in no changes to the SRGs as they also align with ELF and HSPS.

The parents participated in a pre and post school readiness survey that assessed frequency of activities carried out with their children to prepare them for school. Outcomes indicated families value the following activities: ensuring children are fed, go to bed on time, and are clothed for the weather; ensure they have time and a safe place to play; children's strengths are praised; and parents are helping children care about others. Activities scoring highest for the frequency of the "Not Yet" category indicating families have not done this activity with their children include: families taking children to the library; showing children books and pictures of people from other cultures; and helping children say parent's name, address, and phone number. Areas demonstrating the most growth from pre to post survey were teaching children how to calm down; reading to them; helping children find and name shapes and colors around them; show words and symbols to children in their language and the sounds they make; and talk with them about the weather and/or seasonal changes.

Adams County Head Start recognizes the importance of family involvement in school readiness. The program implemented literacy efforts to increase parent involvement in their child's learning by building a stronger school readiness foundation for children by providing books on problem-solving concepts, social-emotional, and imagination topics. This fall and spring ACHS continued a ten week family literacy class utilizing the Motheread/Fatheread (MF) curriculum which complements the dialogic reading already implemented in the classrooms. The focus of the curriculum is to teach parents how to enhance reading skills while reading to their children. The fall class was in English and had four enrollees with two completing the

program. The spring class was in Spanish. Three parents enrolled and all finished the program. As a component of MF, participants complete a pre and post assessment to gauge where they are at in family literacy and how they read to their child. According to the post assessment, all participants experienced growth across all areas. For next year, ACHS plans to implement two MF classes, one in the fall and one in the spring. Efforts to promote parent participation will continue next year for MF.

Program Goals - Challenges and Revisions: No changes in this section.

SUB-SECTION B: Service Delivery

Service and Recruitment Area Updates: No major changes or updates have occurred.

Needs of Children and Families Updates: No major changes or updates have occurred.

Chosen Program Option(s) and Funded Enrollment Slots Updates:

This year ACHS served 295 children in full day center-based options. These options included four full day classrooms implementing the 1020 duration requirement five days a week and 12 full day classes offering 137 days for four days a week. Six and a half hours of daily instruction took place in all full day sessions from August to May.

For the next year ACHS will serve 256 children. The four 1020 full day classrooms will be in session Monday through Friday with occasional no school days to accommodate training, parent/teacher conferences, home visits and planning. The 1020 full day classrooms will provide more than 1020 hours of classroom time for students. The additional 12 full day classrooms will be in session Monday through Thursday and for at least 128 days.

The implementation of four 1020 duration classrooms was met with a few challenges. The

most challenging was providing coverage in order to give teachers sufficient time for weekly lesson planning, administrative tasks, analyzing children's data, attending trainings, etc. After analyzing program needs, two viable options were identified. One is to hire additional classroom aides. The other is to make schedule adjustments for teacher assistants in the full day sessions in order to support the 1020 classrooms at least once a week. Due to the funding impact of hiring additional classroom aides, ACHS will pilot using current staff to support in the 1020 classrooms. In order to accomplish this, full day classrooms will have fewer days in session than last year. This still meets HSPS and will provide some flexibility to support the 1020 classrooms.

The need for full day sessions is reflected in the community needs assessment and the program's success of maintaining full enrollment this year. It is imperative to secure additional funds to continue this option. To ensure sustainability for full day sessions, ACHS continues identifying and securing additional funds. The program anticipates a percentage of the cost will come from the OHS and the rest from other funding sources as these are secured.

Centers and Facilities Updates: Securing classroom space continues to be a challenge for the program. ACHS is currently seeking locations to house two classrooms.

Eligibility, Recruitment, Selection, Enrollment, and Attendance Updates:

Adams County Head Start implemented an enrollment action plan in February of 2017 to address last year's challenges in maintaining full enrollment. It included transitioning double sessions to full day classrooms. The implementation of all full day classrooms has significantly improved enrollment and is no longer an issue. All slots were filled before the 30 day vacancy threshold. The program contributes this to the need for full day sessions in the community.

Education and Child Development Updates:

There was a focus on streamlining curriculums used for consistency and effectiveness. The program's curriculums are Incredible Years (IY), Culture of Wellness and Creative Curriculum. The newest version of Creative Curriculum was implemented in all 16 classrooms this year.

The program received an IY grant this year to continue training and coaching the education team on classroom management and curriculum implementation. The main goal is for all education staff to be trained on both components of the IY program; classroom management and IY curriculum by the end of next year. Two lead teachers in the program obtained their Incredible Years Coach certification this year, making them reliable coaches to support other education staff. Adams County Head Start, in partnership with Invest in Kids, plans to expand the number of staff who will become peer coaches to support the sustainability of the IY curriculum in the program.

The mental health team introduced a new classroom observation tool to the education team, the TPOT. In the fall the mental health team conducted 16 observations to measure how well teachers implemented the 3-tiered Pyramid Model of practices supporting children's social competence and preventing challenging behaviors. This tool has the same framework used in the IY program. The outcomes of the TPOT provided data to identify strengths, opportunities for professional growth, and red flags to consider for potential training, coaching and professional improvement.

This was the first year the TPOT was utilized and only one observation per classroom was conducted. The mental health team will continue utilizing the pre and post TPOT next year.

The first observation will take place within the first 45 days of school and the second within the last two months of school.

Health Updates:

The health area developed two videos with the assistance from the county's Communications Department. One video specifically targets families and explains the screening process from start to finish. The goal of this video is to build parent awareness on early screening practices and why this is such an important piece to detect health issues early in the child's education process. The second video targets education training and highlights how to provide family-style meal service that is both effective and beneficial to the learning process and in forming healthy eating habits within the preschool population.

The health area's newest endeavor for next year entails the creation of a tobacco cessation program for families. According to the program's 2017-2018 data, five percent of enrolled children are diagnosed with asthma. Out of these, 36% have adults who verbalized smoking in the household and around their child(ren). The program is partnering with the American Lung Association. The collaboration will provide the HS and the FSSs with more focused training on counseling, including how to utilize motivational interviewing skills to understand where families are in their cessation process and assist families with reducing/quitting smoking in order to improve their children's health outcomes as well as their own health outcomes. The program has sought funding and is pending response from the PHS Commissioned Officers Foundation for the Advancement of Public Health to support the program's smoking cessation efforts being implemented next year.

This year the program piloted the initiation of "Family Yoga" classes. These classes were provided in English and Spanish. The classes introduced families to the benefits of yoga and mindfulness for children, teens, and adults.

The Resilient Educators Group was introduced by the mental health team. The group met monthly and experienced a gradual increase in attendance after the first month. Teachers expressed their desire to continue with the group during the next school year and the program plans to implement them on a monthly basis.

Family and Community Engagement Updates:

Adams County Head Start's transition to full day classes reduced the number of children served and, as a result, FSSs' case loads decreased which improved intentionality and the implementation of MI. Two programs specifically promoting father involvement were FFRED and MF. These programs are specific to family literacy as to include relationship building among the parent and their child. The MF program provides classes and books in both English and Spanish.

Services for Children with Disabilities Updates:

Full day classes have impacted the special education services. The program observed a slight increase of parents, whose children have an IEP, expressing difficulties transporting their children from the program to the school district's preschool classrooms. Six out of 37 families declined IEP services. Adams County Head Start supported families in finding other therapeutic services that fit parents' schedules. The program also advocated for children to have transportation from the school districts. Only one out of five school districts was able to provide

transportation. The program continues to collaborate with school districts to explore potential solutions.

Transition Updates: No major changes have occurred. Please see Program Goal 2 for updates.

Services to Enrolled Pregnant Women Updates: It is not applicable.

Transportation Updates: No changes or updates have occurred.

SUB-SECTION C: Governance, Organizational and Management Structures

Governance Updates

Structure - No changes have been made in this area.

Processes - Policy Council bylaws were revised to incorporate changes in the HSPS, such as, PC Representatives' ability to serve five years instead of three. Information on the new regulations in the HSPS was also provided. An in depth discussion took place with PC representatives and Head Start management after potential changes to the PC bylaws were introduced. For example, it was recommended that a quorum consist of three PC representatives instead of five. After a detailed discussion of the pros and cons of having three or five, PC recommended that we continue to have five as a quorum and it was implemented into the bylaws.

The recommended changes to the bylaws were also presented to the governing board during a study session. BOCC agreed with the recommendations. The proposed new PC bylaws were approved through a Public Hearing by the BOCC. The BOCC's approval was shared with PC at the following PC meeting.

The PC meeting minutes are approved by representatives and the minutes are also posted at each center for parents to have access to them. They share parent ideas/comments from their

centers and take information shared at the PC meeting back to the centers they represent.

Relationships- no changes have been made in this section.

Human Resources Management Updates

Current Organizational Chart - The organizational chart reflects a position upgrade. The senior administrative clerk position is now support services specialist. Please reference the organizational chart on Attachment H (i).

Criminal Background Checks System - Adams County Head Start implemented a process to ensure compliance of HSPS 1302.90 (b)(5) in regard to completing four background checks for each employee, consultant, or contractor at least once every five years. Adams County Head Start moved forward with the implementation of a rotating system even though Office of Head Start (OHS) extended the deadline to implement the regulation. A tracking system was developed to monitor when the next round of employees are due to complete their background checks.

New Hire, Consultants, and Contractors, and Volunteer Orientation - A few changes were implemented to enhance the process of orientation for new hires, consultants, contractors and volunteers. For example, the orientation checklist was updated to ensure all required documents, policy reviews, position timelines, in addition to new orientation guidelines set by the county were reviewed with the individual. The regulation to complete background checks at least every five years was also implemented into program SOPs.

Program Staff Training and Professional Development Key Features- A few key implementations took place regarding staff training and professional development. Adams

County Head Start continues to strengthen the process for training documentation using databases with fidelity.

Adams County Head Start has also implemented a research-based coordinated coaching strategy with an intentional facilitation of the Creative Curriculum. The coach will observe, assess, and analyze the teachers through a guided set of methods and routines developed by Teaching Strategies Creative Curriculum. The coach will provide a framework to the curriculum, offer guidance and strategies, and support to encourage the growth and development of the teachers as well as the children. The coach will attend trainings on the proper implementation of the Creative Curriculum Coaching to Fidelity Assessment tool, CLASS tool, and IY curriculum.

The education coach, hired in May, is currently working on the program's coaching philosophy and approach. The focus is on peer coaching, curriculum and assessment tool implementation with fidelity along with individualized approaches for staff's professional development.

Program Management and Quality Improvement Updates:

Program Oversight Systems Key Features- The education area identified a need to enhance the fidelity of the program's TS Gold and CLASS observations. These were included in the program's self-assessment action plan (see Attachment A) and in the training plan for next year.

Program Continuous Improvement Key Features - Key components of the program's ongoing oversight are internal audits, state program inspections, and ongoing monitoring. All of these took place throughout the year identifying areas in need of enhancement and all findings were corrected, strengthening the program's monitoring capacities. Key features of the program's

continuous improvement included the successful implementation of listening sessions, providing staff with the opportunity to voice their thoughts and ideas to their manager. Additionally, the administrator as well as the quality assurance manager met with staff at their centers to discuss challenges and strengths experienced at their respective centers and their roles.

Goal/objective outcomes, audits, monthly monitoring reports, classroom observations, staff input, FPA outcomes, child developmental outcomes, CLASS scores, PIR data, self-assessment action plan, HSPS, and state regulations were used to develop the 2018 - 2019 Training Plan. Trainings are designed to provide staff the knowledge and skills needed for serving children and families. Additionally, new ACHS staff participates in a new employee orientation where the program's policies and procedures are reviewed. See Attachment E for ACHS's 2018 – 2019 Training Plan.

Strategic Planning took place with several stakeholders including PC members, staff, parents, leadership, and providers. Several tools were utilized to gather information for future program improvements; from clicker evaluations, surveys, group-based discussions, and data analysis. Stakeholders also participated in the program's annual self-assessment, an ongoing continuous improvement tool, focusing on the program's five year goals (see Attachment G), external evaluations, and ERSEA.

Management Budget and Staffing System Key Features- The program has experienced challenges with staffing for the 1020 classrooms. Please refer to the *Chosen Program Option(s) and Funded Enrollment Slots* sections of this application.

Section II. BUDGET AND BUDGET JUSTIFICATION NARRATIVE

Financial and Property Management

Adams County Head Start annually reviews their SOPs to ensure all existing Performance Standards and Code of Federal Regulations (CFR) for Head Start are met. These procedures support internal controls to effectively manage grant funds, property, and other assets. As a program under Adams County, there are several systems in place for checks and balances. These systems include standard procedures from the Attorney's office, the BOCC, and the Finance, Purchasing, and Payroll departments. The Purchasing Department has a thorough system for purchases, based on the monetary amounts for services, equipment, and or supplies that require authorizations from various levels of management for approval.

Adams County Head Start internal controls include procedures that address cost principles; the Davis-Bacon Act; disposition of equipment and facilities; general ledger; how to manage ACHS property; purchase requests; holding periodic cost projections, budgeting, and budget variance.

Equipment Purchases over $5,000

Adams County Head Start abides by the C.F.R part 75.439(b)(2) rules. Adams County Head Start has a SOP on purchasing equipment costing $5,000 or more. The SOP states that in the event that ACHS would like to purchase equipment costing $5,000 or more, an approval by PC is required followed by a request sent to the OHS for written approval.

In addition, Adams County has a procedure for the procurement of materials, equipment, services, and supplies over $5,000. A documented request of at least three quotes is required for

purchases ranging from $5,000 to $25,000. A formal solicitation including a public advertisement or a sole source justification, and approval from the BOCC is required for purchases over $25,000.

Funding Sources

Adams County Head Start's full year budget, November 1, 2018 to October 31, 2019, is $5,403,138. The funding sources include the requested amount from the Office of Head Start Program Operations (OHSPO), OHS Training and Technical Assistance (TTA), and the United States Department of Agriculture (USDA). Non-federal share in-kind contributions include Adams County contributions, Temple Buell grant, Seed grant, CPP. The funding sources are listed below in detail.

The USDA provides up to $250,000 for reimbursement of food (breakfast, lunch, and snacks) for children, food supplies, and a portion of the nutrition staff salary/benefits.

Adams County provides $50,000 towards salary and benefits.

The Temple Buell grant award of $25,000 will be used to purchase new technology and software systems. These systems will give teachers the tools to gather data to individualize each child's developmental outcomes and school readiness.

The Seed grant award of $5,000 will be used to create and sustain a tobacco cessation initiative. The initiative can be easily integrated into the current health screening and family advocacy model.

Colorado Preschool Program funds of $219,547 will be used toward teacher and paraprofessional salaries and benefits.

The non-federal in-kind contribution of $1,030,628 is attained through contributions through Adams County, Adams County cost allocations plan, Temple Buell grant, Seed grant, CPP funds, parent/guardian volunteer work, and donated contract vendor program hours.

The total requested amount from the OHS is $4,122,510 ($4,073,703 for PA 22 and $48,807 for PA 20). Office of Head Start Program Operations funds will be used for personnel salary and benefits, supplies, contracts, and other expenses. Office of Head Start TTA funds will be used for travel and training. Administrative costs will not exceed 15% of the budget. Below is a description of the costs by object class category within SF-425A Section B-6.

Object Class Category (a) Personnel

Salaries – (see Attachment H (ii)) ACHS has 70 staff members. The total cost for salaries is $2,604,956. Salary cost of $2,285,758 is being requested from OHSPO. United States Department of Agriculture will contribute $42,151 for salary costs. In-kind contributions of $277,047 include Adams County's contribution of $50,000, the state's CPP contribution of $219,547 and Adams County's cost allocations plan contribution of $7,500.

Child Health and Development Personnel

- The total cost for program managers and content area experts is $317,199. The USDA funds will cover $9,316 and $307,883 is being requested from the OHSPO. Program managers and content area experts include the health and nutrition manager, nutrition supervisor, education manager, two education supervisors, and one education coach.

- The total cost for education personnel is $1,165,145. Colorado Preschool Program funds will cover $219,547 and $945,598 is being requested from the OHSPO. Education personnel include 16 teachers, 16 teacher assistants, and eight classroom aides.
- Family child care personnel incur $0 as there are no employees in this section.
- Home visitors incur $0 as there are no employees in this section.
- The total cost for health services is $85,359 which is being requested from the OHSPO. Health services include two health specialists.
- The total cost for nutrition services personnel is $65,186. The USDA funds will cover $32,835 and $32,351 is being requested from the OHSPO. Nutrition services personnel include one lead cook and two assistant cooks.

Special Education and Support Services Personnel

- The total cost is $109,847 for the special education support services program supervisor and support services specialist. The total of $66,847 is being requested from the OHSPO and $43,000 is covered by Adams County.

Family and Community Partnership Personnel

- The total cost for program manager and content area expert is $118,705 which is being requested from the OHSPO. Program manager and content area expert include one family services manager and one family services supervisor.
- The total cost for other family and community partnership personnel is $288,686 which is being requested from the OHSPO. Other family and community partnership personnel include seven family services specialists.

Program Design and Management Personnel

- Total salary cost for the executive director is $150,204. The executive director works approximately 5% of the time with the Head Start team totaling up to $7,500. In-kind contribution of $7,500 will be paid by Adams County and $0 is being requested from the OHSPO. The executive director is the Adams County Human Services Department director.
- The total cost for the Head Start director (administrator) is $101,555 which is being requested from the OHSPO.
- The quality assurance manager incurs a total cost of $77,843 which is being requested from the OHSPO.
- Staff development incurs $0 as there are no employees in this section.
- Managers are included in specialized areas.
- The total cost for clerical personnel is $102,351and is being requested from the OHSPO. Clerical personnel include one data management specialist and one administrative coordinator.
- The total cost is $66,687 for fiscal personnel. Adams County funds will cover $7,000 and $59,687 is being requested from the OHSPO. Fiscal personnel include one fiscal grants analyst.

Other Personnel

- The total cost for maintenance personnel is $98,893 which is being requested from the OHSPO. Maintenance personnel include one facilities supervisor and one maintenance/bus driver.
- Transportation personnel incur $0 as there are no employees in this section. Bus driver is included with maintenance personnel.

Object Class Category (b) Fringe Benefits

Benefits provided to employees include health, dental, vision, life insurance, long term disability, FICA, worker's compensation, Medicare, unemployment, and Adams County retirement plan. The total estimated cost for benefits is based on the most recent factors as provided by the Payroll Department (see Attachment H (iii). The total cost is $1,032,500 which is being requested from the OHSPO. The allocated funds are explained below.

Health Insurance

The annual estimated cost for health insurance is based on last year's rate as provided by as provided by the Payroll Department. The cost is $555,884 which is being requested from the OHSPO. The breakdown is as follows:

- Single coverage incurs an average annual cost of $7,506. The employee's average annual contribution is $1,005 and the remaining annual average cost of $6,501 is being requested from the OHSPO.
- Two-party coverage incurs an average annual cost of $15,754. Average annual contribution by employee is $2,898 and the remaining annual average cost of $12,856 is being requested from the OHSPO.

- Family coverage incurs an average annual cost of $22,659. Average annual contribution by employee is $4,963 and the remaining annual average cost of $17,696 is being requested from the OHSPO.

Dental Insurance

Dental insurance estimated annual cost is based on last year's rate as provided by the Payroll Department. The cost is $11,321 which is being requested from the OHSPO. The breakdown is as follows:

- Single coverage incurs an average annual cost of $411. The average annual contribution by employee is $308 and the remaining annual average cost of $103 is being requested from the OHSPO.
- Two-party coverage incurs an average annual cost of $832. The average annual contribution by employee is $624 and the remaining annual average cost of $208 is being requested from the OHSPO.
- Family coverage incurs an average annual cost of $1,446. The average annual contribution by employee is $1,084 and the remaining annual average cost of $362 is being requested from the OHSPO.

Vision Insurance

The estimated annual cost for vision insurance is based on the most recent based on last year's rate as provided by the Payroll Department. The total cost is $2358 which is being requested from the OHSPO. The breakdown is as follows:

- Single coverage incurs an annual cost of $60. The annual contribution by employee is $41 and the remaining annual cost of $19 is being requested from the OHSPO.
- Two-party coverage incurs an annual cost of $146. The annual contribution by employee is $101 and the remaining annual cost of $45 is being requested from the OHSPO.
- Family coverage incurs an annual cost of $263. The annual contribution by employee is $181 and the remaining annual cost of $82 is being requested from the OHSPO.

Life Insurance, Long-Term Disability, FICA, Worker's Compensation and Medicare

The estimated annual cost is based on the most recent based on last year's rate as provided by the Payroll Department. The cost is $235,677 which is being requested from the OHSPO.

Adams County Retirement Plan

The estimated annual cost for the Adams County Retirement Plan is based on the most recent based on last year's rate as provided by the Payroll Department. The cost is $212,260 which is being requested from the OHSPO.

Unemployment

The estimated annual cost for unemployment is based on the most recent based on last year's rate as provided by the Payroll Department. The total cost is $15,000 which is being requested from the OHSPO.

Object Class Category (c) Travel

Travel funds needed for ACHS are included in the OHS TTA section which includes regional conferences. This section is where ACHS budgets to send employees, parents, and volunteers to conferences. The total cost for regional conferences is $3,500. In addition, state and national

conferences are also budgeted in this section. The total cost for state and national conferences is $8,000. The total amount requested by OHS TTA is $11,500 for travel.

Object Class Category (d) Equipment

Equipment requests $0 as there is no need at this time.

Object Class Category (e) Supplies

Supplies needed for ACHS include classroom, office, health and safety, and "other" supplies. The total annual cost for supplies is $186,690. The total amount requested from the OHSPO is $170,490. The in-kind total of $16,200 is provided by the Temple Buell grant. The breakdown is as follows:

- The total cost for classroom supplies is $49,873 which is being requested from the OHSPO. Classroom supplies are for education, health, disability, nutrition, and family services. Examples include books, paper, pencils, crayons, markers, reading materials, learning activities, toothbrushes, homework projects, toothpaste, supplies for special needs, and literacy materials for children and their families.
    - The total cost for office supplies is $34,791 which is being requested from the OHSPO. Office supplies will be used by staff.
    - The total cost for health and safety materials and medical supplies is $48,977 which is being requested from the OHSPO. Health and safety materials and medical supplies include first aid supplies and lead and anemia testing supplies.
    - The total cost for the teacher Creative Curriculum supplies is $16,200 which is provided by the Temple Buell grant as in-kind. The total requested from OHSPO is $0.

- The total cost for "other" supplies is $36,849 which is being requested from the OHSPO. "Other" supplies include laundry services, cleaning supplies, miscellaneous institutional supplies, and supplies for field trips that do not fit under office, classroom, health and safety materials, and medical supplies.

Object Class Category (f) Contractual

Adams County Head Start contracts with many companies and organizations to provide health, mental health, dental, nutrition, and translation services. The total cost of contractual services is $443,550. The USDA will provide $207,849 and $235,701 is being requested from the OHSPO. The breakdown is as follows:

- Administrative services incur $0 as there are no costs associated with contractual costs.
- Adams County Head Start does not currently have any single item in "contractual" costing more than $150,000.
- The total cost for health services is $62,000 which is being requested from the OHSPO. The health services contract will be with Children's Hospital, which will provide nursing consultation services, staff training, and supervision on health issues. Additionally, medical clinics will provide health screenings and immunizations to ACHS children who do not have insurance.
- The total cost for dental services is $49,807 which is being requested from the OHSPO. The dental service contract with Salud Family Health Centers provides dental check-ups, sealants for children's teeth, and direct services to children.

- The total cost for mental health services is $76,894 and is being requested from the OHSPO. Mental health services include Denver Children's Advocacy Center which provides mental health services to ACHS children and families.
- The total cost for food service supplies is $222,849. The USDA will provide $207,849 and $15,000 is being requested from the OHSPO. Food services contracts include Sysco, Andrews Food Service, and Meadow Gold. They provide food supplies for breakfast, lunch, and snack for children and food for parent meetings, PC meetings, and family activity events.
- The total cost for translation and interpretation services is $32,000 and is being requested from the OHSPO. The translation and interpretation services contract is with Cesco Linguistic Services. Cesco provides on-site interpretation and written translation. They will also translate documents for personal identifiable information (HSPS 1303C).
- Child transportation services incur $0 as there are no associated contractual costs.
- Training and technical assistance incur $0 as there are no associated contractual costs.
- Family child care services incur $0 as there are no associated contractual costs.
- Delegate agency costs incur $0 as there are no associated contractual costs.

Object Class Category (g) Construction

- There are no costs associated with our program in this area.

Object Class Category (h) Other

Adams County Head Start incurs many other costs that do not fit in the above categories. The total cost for "other" is $1,052,835. The total in-kind contribution is $703,581 which includes

$605,959 from the Adams County cost allocation plan, $5,000 from the Seed grant, $92,622 from volunteers, and $349,254 is being requested from the OHSPO. These other costs are outlined and broken down as follows:

- Depreciation Method – ACHS currently occupies one Adams County owned building. Adams County uses a depreciation schedule for this building. The total cost using depreciation method is $17,255. Non-federal contribution by Adams County is $5395 and $11,860 is being requested from the OHSPO.
- Lease agreements include five different classroom locations (see Attachment H (iv)). The total cost for lease agreements is $132,111 and is being requested from the OHSPO.
- Mortgage – There are no costs associated with our program in this area.
- Utilities and telephone costs include cell phone, internet service, water, gas, electricity, sewer, and sanitation. The total cost for utilities and telephone is $32,270 which is being requested from the OHSPO.
- Building and child liability insurance –Child liability insurance is covered by the county's insurance policy; they also provide a child liability insurance policy for the program. The total costs for insurance is $34,114. In-kind contribution of $34,114 will be given by Adams County and $0 is being requested from the OHSPO.
- Building maintenance / repair and other occupancy include janitorial services at all non-county owned facilities, supplies for minor facility and playground repairs, and building repair and maintenance. The total costs for building maintenance / repair and other occupancy is $54,300 which is being requested from the OHSPO.

- Incidental alterations /renovations – There are no costs to our program for this area.
- Local travel costs include mileage reimbursement, vehicle maintenance and repair, gas and oil. Adams County Head Start uses a mileage reimbursement rate established by the IRS. Currently the rate is $0.545 per mile. The total cost for local travel is $30,902 and is being requested from OHSPO.
- Nutrition Services – There are no costs to our program in this area.
- Child Services Consultants – There are no costs to our program in this area.
- Volunteers include parents and guardians who spend time helping with meals, clean up, classroom organization. The program also sends projects home for volunteers to cut, color, or prepare so they can be used in the classroom. All of this time is valued at the rate of an assistant teacher's salary and benefits. The total in-kind contribution is estimated to be $92,622.
- Substitutes – There are no costs to our program in this area.
- Parent services include costs associated for parent trainings and PC meetings, and child care for these meetings. Costs also include meetings supplies. The total cost for parent services is $35,285 being requested from the OHSPO.
- Accounting, human resources, and legal services are provided by Adams County. These include costs for accountants, accounts payable clerks, purchasing agents, accounts receivable clerks, payroll technicians, budget specialists, human resources specialists, and training and legal services. The total cost for these services is $325,511. An in-kind

contribution of $325,511 is provided by Adams County and $0 is requested from the OHSPO.

- Information technology and facility services are provided by Adams County. The total cost for these services is $246,334. An in-kind contribution of $246,334 is provided by Adams County and $0 is requested from the OHSPO.
- Publications/advertising/printing include all printing costs for the program. Printed materials include the annual report, staff calendars, parent calendars, parent handbooks, forms, letterhead, and business cards. Total costs for publications/advertising/printing is $16,004 is being requested from the OHSPO.
- Other includes the cost for membership dues for the National Head Start Association and the Colorado Head Start Association, licensing fees and postage costs, and lease payments for copiers. The total cost is $36,522 and is being requested from the OHSPO.
- The tobacco cessation initiative that will be implemented into the current health screening and family advocacy model is also in the other category. The total cost is $5,000 and is being provided by the Seed grant award as in-kind. $0 is requested from OHSPO.

Object Class Category (h) Other Training

Training and staff development for staff is an important piece of ACHS. Workshops and classes are actively sought to give employees additional knowledge. The total cost for training or staff development is $71,107. Adams County Head Start is requesting $37,307 from OHS TTA. The total in-kind contribution for training is $33,800 and includes $25,000 provided by Invest in Kids for the IY. A total of $8,800 from Temple

Buell grant. Total costs are outlined and broken down as follows:

- Tuition and books for college courses, for approximately 16 college courses, are available to support employees pursuing college degrees. The total cost for tuition and books for college courses is $11,000 which is being requested from the OHSPO.
- Education staff workshops include language and literacy, Creative Curriculum with fidelity, CLASS, coaching training, TS Gold, and social/emotional development. Total cost for education staff workshops is $29,150. In-kind training $8,800 is provided by Temple Buell grant and $20,350 is being requested from OHSPO.
- Pre-service trainings include HSPS training and SOPs training with all staff. The total cost for pre-service training including consultants that facilitate the trainings, is $2,000 which is being requested from the OHSPO.
- Staff workshops cover topics such as health, nutrition, cultural diversity, team building, and family and support services. The total cost for staff workshops is $3,957 and is being requested from the OHSPO. These workshops include consultant fees and training materials.
- In-kind contribution of $25,000 is provided by the Invest in Kids program for the continued support of the IY curriculum.
- Adams Count Head Start does not currently have any single item in "other" costing more than $150,000

Object Class Category (i) Total Direct Charges

Total direct charge requested from OHSPO is $4,073,703. Total direct charge requested

from OHS TTA is $48,807.

Object Class Category (j) Indirect Charges

Adams County Head Start does not have any indirect charges.

Object Class Category (k) Totals

Category totals requested from OHSPO is $4,073,703. Category totals requested from OHS TTA is $48,807.

Adams County Head Start does not have plans, for this budget year, to make a single item purchase of $150,000 or more.

Adams County Head Start follows Adams County Capital Assets Policies and Procedures once ACHS takes procession of property or asset. The procedures state that once it is acquired, general accounting creates an asset record in the capital asset module using the JD Edwards software program. This system helps maintain complete and accurate information relating to its capital assets as required by the Governmental Accounting Standards Board for the purpose of financial presentation in accordance with Generally Accepted Accounting Principles. Once in the system a physical capital asset tag for equipment will be issued with an asset number and bar code. On a rotating base accounting staff conducts an annual inventory review.

ADAMS COUNTY HEAD START NON-FEDERAL MATCH

Adams County Head Start complies with Federal Statutes, regulations, and the terms and conditions of the Federal Awards CFR75.303. Adams County Head Start monitors to ensure compliance with internal controls. Below are the total contributions that ACHS will use as the non-federal resources per grant agreement.

Donated services provided by the grantee's, Adams County, Cost Allocation Plan is $613,459. The Cost Allocation Plan is used by the county to claim indirect costs as charges against grants. The document is prepared in compliance with 2 CFR Part 200. Consultants prepared the Cost Allocation Plan utilizing a double step-down methodology.

Volunteer time (4,312 hours based on a rate of $21.48 per hour) is $92,622. This rate is based on the average teacher assistant's salary and benefits. The projected hours is based on last year's total parent volunteer hours.

Invest in Kids gives ACHS an in-kind contribution of $25,000. This is based on training expenses and materials per application.

Adams County contribution of $50,000 is a non-federal contribution to Head Start's personnel and based on current salaries.

Temple Buell grant of $25,000 is a non-federal contribution given to ACHS to purchase equipment for the program.

Colorado Preschool Program of $219,547 is a state, non-federal contribution used on education staff salary and benefits.

Seed grant of $5,000 is a non-federal contribution given ACHS for tobacco cessation.

Total in-kind contribution and non-federal match from donated goods, services and volunteer hours is $ 1,030,628.

Human Services Department
Head Start
www.adcogov.org

ADAMS COUNTY
COLORADO

Pete Mirelez Human Services Center
11860 Pecos Street
Westminster, CO 80234
PHONE 720.523.4602
FAX 720.523.7991

July 17, 2018

Cheryl Lutz
Office of Head Start, Region VIII
Administration for Children & Families
999 18th Street, South Terrace, Ste 499
Denver, CO 80202

Re: Approval of Adams County Head Start U.S. Department of Health & Human Services Year Four of Five Continuation Grant application for 2018-2019 (November 1, 2018 – October 31, 2019); 08CH010252

Dear Ms. Lutz:

As the Authorized Representative and Certifying Officer of the Adams County Board of County Commissioners on behalf of ACHS, I am writing to confirm that during a regularly scheduled Public Hearing session the Adams County Board of County Commissioners, ACHS governing board, approved the Adams County Head Start Year Four of Five Continuation Grant application for 2018-2019 (November 1, 2018 – October 31, 2019).

Sincerely,

Mary Hodge
Board of County Commissioners

ATTACHMENT A

ACHS Self Assessment Action Plan

Program year 2017 - 2018

Goals and Objectives				
Quality Improvement Area	**Action Plan**	**Person(s) Responsible**	**Timeline**	**Date Accomplished**
Education Goal 1 Objective 1 - CLASS	1. Education Supervisors will receive additional training on observation and scoring of the tool to ensure scoring is consistent and that the tool is administered with fidelity. 2. Teachers will receive CLASS training to increase knowledge in all domains 3. Pre and Post CLASS will be completed annually on each teacher	1. Education Manager and Ed Supervisors 2. Education Manager 3. Education Manager and Ed Supervisors	1. Aug. 2018 2. March 2019 3. Pre – Sept. 2018 Post – April 2019	
Family Services -Emergency Contact	1. Train Family Services and Education staff on process of updating and maintain emergency contact information 2. Implement ongoing monitoring. Conduct ongoing audits to ensure emergency contact forms in folders/backpacks are updated.	1. Family Services Manager and Supervisor, Education Manager and Supervisors 2. Family Services Manager and Supervisor	1. FSS – Aug. 2018 Ed – Aug. 2018 2. FSS – Aug. 2018	

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: July 17, 2018
SUBJECT: Approval of CSBG Agreement Amendment between Adams County and Almost Home
FROM: Chris Kline, Human Services Director
AGENCY/DEPARTMENT: Human Services
HEARD AT STUDY SESSION ON
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners Approves of the CSBG Agreement Amendment between Adams County and Almost Home

BACKGROUND:

Adams County has received Community Service Block Grant funds to ameliorate the effects of poverty in local communities from the State Department of Local Affairs (DOLA) since 1974. The State receives funds from the U.S. Department of Health and Human Services as an annual formula allocation based on the State's poverty statistics. The County receives a letter from DOLA awarding funds based on the allocation formula. Adams County has $67,000 unspent 2017 CSBG funds that can only be spent on already approved 2015-2018 subgrantees.

The recommendation is to approve the 2018 Agreement Amendment with Almost Home to utilize $20,000 of the 2017 unspent funds towards the 2015-2018 approved subgrantees. Funding has to be spent by September 30, 2018.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Human Services and Almost Home

ATTACHED DOCUMENTS:

2015-2018 Original Resolution
Almost Home 15-18 Agreement
2018 Resolution
2018 Almost Home Agreement Amendment

FISCAL IMPACT:

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

Fund: 34

Cost Center: 00034, 9418

	Object Account	Subledger	Amount
Current Budgeted Revenue:	5335		$67,000
Additional Revenue not included in Current Budget:			
Total Revenues:			$67,000

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:	8810		$67,000
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			$67,000

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

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

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING THE 2018 COMMUNITY SERVICES BLOCK GRANT SUBGRANTEE CONTRACT AMENDMENT BETWEEN ADAMS COUNTY AND ALMOST HOME

Resolution 2018

WHEREAS, the Federal government has established the Community Services Block Grant Program (CSBG) to provide a range of services and activities designed to have an impact on the causes of poverty in local communities; and

WHEREAS, U.S Department of Health and Human Services (HHS) allocates Community Services Block Grant funds to the State of Colorado, Department of Local Affairs through an annual formula allocation; and

WHEREAS, Adams County is eligible to receive an estimated $485,715 for each program year from the State of Colorado, Department of Local Affairs and has $67,000 in unspent 2017 CSBG funds; and

WHEREAS, the Community Services Block Grant Advisory Council held a meeting on June 8, 2018 to review and recommend Almost Home to receive an additional $20,000 to be spent by September 30, 2018; and

WHEREAS, the project award will continue to be included as part of the 2015-2018 Adams County Community Action Plan to the State of Colorado, Department of Local Affairs; and

WHEREAS, much of this information is regular and routine, and the Board of County Commissioners wishes to designate the Director of the Human Services Department and the Specialty Programs Manager to sign necessary non-contractual documents to carry out the ongoing activities of the program.

NOW THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, and State of Colorado, that the 2018 Community Services Block Grant Subgrantee Contract Amendment between Adams County and Almost Home be approved.

BE IT FURTHER RESOLVED, that the Chair is authorized to sign said sub grantee agreement on behalf of Adams County.

BE IT FURTHER RESOLVED, that the Director of the Human Services Department and the Specialty Programs Manager are authorized to sign necessary non-contractual documents to carry out the ongoing activities of the program.

Human Services Department
Community Support Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

7190 Colorado Boulevard
Commerce City, CO 80022
PHONE 303.287.8831
FAX 303.227.2106

Community Services Block Grant (CSBG)
Subgrantee Contract Amendment
PY2018

Section I. Provisions

PARTIES TO THIS Contract Amendment: This Contract Amendment, dated this 8th day of June, 2018, by and between Adams County, a body politic and corporate, known hereafter as "COUNTY", and Almost Home, Inc. located at 231 N. Main St. Brighton, Colorado 80601, known hereafter as the "GRANTEE" is made for the purpose of amending the funding amount set forth in the Community Services Block Grant ("CSBG") Agreement dated January 1, 2018.

The COUNTY requires the provision of certain services and products in connection with the program funded by grants from the CSBG and which must conform to the following:

(A) Scope of Service:
Almost Home case managers will provide essential services for the rent and utility assistance program and homeless shelter. Case managers will assist in client connections with other programs and agencies that will help them on their road to self-sufficiency.

(B) Payment Requests:
Payment Requests for reimbursement must be submitted monthly no later than the 10th of the month for expenses incurred during the previous month. The submission of payment requests in a timely manner shall be the responsibility of the GRANTEE and failure to comply may result in a reduction of payment of funds or termination of this Agreement. Reduction of award amount will be in the amount remaining unspent by expenditure deadline.

(C) Reporting:
The GRANTEE shall provide to the COUNTY a CSBG Quarterly Performance Report summarizing the Services which includes activities, progress, outcomes, and number of clients served (report format will be provided). The GRANTEE shall provide the COUNTY a Final Report containing the required completed sections (report form to be provided) summarizing the Services which include activities, progress, outcomes, and number of clients served. The submission of reports in a timely manner shall be

the responsibility of the GRANTEE and failure to comply may result in a reduction of payment of funds or termination of this Agreement.

Section II. General Information

Project Name			
Case Management for Emergency Services			
Agency Name			
Almost Home			
Contact Person	Phone	Email	Fax
Shawna Miller	303-659-6199	shawna@almosthomeonline.org	
Project Manager	Phone	Email	Fax

Section III. Affected Areas

Check all that apply.			
☐ Project Start Date	☐ Project End Date	☒ Contract Amount	☐ Project Costs
☐ Project Scope	☐ Technology	☒ Major Deliverables/ Outcomes	☐ Roles/Responsibilities

Section IV. Change Summary

Currently Recorded Dates/Costs:			Requested Revisions to Dates/Costs:			
Start Date	End Date	Contract Amount	Start Date	End Date	Contract Amount	Comments
01/01/2018	12/31/2018	$39,528.80	01/01/2018	12/31/2018	$59,528.80	At least $20,000 must be spent by September 30, 2018

Section V. Justification Summary

We have $67,000 unspent 2017 funds and we have gotten permission from the state to reallocate the funding to 3 of our 2015-2018 subgrantees, which were approved on January 20, 2105 by the BOCC.

SIGNATURE PAGE

In Witness Whereof, the parties have caused this contract amendment to be duly executed as of the date first above written.

Adams County Board of County Commissioners
Adams County, Colorado

By: _____
Board Chairman

SubGrantee

_____
By (Signature)

_____
Title

_____
Address

_____
City, State, Zip Code

2015 AGREEMENT
PY 2015-2016 Funds

For Performance of a Community Services Block Grant Activity
Catalog of Federal Domestic Assistance (CFDA) Number: 93.569

ARTICLE I: GENERAL PROVISIONS

PARTIES TO THIS AGREEMENT: This Agreement, dated for reference purposes only this 1st day of March, 2015, by and between Adams County, a body politic and corporate, known hereafter as "COUNTY", and Almost Home, Inc., located at 231 North Main Street, Brighton, CO 80601, known hereafter as the "GRANTEE".

WHEREAS, the COUNTY requires the provision of certain services and products in connection with the program funded by grants from the Community Services Block Grant (CSBG) and which must conform to one or more of the following objectives ("Program"):

A. To provide a range of services and activities having a measurable and potentially major impact on causes of poverty in the community or those areas of the community where poverty is a particularly acute problem.

B. To provide activities designed to assist low-income participants;

(i) to secure and retain meaningful employment;
(ii) to attain an adequate education;
(iii) to make better use of available income;
(iv) to obtain and maintain adequate housing and a suitable living environment;
(v) to obtain emergency assistance through loans or grants to meet immediate and urgent individual and family needs, including the need for health services, nutritious food, housing, and employment-related assistance;
(vi) to remove obstacles and solve problems which block the achievement of self-sufficiency;
(vii) to achieve greater participation in the affairs of the community; and
(viii) to make effective use of other related programs.

C. To provide on an emergency basis for the provision of such supplies and services, nutritious food and related services, as may be necessary to counteract conditions of starvation and malnutrition among the poor;

D. To coordinate and establish linkages between governmental and other social services programs to assure the effective delivery of such services to low-income individuals;

E. To encourage the use of entities in the private sector of the community in efforts to ameliorate poverty in the community.

WHEREAS, the Community & Neighborhood Resources Advisory Council (CNRAC) has recommended that the services and products provided for herein be included in the COUNTY's Application and Work Plan to the State for CSBG funds ("Project Plan"); and

WHEREAS, the GRANTEE is qualified to provide the services and products as identified in this Agreement.

NOW, THEREFORE, in consideration of the mutual promises, payments and other provisions hereof, the parties agree as follows:

ARTICLE II: SCOPE OF SERVICES

Section 1. The COUNTY hereby agrees to engage the GRANTEE, and the GRANTEE agrees to provide the following services and products as described in the attached Exhibit 1 (the "Services"). The Services shall be provided to individuals and families at or below 125% of "poverty income" as defined annually by the United States Department of Health & Human Services only to Adams County residents that provide proof that they are in the country legally and sign the Affidavit of Legal Residency. Income eligibility and legal residency information must be collected and kept in each CSBG customer file.

Section 2. The GRANTEE covenants that it has, or will obtain at its own expense, all personnel, goods, services and equipment required to perform the Services and shall use no funds provided hereunder for any expense other than those expenses required to perform the Services and that are outlined in this agreement.

Section 3. All Services provided hereunder shall be performed by the GRANTEE. No personnel engaged in the performance of those Services shall be employees of the COUNTY, nor shall any personnel providing those Services have any contractual relationship with the COUNTY.

Section 4. The COUNTY reserves the right to enter into other contracts related to the Services, and the GRANTEE agrees to cooperate with the COUNTY and its other contractors with respect to the coordination of those Services.

ARTICLE III: DURATION OF CONTRACT

Section 1. Services provided hereunder shall commence on:
March 1, 2015 and shall continue through February 28, 2016, (the "Period of Performance") unless this Agreement is terminated as provided hereunder.

Section 2. The COUNTY, at its sole option, may offer to extend this Agreement as necessary for up to two years providing satisfactory service is given and all terms and conditions of this Agreement have been fulfilled. Such extensions must be mutually agreed upon and is contingent upon federal funding from the United States Department of Health & Human Services through the Colorado Department of Local Affairs, known hereafter as "DOLA". Any single extension by the COUNTY shall include additional funding not to exceed an amount equal to the original amount of award to allow for continuation of GRANTEE services described in Exhibit 1 and this contract, any and all extensions, shall conclude February 28, 2018. Extension of the contract will follow the process for substantial project modification outlined in Exhibit 3.

Section 3. If the GRANTEE fails to comply with any contractual provision, the COUNTY, may, after notice to the GRANTEE, suspend the Agreement and withhold further payment or prohibit the GRANTEE from incurring additional obligation of contractual funds, pending corrective action by the GRANTEE or a decision by the COUNTY to terminate in accordance with this Agreement. The COUNTY may determine to allow such necessary and proper costs which the GRANTEE could not reasonably avoid during the period of suspension.

Section 4. If, through any cause, either party shall fail to honor or otherwise fulfill any of the promises, covenants, obligations, agreements or stipulations of this Agreement, the other party shall have the right to terminate this Agreement by giving ten (10) days written notice to the other party of such termination, specifying the reasons for such termination and the effective date thereof. In the event the GRANTEE is terminated under this section, the GRANTEE shall not be relieved of liability to the COUNTY or the State for any damages sustained by the COUNTY or the State by virtue of any breach of this Agreement by the GRANTEE, and the COUNTY or the State may withhold any payment to the GRANTEE for the purpose of settlement until such time as the exact damage due the COUNTY from the GRANTEE is determined.

Section 5. In addition to other specified remedial actions, the State or COUNTY may exercise the following remedial actions should it find that the GRANTEE substantially failed to satisfy or perform the duties and obligations in this Agreement. Substantial failure to satisfy the duties and obligations shall be defined to mean

insufficient, incorrect, improper activities or inaction by the GRANTEE. These remedial actions are as follows:

1) Withhold payment to the GRANTEE until the necessary services or corrections in performance are satisfactorily completed;

2) Request the removal from work on the Agreement of employees of the GRANTEE whom the COUNTY or the State justifies as being incompetent, careless, insubordinate, unsuitable, or otherwise unacceptable, or whose continued employment on the Agreement it deems to be contrary to the public interest or not in the best interest of the COUNTY or the State;

3) Deny payment for those services or obligations which have not been performed and which due to circumstances caused by the GRANTEE cannot be performed or if performed would be of no value to the COUNTY or the State. Denial of the amount of payment must be reasonably related to the amount of work or performance lost to the COUNTY or the State;

or

4) Terminate the Agreement for cause.

Section 6. The parties hereto may terminate this Agreement by mutual consent by setting forth in writing the terms, conditions and effective date of such termination, in which case the GRANTEE shall be reimbursed an amount equal to actual eligible expenses incurred as of the date of termination.

Section 7. If the State terminates the COUNTY's Contract with the State as identified in Article V, Section 8, whether for the convenience of the State or for cause, this Agreement shall immediately terminate. If such termination is for cause due to GRANTEE's failure of performance, the provisions of Article III, Section 2, 3, 6 and 7 shall apply and the GRANTEE shall not be relieved of liability to the COUNTY for any damages sustained by the COUNTY by virtue of any breach of the Contract by the GRANTEE, and the COUNTY may withhold any payment to the GRANTEE for the purpose of settlement until such time as the exact damage due the COUNTY from the GRANTEE is determined. If such termination is for the convenience of the State, the GRANTEE shall be reimbursed in an amount equal to actual expenses incurred as of the date of termination.

Section 8. The COUNTY without cause may terminate this Agreement at any time if written notice to terminate is provided to the GRANTEE more than ten (10) days prior to the effective date of the termination. In such event, the GRANTEE shall be paid for all eligible work satisfactorily completed commensurate with the amount of work done on the Scope of Services up to the date of termination less all amounts previously paid, and in addition thereto, any other amount as mutually agreed upon by the parties for the documented direct and incidental termination expenses due to the termination.

Section 9. Should the COUNTY terminate this Agreement for cause, as provided in Section 3 above, no further payments shall be due to the GRANTEE, including payment for Services provided prior to the effective date of termination.

Section 10. Nothing herein shall preclude either party from pursuing such remedies at law or at equity as may be appropriate.

Section 11. If, this Agreement is terminated for cause, all finished or unfinished documents, data, studies, surveys, drawings, maps, models, photographs, and reports or other material prepared by the Contractor under this Contract shall, at the option of the State or COUNTY, become the State or the COUNTY's property, and the Contractor shall be entitled to receive just and equitable compensation for any satisfactory work completed on such documents and other materials.

ARTICLE IV: COMPENSATION AND PROJECT BUDGET

Section 1. The COUNTY shall reimburse the GRANTEE for the actual cost of Services provided hereunder,

however, such reimbursement shall not exceed Thirty Thousand Dollars and 00/100 ($30,000) over the Period of Performance.

A. Funds under this Agreement shall be spent as set forth in the "Project Budget" attached hereto as Exhibit 2 and incorporated herein by reference.

B. The GRANTEE shall adhere to the Project Budget as set forth more specifically in subparagraph (A) above to the fullest practicable extent, but the GRANTEE is not precluded from making minor changes within the Scope of Services and Project Budget as necessary, when preapproved by the COUNTY in the manner set forth in the Community Development Amendment Policy attached hereto as Exhibit 3 and incorporated herein by reference. Such minor changes, however, may only be approved by the COUNTY if the total amount to be paid does not change and does not exceed the total amount budgeted and provided the expenditure is eligible for reimbursement.

Section 2. The COUNTY shall invoice DOLA for payments due and may make payment to the GRANTEE before the receipt of such DOLA CSBG funds for the purpose of the continuation of Services provided in accordance with the State CSBG Plan, the State of Colorado Local Government Financial Management Manual and this Agreement.

Section 3. The parties hereto recognize that compensation paid to the GRANTEE hereunder is funded from CSBG. If funding is not secured under CSBG, or if compensation to the GRANTEE is disapproved thereunder, then this Agreement shall be null and void and no payment will be due the GRANTEE from the COUNTY. Furthermore, if, for any reason, reimbursements from CSBG to the COUNTY are delayed, payments to the GRANTEE by the COUNTY may be delayed for the same length of time.

Section 4. GRANTEE acknowledges and is hereby given notice that the financial obligations of the COUNTY under this Agreement, payable after the current fiscal year, are contingent upon funds for this Agreement being appropriated, budgeted and otherwise made available for each fiscal year thereafter. In the event it is determined that funds will not be budgeted and appropriated, the COUNTY may terminate this Agreement by giving GRANTEE notice of such non-appropriation. The COUNTY's fiscal year commences January 1 and ends December 31.

Section 5. If the COUNTY makes any payments for all or any portion of the Services done by the GRANTEE prior to the COUNTY receiving payment from the State and the COUNTY is notified by the State that the State will not reimburse the COUNTY for the services provided by the GRANTEE, the GRANTEE agrees to repay the COUNTY within thirty (30) days of receipt of notice from the COUNTY that the funds must be repaid to the COUNTY.

ARTICLE V: ASSURANCES

Section 1. The GRANTEE will not discriminate against any employee or applicant for employment, or against any applicant for services or benefits because of race, color, religion, sex or national origin except to the extent that the religious organization exemption provided under 702 of the Civil Rights Act of 1964 (42 U.S.C. 2000e-1) applies. The GRANTEE shall adhere to acceptable affirmative action guidelines in selecting employees, and shall ensure that employees are treated equally during employment without regard to race, religion, sex or national origin. Such action shall include, but is not limited to the following: employment, upgrading, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay and other compensation and selection for training, including apprenticeship. Furthermore, the GRANTEE will not discriminate on the grounds of race, color, sex or national origin in the selection and retention of GRANTEEs, including suppliers of materials and lessor of equipment. Any prohibition against discrimination on the basis of age under the Age Discrimination Act of 1975 or with regard to otherwise qualified disabled individuals as provided in Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act shall also apply to the Services provided herein. The GRANTEE agrees to take positive steps to comply and advance in employment qualified disabled persons and to comply with applicable U.S. Department of Health and Human Services Regulations

(45 CFR Part 84). GRANTEE agrees to indemnify and hold harmless the COUNTY and the State of Colorado from any claims or demands which may arise under this provision.

Section 2. The GRANTEE shall not compel any employee or volunteer in performing the work of this Agreement to work in surroundings or under working conditions which are unsanitary or dangerous or hazardous to his or her health or safety.

Section 3. The GRANTEE shall comply with Executive Order No. 11426 entitled "Equal Employment Opportunity" as supplemented in the Department of Labor Regulations (41 CFR Section 84) and to execute such provisions as may be required.

Section 4. Independent Contractor/GRANTEE and Indemnification.

A. In performing the Work, the GRANTEE acts as an independent contractor responsible for calculating, withholding, and paying all Federal and State taxes and for obtaining necessary and adequate Workers Compensation Insurance, general liability insurance and any other insurance required under this Agreement. GRANTEE employees are not and shall not become employees, agents or servants of the COUNTY hereunder. The GRANTEE and GRANTEE employees are not entitled to unemployment insurance benefits unless unemployment compensation coverage is provided by the GRANTEE or some other entity and the GRANTEE is obligated to pay Federal and State income tax on any monies paid pursuant to this Agreement.

B. The GRANTEE shall indemnify, save and hold harmless the State and the COUNTY, and their employees, officials, board members, officers and agents, against any and all claims, losses, injuries, damages, expenses, liability and court awards including costs, expenses, and attorney fees incurred as a result of any act or omission by the GRANTEE, or its employees, agents, subcontractors, or assignees pursuant to the terms of this Agreement. This indemnification provision shall survive completion of the services and termination of this Agreement. Nothing herein shall be construed as a waiver of defenses available to the COUNTY under the Governmental Immunity Act.

Section 5. The GRANTEE shall comply with all applicable State and Federal laws, rules, regulations and Executive Orders of the Governor of Colorado, involving non-discrimination on the basis of race, color, religion, national origin, age, handicap, or sex. GRANTEE may utilize the expertise of the State Minority Business Office within the Office of the Governor, for assistance in complying with the non-discrimination and affirmative action requirements of this Agreement and applicable statutes.

Section 6. The GRANTEE shall not utilize any funds provided through this Program for political activities.

Section 7. The GRANTEE shall not utilize any funds provided through this Program to provide voters and prospective voters with transportation to the polls or provide similar assistance in connection with an election or any voter registration activity.

Section 8. The GRANTEE shall comply with all applicable State and Federal laws, rules, circulars, guidelines, regulations and requirements and all obligations imposed on the COUNTY or its subcontractors in the COUNTY's Contract with the State of Colorado, Department of Local Affairs for the CSBG 2013 program; the Special Provisions attached and incorporated therein; the Federal Terms and Conditions and Assurance in Appendices thereto; and any special conditions incorporated into or attached to a grant award letter which covers funds paid to the GRANTEE. The terms and conditions of that Contract and the Special Provisions are applicable to this Agreement and are made a part hereof and incorporated herein by reference, whether or not attached hereto. The GRANTEE agrees that it shall cooperate with the COUNTY in the compliance by the COUNTY of all the requirements set forth in the Certifications attached hereto as Exhibit 4 and incorporated herein by reference. The GRANTEE by execution of this Agreement hereby makes the applicable assurances and certifications set forth in the Certifications attached hereto as Exhibit 4.

Section 9. The GRANTEE covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of Services required to be performed under this Agreement. The GRANTEE further covenants that in the performance of this Agreement no person having any such interest will be employed.

Section 10. The GRANTEE assures that it shall comply with Public Law 101-121, Section 319, 29 CFR Part 93, restrictions on lobbying.

Section 11. The GRANTEE shall ensure compliance with the Drug-Free Workplace Requirements for Federal Grant Recipients under Sections 5153-5158 of the Anti-Drug Abuse Act of 1988 (41 U.S.C. 702-707).

Section 12. The GRANTEE will ensure compliance with Public Law 103.227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act). This Act requires that smoking may not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments. The above requirement will be included in any subawards which contain provisions for children's services and that all subcontractors shall certify compliance accordingly.

Section 13. The GRANTEE shall indemnify, save and hold harmless the State and the COUNTY, and their employees and agents, against any and all claims, damages, liability and court awards including costs, expenses, and attorney fees incurred as a result of any act or omission by the GRANTEE, or its employees, agents, subcontractors, or assignees pursuant to the terms of this Agreement. This indemnification provision shall survive completion of the services termination of this Agreement. Nothing herein shall be construed as a waiver of defenses available to the COUNTY or the CITY under the Governmental Immunity Act.

ARTICLE VI: CONTINGENT FUNDING

The parties hereto agree that should the State of Colorado or the Federal government disapprove this Agreement or refuse or fail to make the grant to the GRANTEE or the COUNTY as contemplated by this Agreement, then this Agreement shall be void and shall not be binding on any party to it. Unearned payments hereunder may be suspended or terminated in the event the GRANTEE refuses to accept additional terms or conditions to this Agreement that may be imposed by the Federal government, the COUNTY, or the State of Colorado after the effective date hereof.

ARTICLE VII: RECORDS, REPORTS, AUDITS AND INSPECTIONS

Section 1. The GRANTEE shall permit the COUNTY, and State and Federal representatives, to inspect, examine, copy or mechanically reproduce, on or off premises, as deemed necessary for grant purposes, all records pertaining to this Agreement for its term and for a period of five (5) years after its final payment hereunder or for such further period as may be necessary to resolve any matters which may be pending.

Section 2. The GRANTEE is subject to all procurement, fiscal and Program requirements to which the COUNTY is subject under the CSBG grant, including pertinent Federal and State guidelines including OMB Circulars A-110 "Grants and Agreements with Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations - Uniform Administrative Requirements", A-122 "Cost Principles for Non-Profit Organizations", and A-133 "Audits of Institutions of Higher Education and Other Non-Profits".

Section 3. The GRANTEE will follow the COUNTY's rules and procedures for reporting expenditures, travel, per diem expenses, purchases and bid procedures.

Section 4. During the Agreement term, the retention period set forth in Section 1 above, and as long thereafter as records are maintained, at any time during normal business hours, the authorized representatives of the COUNTY, the State of Colorado, and Comptroller General of the United States shall have the right of access to

any books, documents, papers or other records of the GRANTEE with respect to all matters covered by this Agreement in order to make audits, investigations, inspections, examinations, excerpts, and transcripts.

Section 5. For work performed under this Agreement the GRANTEE shall cause an audit to be conducted and submitted to the COUNTY in accordance with the applicable requirements of OMB Circular A-133 entitled, "Audits of Institutions of Higher Education and Other Nonprofit Institutions". If an audit is not required in accordance with OMB Circular 133, the GRANTEE shall provide a year-end financial statement for each fiscal year in which the GRANTEE has received funding for this project.

The audits or financial statement shall be furnished to the COUNTY within six (6) months after the end of the GRANTEE's fiscal year.

Section 6. The GRANTEE shall provide to the COUNTY quarterly on: ***Execution of agreement, September 10, 2015, December 10, 2015 and March 10, 2016*** a CSBG Quarterly Performance Report summarizing the Services which includes activities, progress, outcomes, and number of clients served (report format will be provided). The GRANTEE shall provide the COUNTY by ***March 15, 2016*** a Final Report (including Section G and NPI Report; report form to be provided) summarizing the Services which includes activities, progress, outcomes, and number of clients served. GRANTEE shall meet all other reporting requirements in accordance with the State CSBG Plan and the Local Government Financial Management Manual and any other reporting requirements required by the COUNTY, Federal government or the Colorado Department of Local Affairs. The submission of reports in a timely manner shall be the responsibility of the GRANTEE and failure to comply may result in a delay of payment of funds or termination of this Agreement.

Section 7. The GRANTEE shall follow all State of Colorado Local Government Financial Management Manual financial rules and procedures including, but not limited to, procedures for accounting, reporting, expenditures and budgeting. Minimum standards to be adhered to are those contained in the Local Government Financial Management Manual.

Section 8. In the event the GRANTEE shall obtain access to any records or files of the State or COUNTY in connection with, or during the performance of, this contract, the GRANTEE shall keep such records and information confidential and shall comply with all laws and regulations concerning the confidentiality of such records to the same extent as such laws and regulations apply to the State or the COUNTY. The GRANTEE agrees to notify and advise in writing all employees, agents, consultants, licensees, or sub-contractors of the said requirements of confidentiality and of possible penalties and fines imposed for violation thereof, and secure from each an acknowledgment of such advisement and agreement to be bound by the terms of this agreement as an employee, agent, consultant, licensee, or sub-contractor of the GRANTEE, as the case may be. Any breach of confidentiality by the GRANTEE or third party agents of the GRANTEE shall constitute good cause for the COUNTY or the State to cancel this contract without liability; any and all information delivered to the GRANTEE shall be returned to the COUNTY. Any COUNTY or State waiver of an alleged breach of confidentiality by the GRANTEE or third party agent of the GRANTEE is not to imply a waiver of any subsequent breach.

Section 9. All costs charged to the contract must be documented. For example, the GRANTEE must maintain signed time and attendance records for each and every individual employee and payroll documents approved by an official of the organization. Individual time distribution records must be maintained for allocating an employee's salary between this contract and other funding sources. Source documentation must be maintained for other costs such as receipts, travel vouchers, invoices, bills, or affidavits. Volunteer costs must be documented. All in-kind and other matching contributions, including grant award documents and receipts from other funding sources must be documented.

ARTICLE VIII: AMENDMENTS

Section 1. This Agreement contains the entire understanding between the parties. Either party to this Agreement may request Amendments to this Agreement at any time, but no change shall be binding unless it is mutually agreed upon by the parties to this Agreement. All Amendments shall be in writing, authorized and executed prior to any work being done thereon, as described in the attached Exhibit 3 ("ACCD Amendment Policy").

Section 2. Any change in or new Federal, State or local law, rule, Executive Order, Office of Management & Budget Circular, or other regulation under which the Services are to be performed which may constitutionally be applied to the Services and which, by its terms, is intended to be applied to the Services, shall be deemed to be incorporated into this Agreement.

ARTICLE IX: APPLICABLE LAWS

Section 1. The parties hereto agree that this Agreement shall be governed by and construed according to the laws of the State of Colorado.

Section 2. The courts of the State of Colorado shall have sole and exclusive jurisdiction of any disputes or litigation arising hereunder. Venue for any and all legal actions arising hereunder shall lie in the District Court in and for Adams County, State of Colorado.

Section 3. The GRANTEE specifically agrees to comply in the performance hereof with all local, State and Federal ordinances, codes, laws, rules, regulations, orders, and guidelines that are referenced herein and applicable to the Services or that may be or become applicable to the Services even though not stated herein, as described in the attached Exhibit 4 ("Certifications").

ARTICLE X: NON-ASSIGNMENT

The GRANTEE represents, covenants and warrants that it will not assign its rights nor delegate its obligations hereunder and breach of this provision shall void the obligations of the COUNTY hereunder as of the date of breach and this Agreement shall be void as of said date.

ARTICLE XI: SUCCESSORS

The GRANTEE covenants that the provisions of this Agreement shall be binding upon its successors and agents.

ARTICLE XII: REPRESENTATIVES

All applicable invoices, statements, notices, inquiries, and replies shall be addressed and served upon the respective representatives at the addresses below. The following individuals are designated for the purposes of this Agreement as representatives of the COUNTY and the GRANTEE (or their successors or assigns), respectively:

Adams County Attorney's Office 4430 S. Adams County Parkway Brighton, Colorado 80601 Phone: 720-523-6116 Fax: 720-523-6114
Adams County Community Development Contact: Joelle Greenland Address: 4430 S. Adams County Parkway Brighton, CO 80601 Phone: 720-523-6851 E-mail: jgreenland@adcogov.org

GRANTEE NAME:	Almost Home, Inc.
Contact:	Terry M. Moore
Address:	231 N. Main St.
Phone:	303-659-6199
Fax:	303-659-8859
E-mail:	Terry@AlmostHomeOnline.org

The parties may change their representatives at any time by written notice to the other party.

ARTICLE XIII: ILLEGAL ALIENS

Section 1. COMPLIANCE WITH C.R.S. § 8-17.5-101, ET. SEQ. AS AMENDED 5/13/08: Pursuant to Colorado Revised Statute (C.R.S.), § 8-17.5-101, *et. seq.*, as amended 5/13/08, the Contractor shall meet the following requirements prior to signing this Agreement (public contract for service) and for the duration thereof:

1.1. The Contractor shall certify participation in the E-Verify Program (the electronic employment verification program that is authorized in 8 U.S.C. § 1324a and jointly administered by the United States Department of Homeland Security and the Social Security Administration, or its successor program) or the Department Program (the employment verification program established by the Colorado Department of Labor and Employment pursuant to C.R.S. § 8-17.5-102(5)) on the attached certification.

1.2. The Contractor shall not knowingly employ or contract with an illegal alien to perform work under this public contract for services.

1.3. The Contractor shall not enter into a contract with a subcontractor that fails to certify to the Contractor that the subcontractor shall not knowingly employ or contract with an illegal alien to perform work under this public contract for services.

1.4. At the time of signing this public contract for services, the Contractor has confirmed the employment eligibility of all employees who are newly hired for employment to perform work under this public contract for services through participation in either the E-Verify Program or the Department Program.

1.5. The Contractor shall not use either the E-Verify Program or the Department Program procedures to undertake pre-employment screening of job applicants while this public contract for services is being performed.

1.6. If Contractor obtains actual knowledge that a subcontractor performing work under this public contract for services knowingly employs or contracts with an illegal alien, the Contractor shall: notify the subcontractor and the County within three days that the Contractor has actual knowledge that the subcontractor is employing or contracting with an illegal alien; and terminate the subcontract with the subcontractor if within three days of receiving the notice required pursuant to the previous paragraph, the subcontractor does not stop employing or contracting with the illegal alien; except that the contractor shall not terminate the contract with the subcontractor if during such three days the subcontractor provides information to establish that the subcontractor has not knowingly employed or contracted with an illegal alien.

1.7. Contractor shall comply with any reasonable requests by the Department of Labor and Employment (the Department) made in the course of an investigation that the Department is undertaking pursuant to the authority established in C.R.S. § 8-17.5-102(5).

1.8. If Contractor violates this Section of this Agreement, the County may terminate this Agreement for breach of contract. If the Agreement is so terminated, the Contractor shall be liable for actual and consequential damages to the County.

Section 2. GRANTEE must confirm that any individual natural person eighteen years of age of older is lawfully present in the United States pursuant to CRS §24-76.5-101 et seq. when such individual applies for public benefits provided under this Agreement by requiring the following:

A. Identification:
The applicant shall produce one of the following personal identifications:
(1) A valid Colorado driver's license or a Colorado identification card, issued pursuant to article 2 of title 42, C.R.S.; or
(2) A United States military card or a military dependent's identification card; or
(3) A United States Coast Guard Merchant Mariner card; or
(4) A Native American tribal document.

B. Affidavit:
The applicant shall execute an affidavit herein attached as Form 1, Affidavit of Legal Residency, stating:
(1) That they are United States citizen or legal permanent resident; or
(2) That they are otherwise lawfully present in the United States pursuant to federal law.

ARTICLE XIV: OFFICIALS NOT TO BENEFIT

Section 1. No member of the COUNTY government, Commissioners or individual officers elected therein, shall be admitted to any share or part of this Agreement or any benefit that may arise there from.

Section 2. Nothing in this Agreement is intended to create rights in any third party beneficiary.

ARTICLE XV: SEVERABILITY

The declaration by any court or other binding legal authority that any provision of this Agreement is illegal and void shall not affect the legality and enforceability of any other provision of this Agreement unless said provisions are mutually dependent.

ARTICLE XVI: ADVERTISEMENT AND PUBLIC NOTICES

GRANTEE shall ensure that any radio or television announcements, newspaper advertisements, press releases, pamphlets, mail campaigns, or any other method advising the public of their program that is funded with CSBG funds includes the following statement when feasible: "The funding source for this activity is Community Service Block Grant Funds made available through the Community Development Office of Adams County, Colorado."

CONTRACTOR'S CERTIFICATION OF COMPLIANCE

Pursuant to Colorado Revised Statute, § 8-17.5-101, *et.seq.*, as amended 5/13/08, as a prerequisite to entering into a contract for services with Adams County, Colorado, the undersigned Contractor hereby certifies that at the time of this certification, Contractor does not knowingly employ or contract with an illegal alien who will perform work under the attached contract for services and that the Contractor will participate in the E-Verify Program or Department program, as those terms are defined in C.R.S. § 8-17.5-101, *et. seq.* in order to confirm the employment eligibility of all employees who are newly hired for employment to perform work under the attached contract for services.

CONTRACTOR:

Almost Home, Inc
Company Name

6/3/15
Date

Terry M. Moore
Name (Print or Type)

Signature

Executive Director
Title

Note: Registration for the E-Verify Program can be completed at: https://www.vis-dhs.com\employerregistration. It is recommended that employers review the sample "memorandum of understanding" available at the website prior to registering

IN WITNESS WHEREOF, the parties have caused this Agreement to be duly executed on the day, month and year above written.

GRANTEE:
By: Terry M. Moore
Title: Executive Director
Date 6/3/15

WITNESS my hand and official seal.
My commission expires: 9/25/15

Noemi Soria
Notary Public

Noemi Soria NOTARY PUBLIC State of Colorado

STATE OF COLORADO)
) ss.
ADAMS COUNTY)

The foregoing Agreement was executed before me this 30 day of June, 2015, by Charles "Chaz" Tedesco, as the Chairman of BoCC, the agency named herein, the GRANTEE herein named.

WITNESS my hand and official seal.
My commission expires: 3-17-18

Martina Pace
Notary Public

MARTINA PACE
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20024006143
MY COMMISSION EXPIRES MARCH 17, 2018

ADAMS COUNTY
STATE OF COLORADO

By
Charles "Chaz" Tedesco, Chairman, Board of Commissioners

Date June 30, 2015

APPROVED AS TO FORM:

Adams County Attorney's Office

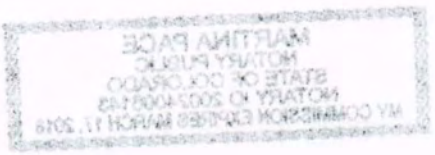

MARTINA PAGE
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20024009143
MY COMMISSION EXPIRES MARCH 11, 2019

EXHIBIT 1

SCOPE OF SERVICES
COMMUNITY SERVICES BLOCK GRANT

Services: ***Description of Project***

Case Managers will provide essential services for the rent and utility assistance program and homeless shelter. Case managers will assist in client connections with other programs and agencies that will help them on their road to self-sufficiency.

Reduction of Poverty: ***Brief Description of Efforts to Reduce Poverty,***

Case managers work with clients on how to make a limited income stretch to cover the necessities and how these expenses, (with the assistance of other services) can cover the costs of housing, child care, food and medical care (to mention a few). They assist with referrals to other programs that assist clients with self-sufficiency/emergency services not provided by Almost Home.

Population Served: ***Brief Description of Population to be Served.***

Homeless, nearly homeless individuals/families residing in and around Brighton Area.

Category:

☐ **Health** ☐ **Nutrition** ☐ **Housing** ☐ **Employment** ☐ **Education**

☒ **Emergency Services**

Number of Residents to be Served by CSBG Specific Project (at or below 125% of poverty):200

EXHIBIT 2

PROJECT BUDGET

CSBG Grant Detailed Budget - Exhibit 2	Adams County Community Development		
Name of Project/Activity: Case Mgmt	Column 1	Column 2	Column 3
Almost Home	ADCO Share	Applicant Share	Total
a. Personnel & Fringe Benefits (Direct Labor)	$30,000.00	N/A	$30,000.00
b. Travel			$0.00
c. Equipment			$0.00
d. Supplies			$0.00
e. Contractual			$0.00
f. Construction			$0.00
g. Other (Direct Costs)			$0.00
h. Subtotal of Direct Costs			$0.00
i. Indirect Costs			$0.00
Grand Total:	***$30,000.00***	***$0.00***	***$30,000.00***

The following Back-up & Source Documentation is required to be submitted with Draw-Down Requests for each eligible expense:

Eligible Expense	Required Back-up & Source Documentation
Direct Labor (Case Management)	Copies of Signed Time Allocation Sheet(s) & Payroll Report(s) including fringe information

EXHIBIT 2
EXHIBIT 3

ADAMS COUNTY COMMUNITY DEVELOPMENT
AMENDMENT POLICY
for Community Development Block Grant (CDBG)
Community Services Block Grant (CSBG)
HOME Investment Partnerships Program (HOME)

I. MINOR BUDGET ADJUSTMENTS

Adjustments in budget line items are allowable as necessary provided the change does not exceed the total amount awarded and provided the expenditure is eligible for reimbursement. The Administrator of Community Development is authorized to approve minor budget adjustments that do not affect the total amount awarded. Recipients of grant awards should request approval of these adjustments in writing. The Administrator of Community Development will notify the recipients in writing of the County's approval.

For modifications in a project affecting the project award amount, approval by the Board of County Commissioners is required.

II. MINOR PROJECT MODIFICATION

A minor project modification is a change in the project which does not result in an increase to the previously determined award amount nor a change to the national objective or activity category as designated for the original project.

To request a minor project modification the recipient must submit a letter describing the changes, including a revised budget, to Adams County Community Development. The Administrator of Community Development will review the requested modification.

The Administrator of Community Development will notify the recipient in writing that the modification has been approved and that the recipient may proceed with project implementation, or that the requested modification has not been approved.

III. SUBSTANTIAL PROJECT MODIFICATION

A substantial project modification is any change that is not a minor budget adjustment or minor project modification as described above.

Prior to formal submission, the Administrator of Community Development must review the proposed modification for grant eligibility and consistency with the Consolidated Plan. Upon formal written request from the recipient, Community Development will:
- review the project for complete information, for compliance as an eligible grant activity, and for consistency with the Consolidated Plan;
- complete an environmental review, if required;
-consult with the County Attorney if standard contract provisions may be at issue; and

- ensure that the public is informed of the proposed change if required by the Citizen Participation Plan.

Substantial project modifications require approval of the Board of County Commissioners and an amendment to the Contract.

EXHIBIT 3

EXHIBIT 4

CSBG CERTIFICATIONS

The grantee assures that activities implemented with CSBG funds will be:

- used to accomplish the State CSBG Goal and Objective stated in the State Plan; and
- within the requirements set forth in the Community Services Block Grant Act, Title IV of the Civil Rights Act, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, Public Law 103-227, Part C, Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), Certification Regarding Drug-Free Workplace Requirements, Certification Regarding Lobbying, Certification Regarding Debarment, Suspension, and Other Responsibility Matters - Primary Covered Transactions, Office of Management and Budget (OMB Circular A110 and A122), and the current State of Colorado CSBG Plan.

The Grantee also assures that it will:

- specifically consider, in a public meeting the designation of any local public or private entity to carry out the county community service activities under contract with the county, any local community action agency (CAA) which received federal fiscal 1981-82 funding; and
- consider, on the same basis as other non-governmental organizations, religious organizations to provide the CSBG services, so long as the program is implemented in a manner consistent with the Establishment Clause of the first amendment to the Constitution. Grantees shall not discriminate against an organization that provides assistance under, or applies to provide assistance, on the basis that the organization has a religious character. (Please review Sec.679 Operational Rule in the CSBG Act); and
- provide for coordination between community anti-poverty programs and ensure, where appropriate, that emergency energy crisis intervention programs under Title XXVI (relating to low-income home energy assistance) are conducted in such community; and
- provide, on an emergency basis, for the provision of such supplies and services, nutritious foods, and related services, as may be necessary to counteract conditions of starvation and malnutrition among low-income individuals; and
- coordinate, to the extent possible, programs with and form partnerships with other organizations serving low-income residents of the community and members of groups served, including religious organizations, charitable groups, and community organizations; and
- establish procedures under which a low-income individual, community organization, or religious organization, or representative of low-income individuals that considers its organization, or low-income individuals, to be inadequately represented on the CSBG board (or other mechanism) to petition for adequate representation; and
- ensure that in order for a public organization to be considered an eligible entity, the entity shall administer the CSBG program through a tri-partite board, which shall have members selected by the organization, and shall be composed so as to assure that no fewer than 1/3 of the members are persons chosen in accordance with democratic selection procedures adequate to assure that these members are:
    1. Representative of low-income individuals and families in the community served; and
    2. Reside in the community served; and
    3. Able to participate actively in the development, planning, implementation and evaluation of the program
- ensure that In order for a private, non-profit agency to be considered an eligible entity, the entity shall administer the CSBG program through a tri-partite board that fully participates in the development, planning, implementation, and evaluation of the program. The members of the board shall be selected by the entity and the board shall be composed so as to assure that:
    1. 1/3 of the members of the board are elected public officials holding office or their representatives; and
    2. Not fewer than 1/3 of the members are persons chosen in accordance with democratic selection procedures adequate to assure that these members are representative of low-income individuals and families in the neighborhood served and resides in the neighborhood represented; and
    3. The remainder of the members are officials or members of business, industry, labor, religious, law enforcement, education or other major groups and interests in the community served.
- prohibit the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than low-cost residential weatherization or other energy-related home repairs) of

any building or facility with CSBG funds; and

- prohibit, including subcontractors, (a) any partisan or nonpartisan political activity or any political activity associated with a candidate, or contending faction or group, in an election for public or party office, (b) any activity to provide voters or prospective voters with transportation to the polls or similar assistance in connection with any such election, or (c) any voter registration activity; and
- prohibit that persons shall, on the basis of race, color, national origin or sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with CSBG. Any prohibition against discrimination on the basis of age under the Age Discrimination Act or 1975 (42 U.S.C 6101 et seq.) or with respect to an otherwise qualified individual with a disability as provided in Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 12131 et seq.) shall also apply to any such program or activity; and
- participate in the Results-Oriented Management and Accountability (ROMA) System, and describe outcome measure to be used to measure performance in promoting self-sufficiency, family stability, and/or community revitalization; and
- make available for public inspection each plan prepared as part of the program planning process. The Grantee may, at its initiative, revise any plan prepared for CSBG funding and shall furnish the revised plan to the Director of the Community Services Block Grant under the Department of Local Affairs. Each plan prepared for submission shall be made available for public inspection within the county and/or service area in such a manner as will facilitate review of, and comments on, the plan; and
- cooperate with the State, to determine whether grantee performance goals, administrative standards, financial management requirements, and other requirements of the State, in conducting monitoring reviews including (1) a full on-site review for each grantee at least once during each 3-year period, (2) on-site review for each newly designated grantee immediately after the completion of the first year in which funds were received, (3) follow-up reviews with grantees that fail to meet the goals, standards, and requirement established by the State, and (4) other reviews as appropriate, including reviews of grantees with other programs that have had other federal, State, or local grants terminated for cause; and
- make available appropriate books, documents, papers, and records for inspection, examination, copying, or mechanical reproduction on or off the premises upon reasonable request by the U.S. Controller General, the State, or their authorized representatives should an investigation of the uses of CSBG funds be undertaken; and
- in the case of county governments or Subgrantees which receive a CSBG award in excess of $100,000, comply with the following three certifications related to the "Limitation on use of appropriated funds to influence certain Federal Contracting and financial transactions (P.L. 101-121, Section 319 and USC Title 31 Section 1352)":
    1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
    2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or any employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instruction.
    3. The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

The Grantee certifies to the best of its knowledge and belief, that it and its principals:

a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

b) have not within a three-year period preceding this proposal been convicted or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public transaction; violation of Federal or State antitrust statues

or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

c) are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

d) have not within a three-year period preceding this application had one or more public transactions (Federal, State or local) terminated for cause or default.

The Grantee further certifies that it:

a) requires that smoking not be permitted in any portion of any indoor routinely owned or leased or contracted for by an entity and used routinely or regularly for provisions of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee.

b) that it will require the language of this certification be included in any sub awards which contain provisions for the children's services and that all Subgrantees shall certify accordingly.

If you are unable to certify to any of the statements in this certification, please attach an explanation to this application.

SIGNATURE: _____

PRINT NAME: Terry M. Moore

POSITION TITLE: Executive Director **DATE:** 6/3/2015

EXHIBIT 4

EXHIBIT 5

INSURANCE

General Liability Insurance: Commercial General Liability Insurance written on ISO occurrence form CG 00 01 10/93 or equivalent, covering premises operations, fire damage, independent contractors, products and completed operations, blanket liability, personal injury, and advertising liability with minimum limits as follows:

General Aggregate	$1,000,000
Each Occurrence	$1,000,000
Products & Completed Operations Aggregate	$1,000,000
Any One Fire	$50,000

If any aggregate limit is reduced below $1,000,000 because of claims made or paid, GRANTEE shall immediately obtain additional insurance to restore the full aggregate limit and furnish to Adams County a certificate or other document satisfactory to Adams County showing compliance with this provision.

Automobile Liability Insurance: To include all motor vehicles owned, hired, leased, or borrowed:

Bodily Injury/Property Damage	$1,000,000 (each accident combined single limit)
Personal Injury Protection	per Colorado Statutes

Worker's Compensation: Worker's Compensation Insurance as required by State statute, and Employer's Liability insurance covering all of GRANTEE employees acting within the course and scope of their employment.

ADAMS COUNTY
COLORADO

Neighborhood Services Department
Community Development
4430 South Adams County Parkway
1st Floor, Suite W6202
Brighton, CO 80601
PHONE 720.523.6200
FAX 720.523.6996
www.adcogov.org

February 2, 2015

Terry Moore
Almost Home, Inc.
231 North Main St.
Brighton, CO 80601

RE: 2015 CSBG Estimated Funding – Case Management
Catalog of Federal Domestic Assistance (CFDA) # 93.569

Dear Mr. Moore,

We truly appreciate the time and effort your organization invested in preparing its 2015 Community Service Block Grant (CSBG) application. Congratulations, your application for the program listed above has been funded for the estimated amount of **$30,000.** Your application was approved to include the following:

- Case Management

Please provide written confirmation that your agency will be accepting this award as listed above no later than ***February 18, 2015.***

This award is contingent upon receipt of funds and does not obligate Adams County if these funds are not received or if final federal funding levels are below amounts currently estimated for the 2015 program year.

Requests received this year exceeded the funds available for distribution. CSBG applicants were screened by Adams County Community Development (ACCD) for program eligibility and funding recommendations were made by the Community & Neighborhood Resources Advisory Council. The Adams County Board of County Commissioners made final funding decisions for all grant awards.

The timeline for this award is March 1, 2015 through February 28, 2016. You will be contacted by ACCD to work out the details of the Subgrantee Agreement. Please do not enter into any agreements that would commit these funds before that time. No activities can begin for the proposed project until the Subgrantee Agreement is fully executed. Beginning activities before funds are officially released will result in program ineligibility and non reimbursement.

Please feel free to contact me at 720.523.6210 or lespinoza@adcogov.org if you have any questions. Thank you again for the important work you do and for your interest in ACCD funding opportunities.

Sincerely,

Liz Espinoza
Grants Coordinator
Adams County Community Development

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING THE ADAMS COUNTY COMMUNITY SERVICES BLOCK GRANT PROJECT FUNDING AWARDS

Resolution 2015-026

WHEREAS, the Federal government has established the Community Services Block Grant Program (CSBG) to provide a range of services and activities designed to have an impact on the causes of poverty in local communities; and

WHEREAS, U.S Department of Health and Human Services (HHS) allocates Community Services Block Grant funds to the State of Colorado, Department of Local Affairs through an annual formula allocation; and

WHEREAS, Adams County is eligible to receive an estimated $409,846 for the 2015/2016 program year from the State of Colorado, Department of Local Affairs; and

WHEREAS, the Adams County Community & Neighborhood Resources Advisory Council held a meeting on December 9, 2014 to review and recommend proposed Community Services Block Grant projects for 2015/2016 to the Board of County Commissioners; and

WHEREAS, a Study Session was held on January 13, 2015 to present recommendations for Commissioner funding consideration; and

WHEREAS, the project awards will be included as part of the 2015-2018 Adams County Community Action Plan to the State of Colorado, Department of Local Affairs; and

WHEREAS, much of this information is regular and routine, and the Board of County Commissioners wishes to designate the Director of the Neighborhood Services Department and the Community Development Manager to sign necessary documents to carry out the ongoing activities of the program.

NOW THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, and State of Colorado, that the following Adams County CSBG project awards be approved for PY2015/16:

Agency	PY2015/16
Almost Home, Inc.	$30,000
Center for People with Disabilities	$33,950
Growing Home, Inc.	$79,050
Lutheran Social Services of Colorado	$20,000
Project Angel Heart	$55,000
Admin & Linkages	$191,846
TOTAL PY2015/16	**$409,846**

Upon motion duly made and seconded the foregoing resolution was adopted by the following vote:

Tedesco_____Aye
O'Dorisio_____Aye
Henry_____Aye
Hansen_____Aye
Pawlowski_____Aye
Commissioners

STATE OF COLORADO)
County of Adams)

I, Stan Martin, County Clerk and ex-officio Clerk of the Board of County Commissioners in and for the County and State aforesaid do hereby certify that the annexed and foregoing Order is truly copied from the Records of the Proceedings of the Board of County Commissioners for said Adams County, now in my office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County, at Brighton, Colorado this 20th day of January, A.D. 2015.

County Clerk and ex-officio Clerk of the Board of County Commissioners

Stan Martin:

By:

E-Signed by Erica Hannah
VERIFY authenticity with e-Sign

Deputy

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

A RESOLUTION CONCERNING THE ADAMS COUNTY
COMMUNITY SERVICES BLOCK GRANT APPLICATION AND WORK PLAN
FOR 2015-2018

Resolution 2015-032

WHEREAS, the Federal government has established the Community Services Block Grant Program (CSBG) to provide a range of services and activities designed to have an impact on the causes of poverty in local communities; and

WHEREAS, the U.S Department of Health and Human Services (HHS) allocates Community Services Block Grant funds to the State of Colorado, Department of Local Affairs through an annual formula allocation; and

WHEREAS, Adams County has received Community Services Block Grant funds since 1974; and

WHEREAS, Adams County is eligible to receive an estimated $409,846 for the 2015/16 program year from the State of Colorado, Department of Local Affairs; and

WHEREAS, the Adams County Community & Neighborhood Resources Advisory Council has provided direction for the proposed Community Services Block grants for 2015-2018 and has made their funding recommendations to the Board of County Commissioners; and

WHEREAS, public notice was provided regarding the Public Hearing for the 2015-2018 CSBG Application and Work Plan; and

WHEREAS, a Public Hearing was held on January 20, 2015, for the approval and adoption for the 2015/16 sub-grantee grant awards; and

WHEREAS, much of this information is regular and routine, and the Board of County Commissioners wishes to designate authorized representatives as signatories for any non-contractual documents as required by the various funding sources; and

WHEREAS, the Director of the Neighborhood Services Department and the Community Development Manager have been authorized to sign necessary documents to carry out the on-going activities of the program; and

NOW, THEREFORE, BE IT RESOLVED by the Adams County Board of County Commissioners, County of Adams, and State of Colorado, that the Adams County Community Services Block Grant 2015-2018 Application and Work Plan be approved.

BE IT FURTHER RESOLVED, that the Chairman of the Adams County Board of County Commissioners be authorized to sign the 2015-2018 CSBG Application and Work Plan, the 2015 CSBG Sub-Grantee Award Agreements, subgrantee option letters and any related Adams County 2015-2018 CSBG program modifications and amendments.

Upon motion duly made and seconded the foregoing resolution was adopted by the following vote:

Tedesco_____Aye
O'Dorisio_____Aye
Henry_____Aye
Hansen_____Aye
Pawlowski_____Aye
Commissioners

STATE OF COLORADO)
County of Adams)

I, Stan Martin, County Clerk and ex-officio Clerk of the Board of County Commissioners in and for the County and State aforesaid do hereby certify that the annexed and foregoing Order is truly copied from the Records of the Proceedings of the Board of County Commissioners for said Adams County, now in my office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County, at Brighton, Colorado this 27th day of January, A.D. 2015.

County Clerk and ex-officio Clerk of the Board of County Commissioners

Stan Martin:

By:

E-Signed by Erica Hannah
VERIFY authenticity with e-Sign

Deputy

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

A RESOLUTION CONCERNING THE ADAMS COUNTY
COMMUNITY SERVICES BLOCK GRANT APPLICATION AND WORK PLAN
FOR 2015-2018

Resolution 2015-032

WHEREAS, the Federal government has established the Community Services Block Grant Program (CSBG) to provide a range of services and activities designed to have an impact on the causes of poverty in local communities; and

WHEREAS, the U.S Department of Health and Human Services (HHS) allocates Community Services Block Grant funds to the State of Colorado, Department of Local Affairs through an annual formula allocation; and

WHEREAS, Adams County has received Community Services Block Grant funds since 1974; and

WHEREAS, Adams County is eligible to receive an estimated $409,846 for the 2015/16 program year from the State of Colorado, Department of Local Affairs; and

WHEREAS, the Adams County Community & Neighborhood Resources Advisory Council has provided direction for the proposed Community Services Block grants for 2015-2018 and has made their funding recommendations to the Board of County Commissioners; and

WHEREAS, public notice was provided regarding the Public Hearing for the 2015-2018 CSBG Application and Work Plan; and

WHEREAS, a Public Hearing was held on January 20, 2015, for the approval and adoption for the 2015/16 sub-grantee grant awards; and

WHEREAS, much of this information is regular and routine, and the Board of County Commissioners wishes to designate authorized representatives as signatories for any non-contractual documents as required by the various funding sources; and

WHEREAS, the Director of the Neighborhood Services Department and the Community Development Manager have been authorized to sign necessary documents to carry out the on-going activities of the program; and

NOW, THEREFORE, BE IT RESOLVED by the Adams County Board of County Commissioners, County of Adams, and State of Colorado, that the Adams County Community Services Block Grant 2015-2018 Application and Work Plan be approved.

BE IT FURTHER RESOLVED, that the Chairman of the Adams County Board of County Commissioners be authorized to sign the 2015-2018 CSBG Application and Work Plan, the 2015 CSBG Sub-Grantee Award Agreements, subgrantee option letters and any related Adams County 2015-2018 CSBG program modifications and amendments.

Upon motion duly made and seconded the foregoing resolution was adopted by the following vote:

Tedesco_____Aye
O'Dorisio_____Aye
Henry_____Aye
Hansen_____Aye
Pawlowski_____Aye
Commissioners

STATE OF COLORADO)
County of Adams)

I, Stan Martin, County Clerk and ex-officio Clerk of the Board of County Commissioners in and for the County and State aforesaid do hereby certify that the annexed and foregoing Order is truly copied from the Records of the Proceedings of the Board of County Commissioners for said Adams County, now in my office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County, at Brighton, Colorado this 27th day of January, A.D. 2015.

County Clerk and ex-officio Clerk of the Board of County Commissioners

Stan Martin:

By:

E-Signed by Erica Hannah
VERIFY authenticity with e-Sign

Deputy

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: July 17, 2018
SUBJECT: Approval of CSBG Agreement Amendment between Adams County and Project Angel Heart
FROM: Chris Kline, Human Services Director
AGENCY/DEPARTMENT: Human Services
HEARD AT STUDY SESSION ON
AUTHORIZATION TO MOVE FORWARD: ☐ YES ☐ NO
RECOMMENDED ACTION: That the Board of County Commissioners Approves of the CSBG Agreement Amendment between Adams County and Project Angel Heart

BACKGROUND:

Adams County has received Community Service Block Grant funds to ameliorate the effects of poverty in local communities from the State Department of Local Affairs (DOLA) since 1974. The State receives funds from the U.S. Department of Health and Human Services as an annual formula allocation based on the State's poverty statistics. The County receives a letter from DOLA awarding funds based on the allocation formula. Adams County has $67,000 unspent 2017 CSBG funds that can only be spent on already approved 2015-2018 subgrantees.

The recommendation is to approve the 2018 Agreement Amendment with Project Angel Heart to utilize $25,000 of the 2017 unspent funds towards the 2015-2018 approved subgrantees. Funding has to be spent by September 30, 2018.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Human Services and Project Angel Heart

ATTACHED DOCUMENTS:

2015-2018 Original Resolution
Project Angel Heart 15-18 Agreement
2018 PAH Resolution - 2017 funds
2018 Project Angel Heart Agreement Amendment

FISCAL IMPACT:

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

Fund: 34

Cost Center: 00034, 9418

	Object Account	Subledger	Amount
Current Budgeted Revenue:	5335		$67,000
Additional Revenue not included in Current Budget:			
Total Revenues:			$67,000

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:	8810		$67,000
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			$67,000

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

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

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING THE 2018 COMMUNITY SERVICES BLOCK GRANT SUBGRANTEE CONTRACT AMENDMENT BETWEEN ADAMS COUNTY AND PROJECT ANGEL HEART

Resolution 2018

WHEREAS, the Federal government has established the Community Services Block Grant Program (CSBG) to provide a range of services and activities designed to have an impact on the causes of poverty in local communities; and

WHEREAS, U.S Department of Health and Human Services (HHS) allocates Community Services Block Grant funds to the State of Colorado, Department of Local Affairs through an annual formula allocation; and

WHEREAS, Adams County is eligible to receive an estimated $485,715 for each program year from the State of Colorado, Department of Local Affairs and has $67,000 in unspent 2017 CSBG funds; and

WHEREAS, the Community Services Block Grant Advisory Council held a meeting on June 8, 2018 to review and recommend Project Angel Heart to receive an additional $25,000 to be spent by September 30, 2018; and

WHEREAS, the project award will continue to be included as part of the 2015-2018 Adams County Community Action Plan to the State of Colorado, Department of Local Affairs; and

WHEREAS, much of this information is regular and routine, and the Board of County Commissioners wishes to designate the Director of the Human Services Department and the Specialty Programs Manager to sign necessary non-contractual documents to carry out the ongoing activities of the program.

NOW THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, and State of Colorado, that the 2018 Community Services Block Grant Subgrantee Contract Amendment between Adams County and Project Angel Heart be approved.

BE IT FURTHER RESOLVED, that the Chair is authorized to sign said Amendment on behalf of Adams County.

BE IT FURTHER RESOLVED, that the Director of the Human Services Department and the Specialty Programs Manager are authorized to sign necessary non-contractual documents to carry out the ongoing activities of the program.

Human Services Department
Community Support Services Division
www.adcogov.org

ADAMS COUNTY
COLORADO

7190 Colorado Boulevard
Commerce City, CO 80022
PHONE 303.287.8831
FAX 303.227.2106

Community Services Block Grant (CSBG)
Subgrantee Contract Amendment
PY2018

Section I. Provisions

PARTIES TO THIS Contract Amendment: This Contract Amendment, dated this 18th day of June, 2018, by and between Adams County, a body politic and corporate, known hereafter as "COUNTY", and Project Angel Heart. located at 4950 Washington St. Denver, Colorado 80216, known hereafter as the "GRANTEE" is made for the purpose of amending the funding amount set forth in the Community Services Block Grant ("CSBG") Agreement dated January 1, 2018.

The COUNTY requires the provision of certain services and products in connection with the program funded by grants from the CSBG and which must conform to the following:

(A) Scope of Service:
Project Angel Heart delivers medically tailored meals, free of charge, to food-insecure Adams County residents living with life-threatening illnesses such as cancer, kidney/heart/lung disease, and HIV/AIDS. Project Angel Heart will provide a minimum of 8,186 meals to at least 70 clients, reimbursed on a per-meal basis.

(B) Payment Requests:
Payment Requests for reimbursement must be submitted monthly no later than the 10th of the month for expenses incurred during the previous month. The submission of payment requests in a timely manner shall be the responsibility of the GRANTEE and failure to comply may result in a reduction of payment of funds or termination of this Agreement. Reduction of award amount will be in the amount remaining unspent by expenditure deadline.

(C) Reporting:
The GRANTEE shall provide to the COUNTY a CSBG Quarterly Performance Report summarizing the Services which includes activities, progress, outcomes, and number of clients served (report format will be provided). The GRANTEE shall provide the COUNTY a Final Report containing the required completed sections (report form to be provided) summarizing the Services which include activities, progress, outcomes, and number of clients served. The submission of reports in a timely manner shall be

the responsibility of the GRANTEE and failure to comply may result in a reduction of payment of funds or termination of this Agreement.

Section II. General Information

Project Name			
Home Delivered Meals			
Agency Name			
Project Angel Heart			
Contact Person	Phone	Email	Fax
Amy Fleming	303-830-0202	afleming@projectangelheart.org	
Project Manager	Phone	Email	Fax

Section III. Affected Areas

Check all that apply.			
☐ Project Start Date	☐ Project End Date	☒ Contract Amount	☐ Project Costs
☐ Project Scope	☐ Technology	☒ Major Deliverables/ Outcomes	☐ Roles/Responsibilities

Section IV. Change Summary

Currently Recorded Dates/Costs:			Requested Revisions to Dates/Costs:			
Start Date	End Date	Contract Amount	Start Date	End Date	Contract Amount	Comments
01/01/2018	12/31/2018	$65,000	01/01/2018	12/31/2018	$90,000	At least $25,000 must be spent by September 30, 2018

Section V. Justification Summary

We have $67,000 unspent 2017 funds and we have gotten permission from the state to reallocate the funding to 3 of our 2015-2018 subgrantees, which were approved on January 20, 2105 by the BOCC.

SIGNATURE PAGE

In Witness Whereof, the parties have caused this contract amendment to be duly executed as of the date first above written.

Adams County Board of County Commissioners
Adams County, Colorado

By: _____
Board Chairman

SubGrantee

_____
By (Signature)

_____
Title

_____
Address

_____
City, State, Zip Code

2015 AGREEMENT
PY 2015-2016 Funds

For Performance of a Community Services Block Grant Activity
Catalog of Federal Domestic Assistance (CFDA) Number: 93.569

ARTICLE I: GENERAL PROVISIONS

PARTIES TO THIS AGREEMENT: This Agreement, dated for reference purposes only this 1st day of March, 2015, by and between Adams County, a body politic and corporate, known hereafter as "COUNTY", and Project Angel Heart, located at 4950 Washington St. Denver, CO 80216, known hereafter as the "GRANTEE".

WHEREAS, the COUNTY requires the provision of certain services and products in connection with the program funded by grants from the Community Services Block Grant (CSBG) and which must conform to one or more of the following objectives ("Program"):

A. To provide a range of services and activities having a measurable and potentially major impact on causes of poverty in the community or those areas of the community where poverty is a particularly acute problem.

B. To provide activities designed to assist low-income participants;

(i) to secure and retain meaningful employment;
(ii) to attain an adequate education;
(iii) to make better use of available income;
(iv) to obtain and maintain adequate housing and a suitable living environment;
(v) to obtain emergency assistance through loans or grants to meet immediate and urgent individual and family needs, including the need for health services, nutritious food, housing, and employment-related assistance;
(vi) to remove obstacles and solve problems which block the achievement of self-sufficiency;
(vii) to achieve greater participation in the affairs of the community; and
(viii) to make effective use of other related programs.

C. To provide on an emergency basis for the provision of such supplies and services, nutritious food and related services, as may be necessary to counteract conditions of starvation and malnutrition among the poor;

D. To coordinate and establish linkages between governmental and other social services programs to assure the effective delivery of such services to low-income individuals;

E. To encourage the use of entities in the private sector of the community in efforts to ameliorate poverty in the community.

WHEREAS, the Community & Neighborhood Resources Advisory Council (CNRAC) has recommended that the services and products provided for herein be included in the COUNTY's Application and Work Plan to the State for CSBG funds ("Project Plan"); and

WHEREAS, the GRANTEE is qualified to provide the services and products as identified in this Agreement.

NOW, THEREFORE, in consideration of the mutual promises, payments and other provisions hereof, the parties agree as follows:

ARTICLE II: SCOPE OF SERVICES

Section 1. The COUNTY hereby agrees to engage the GRANTEE, and the GRANTEE agrees to provide the following services and products as described in the attached Exhibit 1 (the "Services"). The Services shall be provided to individuals and families at or below 125% of "poverty income" as defined annually by the United States Department of Health & Human Services only to Adams County residents that provide proof that they are in the country legally and sign the Affidavit of Legal Residency. Income eligibility and legal residency information must be collected and kept in each CSBG customer file.

Section 2. The GRANTEE covenants that it has, or will obtain at its own expense, all personnel, goods, services and equipment required to perform the Services and shall use no funds provided hereunder for any expense other than those expenses required to perform the Services and that are outlined in this agreement.

Section 3. All Services provided hereunder shall be performed by the GRANTEE. No personnel engaged in the performance of those Services shall be employees of the COUNTY, nor shall any personnel providing those Services have any contractual relationship with the COUNTY.

Section 4. The COUNTY reserves the right to enter into other contracts related to the Services, and the GRANTEE agrees to cooperate with the COUNTY and its other contractors with respect to the coordination of those Services.

ARTICLE III: DURATION OF CONTRACT

Section 1. Services provided hereunder shall commence on:
March 1, 2015 and shall continue through February 28, 2016, (the "Period of Performance") unless this Agreement is terminated as provided hereunder.

Section 2. The COUNTY, at its sole option, may offer to extend this Agreement as necessary for up to two years providing satisfactory service is given and all terms and conditions of this Agreement have been fulfilled. Such extensions must be mutually agreed upon and is contingent upon federal funding from the United States Department of Health & Human Services through the Colorado Department of Local Affairs, known hereafter as "DOLA". Any single extension by the COUNTY shall include additional funding not to exceed an amount equal to the original amount of award to allow for continuation of GRANTEE services described in Exhibit 1 and this contract, any and all extensions, shall conclude February 28, 2018. Extension of the contract will follow the process for substantial project modification outlined in Exhibit 3.

Section 3. If the GRANTEE fails to comply with any contractual provision, the COUNTY, may, after notice to the GRANTEE, suspend the Agreement and withhold further payment or prohibit the GRANTEE from incurring additional obligation of contractual funds, pending corrective action by the GRANTEE or a decision by the COUNTY to terminate in accordance with this Agreement. The COUNTY may determine to allow such necessary and proper costs which the GRANTEE could not reasonably avoid during the period of suspension.

Section 4. If, through any cause, either party shall fail to honor or otherwise fulfill any of the promises, covenants, obligations, agreements or stipulations of this Agreement, the other party shall have the right to terminate this Agreement by giving ten (10) days written notice to the other party of such termination, specifying the reasons for such termination and the effective date thereof. In the event the GRANTEE is terminated under this section, the GRANTEE shall not be relieved of liability to the COUNTY or the State for any damages sustained by the COUNTY or the State by virtue of any breach of this Agreement by the GRANTEE, and the COUNTY or the State may withhold any payment to the GRANTEE for the purpose of settlement until such time as the exact damage due the COUNTY from the GRANTEE is determined.

Section 5. In addition to other specified remedial actions, the State or COUNTY may exercise the following remedial actions should it find that the GRANTEE substantially failed to satisfy or perform the duties and obligations in this Agreement. Substantial failure to satisfy the duties and obligations shall be defined to mean

insufficient, incorrect, improper activities or inaction by the GRANTEE. These remedial actions are as follows:

1) Withhold payment to the GRANTEE until the necessary services or corrections in performance are satisfactorily completed;

2) Request the removal from work on the Agreement of employees of the GRANTEE whom the COUNTY or the State justifies as being incompetent, careless, insubordinate, unsuitable, or otherwise unacceptable, or whose continued employment on the Agreement it deems to be contrary to the public interest or not in the best interest of the COUNTY or the State;

3) Deny payment for those services or obligations which have not been performed and which due to circumstances caused by the GRANTEE cannot be performed or if performed would be of no value to the COUNTY or the State. Denial of the amount of payment must be reasonably related to the amount of work or performance lost to the COUNTY or the State;

or

4) Terminate the Agreement for cause.

Section 6. The parties hereto may terminate this Agreement by mutual consent by setting forth in writing the terms, conditions and effective date of such termination, in which case the GRANTEE shall be reimbursed an amount equal to actual eligible expenses incurred as of the date of termination.

Section 7. If the State terminates the COUNTY's Contract with the State as identified in Article V, Section 8, whether for the convenience of the State or for cause, this Agreement shall immediately terminate. If such termination is for cause due to GRANTEE's failure of performance, the provisions of Article III, Section 2, 3, 6 and 7 shall apply and the GRANTEE shall not be relieved of liability to the COUNTY for any damages sustained by the COUNTY by virtue of any breach of the Contract by the GRANTEE, and the COUNTY may withhold any payment to the GRANTEE for the purpose of settlement until such time as the exact damage due the COUNTY from the GRANTEE is determined. If such termination is for the convenience of the State, the GRANTEE shall be reimbursed in an amount equal to actual expenses incurred as of the date of termination.

Section 8. The COUNTY without cause may terminate this Agreement at any time if written notice to terminate is provided to the GRANTEE more than ten (10) days prior to the effective date of the termination. In such event, the GRANTEE shall be paid for all eligible work satisfactorily completed commensurate with the amount of work done on the Scope of Services up to the date of termination less all amounts previously paid, and in addition thereto, any other amount as mutually agreed upon by the parties for the documented direct and incidental termination expenses due to the termination.

Section 9. Should the COUNTY terminate this Agreement for cause, as provided in Section 3 above, no further payments shall be due to the GRANTEE, including payment for Services provided prior to the effective date of termination.

Section 10. Nothing herein shall preclude either party from pursuing such remedies at law or at equity as may be appropriate.

Section 11. If, this Agreement is terminated for cause, all finished or unfinished documents, data, studies, surveys, drawings, maps, models, photographs, and reports or other material prepared by the Contractor under this Contract shall, at the option of the State or COUNTY, become the State or the COUNTY's property, and the Contractor shall be entitled to receive just and equitable compensation for any satisfactory work completed on such documents and other materials.

ARTICLE IV: COMPENSATION AND PROJECT BUDGET

Section 1. The COUNTY shall reimburse the GRANTEE for the actual cost of Services provided hereunder, however, such reimbursement shall not exceed Fifty-Five Thousand Dollars and 00/100 ($55,000) over the Period of Performance.

A. Funds under this Agreement shall be spent as set forth in the "Project Budget" attached hereto as Exhibit 2 and incorporated herein by reference.

B. The GRANTEE shall adhere to the Project Budget as set forth more specifically in subparagraph (A) above to the fullest practicable extent, but the GRANTEE is not precluded from making minor changes within the Scope of Services and Project Budget as necessary, when preapproved by the COUNTY in the manner set forth in the Community Development Amendment Policy attached hereto as Exhibit 3 and incorporated herein by reference. Such minor changes, however, may only be approved by the COUNTY if the total amount to be paid does not change and does not exceed the total amount budgeted and provided the expenditure is eligible for reimbursement.

Section 2. The COUNTY shall invoice DOLA for payments due and may make payment to the GRANTEE before the receipt of such DOLA CSBG funds for the purpose of the continuation of Services provided in accordance with the State CSBG Plan, the State of Colorado Local Government Financial Management Manual and this Agreement.

Section 3. The parties hereto recognize that compensation paid to the GRANTEE hereunder is funded from CSBG. If funding is not secured under CSBG, or if compensation to the GRANTEE is disapproved thereunder, then this Agreement shall be null and void and no payment will be due the GRANTEE from the COUNTY. Furthermore, if, for any reason, reimbursements from CSBG to the COUNTY are delayed, payments to the GRANTEE by the COUNTY may be delayed for the same length of time.

Section 4. GRANTEE acknowledges and is hereby given notice that the financial obligations of the COUNTY under this Agreement, payable after the current fiscal year, are contingent upon funds for this Agreement being appropriated, budgeted and otherwise made available for each fiscal year thereafter. In the event it is determined that funds will not be budgeted and appropriated, the COUNTY may terminate this Agreement by giving GRANTEE notice of such non-appropriation. The COUNTY's fiscal year commences January 1 and ends December 31.

Section 5. If the COUNTY makes any payments for all or any portion of the Services done by the GRANTEE prior to the COUNTY receiving payment from the State and the COUNTY is notified by the State that the State will not reimburse the COUNTY for the services provided by the GRANTEE, the GRANTEE agrees to repay the COUNTY within thirty (30) days of receipt of notice from the COUNTY that the funds must be repaid to the COUNTY.

ARTICLE V: ASSURANCES

Section 1. The GRANTEE will not discriminate against any employee or applicant for employment, or against any applicant for services or benefits because of race, color, religion, sex or national origin except to the extent that the religious organization exemption provided under 702 of the Civil Rights Act of 1964 (42 U.S.C. 2000e-1) applies. The GRANTEE shall adhere to acceptable affirmative action guidelines in selecting employees, and shall ensure that employees are treated equally during employment without regard to race, religion, sex or national origin. Such action shall include, but is not limited to the following: employment, upgrading, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay and other compensation and selection for training, including apprenticeship. Furthermore, the GRANTEE will not discriminate on the grounds of race, color, sex or national origin in the selection and retention of GRANTEEs, including suppliers of materials and lessor of equipment. Any prohibition against discrimination on the basis of age under the Age

Discrimination Act of 1975 or with regard to otherwise qualified disabled individuals as provided in Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act shall also apply to the Services provided herein. The GRANTEE agrees to take positive steps to comply and advance in employment qualified disabled persons and to comply with applicable U.S. Department of Health and Human Services Regulations (45 CFR Part 84). GRANTEE agrees to indemnify and hold harmless the COUNTY and the State of Colorado from any claims or demands which may arise under this provision.

Section 2. The GRANTEE shall not compel any employee or volunteer in performing the work of this Agreement to work in surroundings or under working conditions which are unsanitary or dangerous or hazardous to his or her health or safety.

Section 3. The GRANTEE shall comply with Executive Order No. 11426 entitled "Equal Employment Opportunity" as supplemented in the Department of Labor Regulations (41 CFR Section 84) and to execute such provisions as may be required.

Section 4. Independent Contractor/GRANTEE and Indemnification.

A. In performing the Work, the GRANTEE acts as an independent contractor responsible for calculating, withholding, and paying all Federal and State taxes and for obtaining necessary and adequate Workers Compensation Insurance, general liability insurance and any other insurance required under this Agreement. GRANTEE employees are not and shall not become employees, agents or servants of the COUNTY hereunder. The GRANTEE and GRANTEE employees are not entitled to unemployment insurance benefits unless unemployment compensation coverage is provided by the GRANTEE or some other entity and the GRANTEE is obligated to pay Federal and State income tax on any monies paid pursuant to this Agreement.

B. The GRANTEE shall indemnify, save and hold harmless the State and the COUNTY, and their employees, officials, board members, officers and agents, against any and all claims, losses, injuries, damages, expenses, liability and court awards including costs, expenses, and attorney fees incurred as a result of any act or omission by the GRANTEE, or its employees, agents, subcontractors, or assignees pursuant to the terms of this Agreement. This indemnification provision shall survive completion of the services and termination of this Agreement. Nothing herein shall be construed as a waiver of defenses available to the COUNTY under the Governmental Immunity Act.

Section 5. The GRANTEE shall comply with all applicable State and Federal laws, rules, regulations and Executive Orders of the Governor of Colorado, involving non-discrimination on the basis of race, color, religion, national origin, age, handicap, or sex. GRANTEE may utilize the expertise of the State Minority Business Office within the Office of the Governor, for assistance in complying with the non-discrimination and affirmative action requirements of this Agreement and applicable statutes.

Section 6. The GRANTEE shall not utilize any funds provided through this Program for political activities.

Section 7. The GRANTEE shall not utilize any funds provided through this Program to provide voters and prospective voters with transportation to the polls or provide similar assistance in connection with an election or any voter registration activity.

Section 8. The GRANTEE shall comply with all applicable State and Federal laws, rules, circulars, guidelines, regulations and requirements and all obligations imposed on the COUNTY or its subcontractors in the COUNTY's Contract with the State of Colorado, Department of Local Affairs for the CSBG 2013 program; the Special Provisions attached and incorporated therein; the Federal Terms and Conditions and Assurance in Appendices thereto; and any special conditions incorporated into or attached to a grant award letter which covers funds paid to the GRANTEE. The terms and conditions of that Contract and the Special Provisions are applicable to this Agreement and are made a part hereof and incorporated herein by reference, whether or not

attached hereto. The GRANTEE agrees that it shall cooperate with the COUNTY in the compliance by the COUNTY of all the requirements set forth in the Certifications attached hereto as Exhibit 4 and incorporated herein by reference. The GRANTEE by execution of this Agreement hereby makes the applicable assurances and certifications set forth in the Certifications attached hereto as Exhibit 4.

Section 9. The GRANTEE covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of Services required to be performed under this Agreement. The GRANTEE further covenants that in the performance of this Agreement no person having any such interest will be employed.

Section 10. The GRANTEE assures that it shall comply with Public Law 101-121, Section 319, 29 CFR Part 93, restrictions on lobbying.

Section 11. The GRANTEE shall ensure compliance with the Drug-Free Workplace Requirements for Federal Grant Recipients under Sections 5153-5158 of the Anti-Drug Abuse Act of 1988 (41 U.S.C. 702-707).

Section 12. The GRANTEE will ensure compliance with Public Law 103.227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act). This Act requires that smoking may not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments. The above requirement will be included in any subawards which contain provisions for children's services and that all subcontractors shall certify compliance accordingly.

Section 13. The GRANTEE shall indemnify, save and hold harmless the State and the COUNTY, and their employees and agents, against any and all claims, damages, liability and court awards including costs, expenses, and attorney fees incurred as a result of any act or omission by the GRANTEE, or its employees, agents, subcontractors, or assignees pursuant to the terms of this Agreement. This indemnification provision shall survive completion of the services termination of this Agreement. Nothing herein shall be construed as a waiver of defenses available to the COUNTY or the CITY under the Governmental Immunity Act.

ARTICLE VI: CONTINGENT FUNDING

The parties hereto agree that should the State of Colorado or the Federal government disapprove this Agreement or refuse or fail to make the grant to the GRANTEE or the COUNTY as contemplated by this Agreement, then this Agreement shall be void and shall not be binding on any party to it. Unearned payments hereunder may be suspended or terminated in the event the GRANTEE refuses to accept additional terms or conditions to this Agreement that may be imposed by the Federal government, the COUNTY, or the State of Colorado after the effective date hereof.

ARTICLE VII: RECORDS, REPORTS, AUDITS AND INSPECTIONS

Section 1. The GRANTEE shall permit the COUNTY, and State and Federal representatives, to inspect, examine, copy or mechanically reproduce, on or off premises, as deemed necessary for grant purposes, all records pertaining to this Agreement for its term and for a period of five (5) years after its final payment hereunder or for such further period as may be necessary to resolve any matters which may be pending.

Section 2. The GRANTEE is subject to all procurement, fiscal and Program requirements to which the COUNTY is subject under the CSBG grant, including pertinent Federal and State guidelines including OMB Circulars A-110 "Grants and Agreements with Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations - Uniform Administrative Requirements", A-122 "Cost Principles for Non-Profit Organizations", and A-133 "Audits of Institutions of Higher Education and Other Non-Profits".

Section 3. The GRANTEE will follow the COUNTY's rules and procedures for reporting expenditures, travel, per diem expenses, purchases and bid procedures.

Section 4. During the Agreement term, the retention period set forth in Section 1 above, and as long thereafter as records are maintained, at any time during normal business hours, the authorized representatives of the COUNTY, the State of Colorado, and Comptroller General of the United States shall have the right of access to any books, documents, papers or other records of the GRANTEE with respect to all matters covered by this Agreement in order to make audits, investigations, inspections, examinations, excerpts, and transcripts.

Section 5. For work performed under this Agreement the GRANTEE shall cause an audit to be conducted and submitted to the COUNTY in accordance with the applicable requirements of OMB Circular A-133 entitled, "Audits of Institutions of Higher Education and Other Nonprofit Institutions". If an audit is not required in accordance with OMB Circular 133, the GRANTEE shall provide a year-end financial statement for each fiscal year in which the GRANTEE has received funding for this project.

The audits or financial statement shall be furnished to the COUNTY within six (6) months after the end of the GRANTEE's fiscal year.

Section 6. The GRANTEE shall provide to the COUNTY quarterly on: ***Execution of Agreement, September 10, 2015, December 10, 2015 and March 10, 2016*** a CSBG Quarterly Performance Report summarizing the Services which includes activities, progress, outcomes, and number of clients served (report format will be provided). The GRANTEE shall provide the COUNTY by ***March 15, 2016*** a Final Report (including Section G and NPI Report; report form to be provided) summarizing the Services which includes activities, progress, outcomes, and number of clients served. GRANTEE shall meet all other reporting requirements in accordance with the State CSBG Plan and the Local Government Financial Management Manual and any other reporting requirements required by the COUNTY, Federal government or the Colorado Department of Local Affairs. The submission of reports in a timely manner shall be the responsibility of the GRANTEE and failure to comply may result in a delay of payment of funds or termination of this Agreement.

Section 7. The GRANTEE shall follow all State of Colorado Local Government Financial Management Manual financial rules and procedures including, but not limited to, procedures for accounting, reporting, expenditures and budgeting. Minimum standards to be adhered to are those contained in the Local Government Financial Management Manual.

Section 8. In the event the GRANTEE shall obtain access to any records or files of the State or COUNTY in connection with, or during the performance of, this contract, the GRANTEE shall keep such records and information confidential and shall comply with all laws and regulations concerning the confidentiality of such records to the same extent as such laws and regulations apply to the State or the COUNTY. The GRANTEE agrees to notify and advise in writing all employees, agents, consultants, licensees, or sub-contractors of the said requirements of confidentiality and of possible penalties and fines imposed for violation thereof, and secure from each an acknowledgment of such advisement and agreement to be bound by the terms of this agreement as an employee, agent, consultant, licensee, or sub-contractor of the GRANTEE, as the case may be. Any breach of confidentiality by the GRANTEE or third party agents of the GRANTEE shall constitute good cause for the COUNTY or the State to cancel this contract without liability; any and all information delivered to the GRANTEE shall be returned to the COUNTY. Any COUNTY or State waiver of an alleged breach of confidentiality by the GRANTEE or third party agent of the GRANTEE is not to imply a waiver of any subsequent breach.

Section 9. All costs charged to the contract must be documented. For example, the GRANTEE must maintain signed time and attendance records for each and every individual employee and payroll documents approved by an official of the organization. Individual time distribution records must be maintained for allocating an employee's salary between this contract and other funding sources. Source documentation must be maintained for other costs such as receipts, travel vouchers, invoices, bills, or affidavits. Volunteer costs must be documented. All in-kind and other matching contributions, including grant award documents and receipts from other funding sources must be documented.

ARTICLE VIII: AMENDMENTS

Section 1. This Agreement contains the entire understanding between the parties. Either party to this Agreement may request Amendments to this Agreement at any time, but no change shall be binding unless it is mutually agreed upon by the parties to this Agreement. All Amendments shall be in writing, authorized and executed prior to any work being done thereon, as described in the attached Exhibit 3 ("ACCD Amendment Policy").

Section 2. Any change in or new Federal, State or local law, rule, Executive Order, Office of Management & Budget Circular, or other regulation under which the Services are to be performed which may constitutionally be applied to the Services and which, by its terms, is intended to be applied to the Services, shall be deemed to be incorporated into this Agreement.

ARTICLE IX: APPLICABLE LAWS

Section 1. The parties hereto agree that this Agreement shall be governed by and construed according to the laws of the State of Colorado.

Section 2. The courts of the State of Colorado shall have sole and exclusive jurisdiction of any disputes or litigation arising hereunder. Venue for any and all legal actions arising hereunder shall lie in the District Court in and for Adams County, State of Colorado.

Section 3. The GRANTEE specifically agrees to comply in the performance hereof with all local, State and Federal ordinances, codes, laws, rules, regulations, orders, and guidelines that are referenced herein and applicable to the Services or that may be or become applicable to the Services even though not stated herein, as described in the attached Exhibit 4 ("Certifications").

ARTICLE X: NON-ASSIGNMENT

The GRANTEE represents, covenants and warrants that it will not assign its rights nor delegate its obligations hereunder and breach of this provision shall void the obligations of the COUNTY hereunder as of the date of breach and this Agreement shall be void as of said date.

ARTICLE XI: SUCCESSORS

The GRANTEE covenants that the provisions of this Agreement shall be binding upon its successors and agents.

ARTICLE XII: REPRESENTATIVES

All applicable invoices, statements, notices, inquiries, and replies shall be addressed and served upon the respective representatives at the addresses below. The following individuals are designated for the purposes of this Agreement as representatives of the COUNTY and the GRANTEE (or their successors or assigns), respectively:

Adams County Attorney's Office 4430 S. Adams County Parkway Brighton, Colorado 80601 Phone: 720-523-6116 Fax: 720-523-6114
Adams County Community Development Contact: Joelle Greenland Address: 4430 S. Adams County Parkway Brighton, CO 80601 Phone: 720-523-6851 E-mail: jgreenland@adcogov.org

GRANTEE NAME: PROJECT ANGEL HEART

Contact: ERIN PULLING

Address: 4950 WASHINGTON ST DENVER CO 80216

Phone: 303-830-0202

Fax: 303-830-1840

E-mail: GRANTS@PROJECTANGELHEART.ORG

The parties may change their representatives at any time by written notice to the other party.

ARTICLE XIII: ILLEGAL ALIENS

Section 1. COMPLIANCE WITH C.R.S. § 8-17.5-101, ET. SEQ. AS AMENDED 5/13/08: Pursuant to Colorado Revised Statute (C.R.S.), § 8-17.5-101, *et. seq.*, as amended 5/13/08, the Contractor shall meet the following requirements prior to signing this Agreement (public contract for service) and for the duration thereof:

1.1. The Contractor shall certify participation in the E-Verify Program (the electronic employment verification program that is authorized in 8 U.S.C. § 1324a and jointly administered by the United States Department of Homeland Security and the Social Security Administration, or its successor program) or the Department Program (the employment verification program established by the Colorado Department of Labor and Employment pursuant to C.R.S. § 8-17.5-102(5)) on the attached certification.

1.2. The Contractor shall not knowingly employ or contract with an illegal alien to perform work under this public contract for services.

1.3. The Contractor shall not enter into a contract with a subcontractor that fails to certify to the Contractor that the subcontractor shall not knowingly employ or contract with an illegal alien to perform work under this public contract for services.

1.4. At the time of signing this public contract for services, the Contractor has confirmed the employment eligibility of all employees who are newly hired for employment to perform work under this public contract for services through participation in either the E-Verify Program or the Department Program.

1.5. The Contractor shall not use either the E-Verify Program or the Department Program procedures to undertake pre-employment screening of job applicants while this public contract for services is being performed.

1.6. If Contractor obtains actual knowledge that a subcontractor performing work under this public contract for services knowingly employs or contracts with an illegal alien, the Contractor shall: notify the subcontractor and the County within three days that the Contractor has actual knowledge that the subcontractor is employing or contracting with an illegal alien; and terminate the subcontract with the subcontractor if within three days of receiving the notice required pursuant to the previous paragraph, the subcontractor does not stop employing or contracting with the illegal alien; except that the contractor shall not terminate the contract with the subcontractor if during such three days the subcontractor provides information to establish that the subcontractor has not knowingly employed or contracted with an illegal alien.

1.7. Contractor shall comply with any reasonable requests by the Department of Labor and Employment (the Department) made in the course of an investigation that the Department is undertaking pursuant to the authority established in C.R.S. § 8-17.5-102(5).

1.8. If Contractor violates this Section of this Agreement, the County may terminate this Agreement for breach of contract. If the Agreement is so terminated, the Contractor shall be liable for actual and consequential damages to the County.

Section 2. GRANTEE must confirm that any individual natural person eighteen years of age of older is lawfully present in the United States pursuant to CRS §24-76.5-101 et seq. when such individual applies for public benefits provided under this Agreement by requiring the following:

A. Identification:
The applicant shall produce one of the following personal identifications:
(1) A valid Colorado driver's license or a Colorado identification card, issued pursuant to article 2 of title 42, C.R.S.; or
(2) A United States military card or a military dependent's identification card; or
(3) A United States Coast Guard Merchant Mariner card; or
(4) A Native American tribal document.

B. Affidavit:
The applicant shall execute an affidavit herein attached as Form 1, Affidavit of Legal Residency, stating:
(1) That they are United States citizen or legal permanent resident; or
(2) That they are otherwise lawfully present in the United States pursuant to federal law.

ARTICLE XIV: OFFICIALS NOT TO BENEFIT

Section 1. No member of the COUNTY government, Commissioners or individual officers elected therein, shall be admitted to any share or part of this Agreement or any benefit that may arise there from.

Section 2. Nothing in this Agreement is intended to create rights in any third party beneficiary.

ARTICLE XV: SEVERABILITY

The declaration by any court or other binding legal authority that any provision of this Agreement is illegal and void shall not affect the legality and enforceability of any other provision of this Agreement unless said provisions are mutually dependent.

ARTICLE XVI: ADVERTISEMENT AND PUBLIC NOTICES

GRANTEE shall ensure that any radio or television announcements, newspaper advertisements, press releases, pamphlets, mail campaigns, or any other method advising the public of their program that is funded with CSBG funds includes the following statement when feasible: "The funding source for this activity is Community Service Block Grant Funds made available through the Community Development Office of Adams County, Colorado."

CONTRACTOR'S CERTIFICATION OF COMPLIANCE

Pursuant to Colorado Revised Statute, § 8-17.5-101, *et.seq.,* as amended 5/13/08, as a prerequisite to entering into a contract for services with Adams County, Colorado, the undersigned Contractor hereby certifies that at the time of this certification, Contractor does not knowingly employ or contract with an illegal alien who will perform work under the attached contract for services and that the Contractor will participate in the E-Verify Program or Department program, as those terms are defined in C.R.S. § 8-17.5-101, *et. seq.* in order to confirm the employment eligibility of all employees who are newly hired for employment to perform work under the attached contract for services.

CONTRACTOR:

Project Angel Heart
Company Name

6/8/15
Date

Erin Pulling
Name (Print or Type)

E. Pulling
Signature

President & CEO
Title

Note: Registration for the E-Verify Program can be completed at: https://www.vis-dhs.com\employerregistration. It is recommended that employers review the sample "memorandum of understanding" available at the website prior to registering

IN WITNESS WHEREOF, the parties have caused this Agreement to be duly executed on the day, month and year above written.

GRANTEE:
By: _____
Title: President & CEO
Date 6/9/15

WITNESS my hand and official seal.
My commission expires: Jan. 30, 2019

MATTHEW B PEDIGO
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20154004418
MY COMMISSION EXPIRES JANUARY 30, 2019

_____
Notary Public

STATE OF COLORADO)
) ss.
ADAMS COUNTY)

The foregoing Agreement was executed before me this 30 day of June, 2015, by Charles "Chaz" Tedesco as the Chairman of BOCC, the agency named herein, the GRANTEE herein named.

WITNESS my hand and official seal.
My commission expires: 3-17-18

_____
Notary Public

MARTINA PACE
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20024006143
MY COMMISSION EXPIRES MARCH 17, 2018

ADAMS COUNTY
STATE OF COLORADO

By _____
Charles "Chaz" Tedesco, Chairman, Board of Commissioners

Date June 30, 2015

APPROVED AS TO FORM:

_____
Adams County Attorney's Office

EXHIBIT 1

SCOPE OF SERVICES
COMMUNITY SERVICES BLOCK GRANT

Services: *Description of Project*

Home-delivered nutritious meals, free of charge, living with life-threatening illnesses. Client meals will be based on individual medical diet restrictions. Our ability to make such individualized meal modifications makes Project Angel Heart unique among Adams County meal programs; this allows us to reach a population that would likely go hungry or eat inappropriately for their conditions were it not for our program.

Reduction of Poverty: ***Brief Description of Efforts to Reduce Poverty,***

Project Angel Heart meals allow ill clients to continue to live independently through the provision of nutritious, individually appropriate, home-delivered meals. Meals are provided at no charge to our clients so they do not have to decide between purchasing food or purchasing medicine. Clients' dependents may also receive meals so clients do not have to choose between feeding themselves or feeding their loved ones. These meals allow clients in poverty to redirect their meager income to other areas of crucial need in their lives, making it less likely they will slide farther in to the vicious cycle of poverty that may have been caused by—or is certainly exacerbated by—illness. By providing meals to dependents of ill members of the community, the hope is to stabilize the entire family unit. In providing meals to often-neglected populations, Project Angel Heart attempts to thwart the effects of poverty within the community.

Population Served: ***Brief Description of Population to be Served.***

Adams County residents living at or below 125% of the federal poverty level living with life-threatening illnesses.

Category:

☐ **Health** ☒ **Nutrition** ☐ **Housing** ☐ **Employment** ☐ **Education**

☐ **Emergency Services** ☐ **Self-Sufficiency**

Number of Residents to be Served by CSBG Specific Project (at or below 125% of poverty): 45

EXHIBIT 2

PROJECT BUDGET

CSBG Grant Detailed Budget - Exhibit 2	Adams County Community Development		
Name of Project/Activity: Meals on Wheels **Project Angel Heart**	**Column 1** **ADCO Share**	**Column 2** **Applicant Share**	**Column 3** **Total**
a. Personnel & Fringe Benefits (Direct Labor)			$0.00
b. Travel			$0.00
c. Equipment			$0.00
d. Supplies			$0.00
e. Contractual			$0.00
f. Construction			$0.00
g. Other (Direct Costs) Meals	$55,000.00	N/A	$55,000.00
h. Subtotal of Direct Costs			$0.00
i. Indirect Costs			$0.00
Grand Total:	***$55,000.00***	***$0.00***	***$55,000.00***

* Total client meal number is based on total projected Adams County clients/meals served during grant term.

The following Back-up & Source Documentation is required to be submitted with Draw-Down Requests for each eligible expense:

Eligible Expense	**Required Back-up & Source Documentation**
Client Meals	Copy of "Cost of Meal" Methodology & report of number of meals provided to Adams County Low-Income individuals

EXHIBIT 2
EXHIBIT 3

ADAMS COUNTY COMMUNITY DEVELOPMENT
AMENDMENT POLICY
for Community Development Block Grant (CDBG)
Community Services Block Grant (CSBG)
HOME Investment Partnerships Program (HOME)

I. MINOR BUDGET ADJUSTMENTS

Adjustments in budget line items are allowable as necessary provided the change does not exceed the total amount awarded and provided the expenditure is eligible for reimbursement. The Administrator of Community Development is authorized to approve minor budget adjustments that do not affect the total amount awarded. Recipients of grant awards should request approval of these adjustments in writing. The Administrator of Community Development will notify the recipients in writing of the County's approval.

For modifications in a project affecting the project award amount, approval by the Board of County Commissioners is required.

II. MINOR PROJECT MODIFICATION

A minor project modification is a change in the project which does not result in an increase to the previously determined award amount nor a change to the national objective or activity category as designated for the original project.

To request a minor project modification the recipient must submit a letter describing the changes, including a revised budget, to Adams County Community Development. The Administrator of Community Development will review the requested modification.

The Administrator of Community Development will notify the recipient in writing that the modification has been approved and that the recipient may proceed with project implementation, or that the requested modification has not been approved.

III. SUBSTANTIAL PROJECT MODIFICATION

A substantial project modification is any change that is not a minor budget adjustment or minor project modification as described above.

Prior to formal submission, the Administrator of Community Development must review the proposed modification for grant eligibility and consistency with the Consolidated Plan. Upon formal written request from the recipient, Community Development will:
- review the project for complete information, for compliance as an eligible grant activity, and for consistency with the Consolidated Plan;

- complete an environmental review, if required;
-consult with the County Attorney if standard contract provisions may be at issue; and
- ensure that the public is informed of the proposed change if required by the Citizen Participation Plan.

Substantial project modifications require approval of the Board of County Commissioners and an amendment to the Contract.

EXHIBIT 3

EXHIBIT 4

CSBG CERTIFICATIONS

The grantee assures that activities implemented with CSBG funds will be:

- used to accomplish the State CSBG Goal and Objective stated in the State Plan; and
- within the requirements set forth in the Community Services Block Grant Act, Title IV of the Civil Rights Act, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, Public Law 103-227, Part C, Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), Certification Regarding Drug-Free Workplace Requirements, Certification Regarding Lobbying, Certification Regarding Debarment, Suspension, and Other Responsibility Matters - Primary Covered Transactions, Office of Management and Budget (OMB Circular A110 and A122), and the current State of Colorado CSBG Plan.

The Grantee also assures that it will:

- specifically consider, in a public meeting the designation of any local public or private entity to carry out the county community service activities under contract with the county, any local community action agency (CAA) which received federal fiscal 1981-82 funding; and
- consider, on the same basis as other non-governmental organizations, religious organizations to provide the CSBG services, so long as the program is implemented in a manner consistent with the Establishment Clause of the first amendment to the Constitution. Grantees shall not discriminate against an organization that provides assistance under, or applies to provide assistance, on the basis that the organization has a religious character. (Please review Sec.679 Operational Rule in the CSBG Act); and
- provide for coordination between community anti-poverty programs and ensure, where appropriate, that emergency energy crisis intervention programs under Title XXVI (relating to low-income home energy assistance) are conducted in such community; and
- provide, on an emergency basis, for the provision of such supplies and services, nutritious foods, and related services, as may be necessary to counteract conditions of starvation and malnutrition among low-income individuals; and
- coordinate, to the extent possible, programs with and form partnerships with other organizations serving low-income residents of the community and members of groups served, including religious organizations, charitable groups, and community organizations; and
- establish procedures under which a low-income individual, community organization, or religious organization, or representative of low-income individuals that considers its organization, or low-income individuals, to be inadequately represented on the CSBG board (or other mechanism) to petition for adequate representation; and
- ensure that in order for a public organization to be considered an eligible entity, the entity shall administer the CSBG program through a tri-partite board, which shall have members selected by the organization, and shall be composed so as to assure that no fewer than 1/3 of the members are persons chosen in accordance with democratic selection procedures adequate to assure that these members are:
    1. Representative of low-income individuals and families in the community served; and
    2. Reside in the community served; and
    3. Able to participate actively in the development, planning, implementation and evaluation of the program
- ensure that In order for a private, non-profit agency to be considered an eligible entity, the entity shall administer the CSBG program through a tri-partite board that fully participates in the development, planning, implementation, and evaluation of the program. The members of the board shall be selected by the entity and the board shall be composed so as to assure that:
    1. 1/3 of the members of the board are elected public officials holding office or their representatives; and
    2. Not fewer than 1/3 of the members are persons chosen in accordance with democratic selection procedures adequate to assure that these members are representative of low-income individuals and families in the neighborhood served and resides in the neighborhood represented; and
    3. The remainder of the members are officials or members of business, industry, labor, religious, law enforcement, education or other major groups and interests in the community served.
- prohibit the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than low-cost residential weatherization or other energy-related home repairs) of

any building or facility with CSBG funds; and

- prohibit, including subcontractors, (a) any partisan or nonpartisan political activity or any political activity associated with a candidate, or contending faction or group, in an election for public or party office, (b) any activity to provide voters or prospective voters with transportation to the polls or similar assistance in connection with any such election, or (c) any voter registration activity; and
- prohibit that persons shall, on the basis of race, color, national origin or sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with CSBG. Any prohibition against discrimination on the basis of age under the Age Discrimination Act or 1975 (42 U.S.C 6101 et seq.) or with respect to an otherwise qualified individual with a disability as provided in Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 12131 et seq.) shall also apply to any such program or activity; and
- participate in the Results-Oriented Management and Accountability (ROMA) System, and describe outcome measure to be used to measure performance in promoting self-sufficiency, family stability, and/or community revitalization; and
- make available for public inspection each plan prepared as part of the program planning process. The Grantee may, at its initiative, revise any plan prepared for CSBG funding and shall furnish the revised plan to the Director of the Community Services Block Grant under the Department of Local Affairs. Each plan prepared for submission shall be made available for public inspection within the county and/or service area in such a manner as will facilitate review of, and comments on, the plan; and
- cooperate with the State, to determine whether grantee performance goals, administrative standards, financial management requirements, and other requirements of the State, in conducting monitoring reviews including (1) a full on-site review for each grantee at least once during each 3-year period, (2) on-site review for each newly designated grantee immediately after the completion of the first year in which funds were received, (3) follow-up reviews with grantees that fail to meet the goals, standards, and requirement established by the State, and (4) other reviews as appropriate, including reviews of grantees with other programs that have had other federal, State, or local grants terminated for cause; and
- make available appropriate books, documents, papers, and records for inspection, examination, copying, or mechanical reproduction on or off the premises upon reasonable request by the U.S. Controller General, the State, or their authorized representatives should an investigation of the uses of CSBG funds be undertaken; and
- in the case of county governments or Subgrantees which receive a CSBG award in excess of $100,000, comply with the following three certifications related to the "Limitation on use of appropriated funds to influence certain Federal Contracting and financial transactions (P.L. 101-121, Section 319 and USC Title 31 Section 1352)":
    1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
    2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or any employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instruction.
    3. The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

The Grantee certifies to the best of its knowledge and belief, that it and its principals:

a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

b) have not within a three-year period preceding this proposal been convicted or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public transaction; violation of Federal or State antitrust statues

or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

c) are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

d) have not within a three-year period preceding this application had one or more public transactions (Federal, State or local) terminated for cause or default.

The Grantee further certifies that it:

a) requires that smoking not be permitted in any portion of any indoor routinely owned or leased or contracted for by an entity and used routinely or regularly for provisions of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee.

b) that it will require the language of this certification be included in any sub awards which contain provisions for the children's services and that all Subgrantees shall certify accordingly.

If you are unable to certify to any of the statements in this certification, please attach an explanation to this application.

SIGNATURE: Erin Pulling

PRINT NAME: Erin Pulling

POSITION TITLE: President & CEO **DATE:** 6/8/15

EXHIBIT 5

INSURANCE

General Liability Insurance: Commercial General Liability Insurance written on ISO occurrence form CG 00 01 10/93 or equivalent, covering premises operations, fire damage, independent contractors, products and completed operations, blanket liability, personal injury, and advertising liability with minimum limits as follows:

General Aggregate	$1,000,000
Each Occurrence	$1,000,000
Products & Completed Operations Aggregate	$1,000,000
Any One Fire	$50,000

If any aggregate limit is reduced below $1,000,000 because of claims made or paid, GRANTEE shall immediately obtain additional insurance to restore the full aggregate limit and furnish to Adams County a certificate or other document satisfactory to Adams County showing compliance with this provision.

Automobile Liability Insurance: To include all motor vehicles owned, hired, leased, or borrowed:

Bodily Injury/Property Damage	$1,000,000 (each accident combined single limit)
Personal Injury Protection	per Colorado Statutes

Worker's Compensation: Worker's Compensation Insurance as required by State statute, and Employer's Liability insurance covering all of GRANTEE employees acting within the course and scope of their employment.

ADAMS COUNTY
COLORADO

Neighborhood Services Department
Community Development
4430 South Adams County Parkway
1st Floor, Suite W6202
Brighton, CO 80601
PHONE 720.523.6200
FAX 720.523.6996
www.adcogov.org

February 2, 2015

Erin Pulling, Executive Director
Project Angel Heart
4950 Washington Street
Denver, CO 80216

RE: 2015 CSBG Estimated Funding – Meals on Wheels Program
Catalog of Federal Domestic Assistance (CFDA) # 93.569

Dear Ms. Pulling,

We truly appreciate the time and effort your organization invested in preparing its 2015 Community Service Block Grant (CSBG) application. Congratulations, your application for the program listed above has been funded for the estimated amount of **$55,000.** Your application was approved to include the following:

- Meals

Please provide written confirmation that your agency will be accepting this award as listed above no later than ***February 18, 2015.***

This award is contingent upon receipt of funds and does not obligate Adams County if these funds are not received or if final federal funding levels are below amounts currently estimated for the 2015 program year.

Requests received this year exceeded the funds available for distribution. CSBG applicants were screened by Adams County Community Development (ACCD) for program eligibility and funding recommendations were made by the Community & Neighborhood Resources Advisory Council. The Adams County Board of County Commissioners made final funding decisions for all grant awards.

The timeline for this award is March 1, 2015 through February 28, 2016. You will be contacted by ACCD to work out the details of the Subgrantee Agreement. Please do not enter into any agreements that would commit these funds before that time. No activities can begin for the proposed project until the Subgrantee Agreement is fully executed. Beginning activities before funds are officially released will result in program ineligibility and non reimbursement.

Please feel free to contact me at 720.523.6210 or lespinoza@adcogov.org if you have any questions. Thank you again for the important work you do and for your interest in ACCD funding opportunities.

Sincerely,

Liz Espinoza
Grants Coordinator
Adams County Community Development

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING THE ADAMS COUNTY COMMUNITY SERVICES BLOCK GRANT PROJECT FUNDING AWARDS

Resolution 2015-026

WHEREAS, the Federal government has established the Community Services Block Grant Program (CSBG) to provide a range of services and activities designed to have an impact on the causes of poverty in local communities; and

WHEREAS, U.S Department of Health and Human Services (HHS) allocates Community Services Block Grant funds to the State of Colorado, Department of Local Affairs through an annual formula allocation; and

WHEREAS, Adams County is eligible to receive an estimated $409,846 for the 2015/2016 program year from the State of Colorado, Department of Local Affairs; and

WHEREAS, the Adams County Community & Neighborhood Resources Advisory Council held a meeting on December 9, 2014 to review and recommend proposed Community Services Block Grant projects for 2015/2016 to the Board of County Commissioners; and

WHEREAS, a Study Session was held on January 13, 2015 to present recommendations for Commissioner funding consideration; and

WHEREAS, the project awards will be included as part of the 2015-2018 Adams County Community Action Plan to the State of Colorado, Department of Local Affairs; and

WHEREAS, much of this information is regular and routine, and the Board of County Commissioners wishes to designate the Director of the Neighborhood Services Department and the Community Development Manager to sign necessary documents to carry out the ongoing activities of the program.

NOW THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, and State of Colorado, that the following Adams County CSBG project awards be approved for PY2015/16:

Agency	**PY2015/16**
Almost Home, Inc.	$30,000
Center for People with Disabilities	$33,950
Growing Home, Inc.	$79,050
Lutheran Social Services of Colorado	$20,000
Project Angel Heart	$55,000
Admin & Linkages	$191,846
TOTAL PY2015/16	**$409,846**

Upon motion duly made and seconded the foregoing resolution was adopted by the following vote:

Tedesco_____Aye
O'Dorisio_____Aye
Henry_____Aye
Hansen_____Aye
Pawlowski_____Aye
Commissioners

STATE OF COLORADO)
County of Adams)

I, Stan Martin, County Clerk and ex-officio Clerk of the Board of County Commissioners in and for the County and State aforesaid do hereby certify that the annexed and foregoing Order is truly copied from the Records of the Proceedings of the Board of County Commissioners for said Adams County, now in my office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County, at Brighton, Colorado this 20th day of January, A.D. 2015.

County Clerk and ex-officio Clerk of the Board of County Commissioners

Stan Martin:

By:

E-Signed by Erica Hannah
VERIFY authenticity with e-Sign

Deputy

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

A RESOLUTION CONCERNING THE ADAMS COUNTY
COMMUNITY SERVICES BLOCK GRANT APPLICATION AND WORK PLAN
FOR 2015-2018

Resolution 2015-032

WHEREAS, the Federal government has established the Community Services Block Grant Program (CSBG) to provide a range of services and activities designed to have an impact on the causes of poverty in local communities; and

WHEREAS, the U.S Department of Health and Human Services (HHS) allocates Community Services Block Grant funds to the State of Colorado, Department of Local Affairs through an annual formula allocation; and

WHEREAS, Adams County has received Community Services Block Grant funds since 1974; and

WHEREAS, Adams County is eligible to receive an estimated $409,846 for the 2015/16 program year from the State of Colorado, Department of Local Affairs; and

WHEREAS, the Adams County Community & Neighborhood Resources Advisory Council has provided direction for the proposed Community Services Block grants for 2015-2018 and has made their funding recommendations to the Board of County Commissioners; and

WHEREAS, public notice was provided regarding the Public Hearing for the 2015-2018 CSBG Application and Work Plan; and

WHEREAS, a Public Hearing was held on January 20, 2015, for the approval and adoption for the 2015/16 sub-grantee grant awards; and

WHEREAS, much of this information is regular and routine, and the Board of County Commissioners wishes to designate authorized representatives as signatories for any non-contractual documents as required by the various funding sources; and

WHEREAS, the Director of the Neighborhood Services Department and the Community Development Manager have been authorized to sign necessary documents to carry out the on-going activities of the program; and

NOW, THEREFORE, BE IT RESOLVED by the Adams County Board of County Commissioners, County of Adams, and State of Colorado, that the Adams County Community Services Block Grant 2015-2018 Application and Work Plan be approved.

BE IT FURTHER RESOLVED, that the Chairman of the Adams County Board of County Commissioners be authorized to sign the 2015-2018 CSBG Application and Work Plan, the 2015 CSBG Sub-Grantee Award Agreements, subgrantee option letters and any related Adams County 2015-2018 CSBG program modifications and amendments.

Upon motion duly made and seconded the foregoing resolution was adopted by the following vote:

Tedesco_____Aye
O'Dorisio_____Aye
Henry_____Aye
Hansen_____Aye
Pawlowski_____Aye
Commissioners

STATE OF COLORADO)
County of Adams)

I, Stan Martin, County Clerk and ex-officio Clerk of the Board of County Commissioners in and for the County and State aforesaid do hereby certify that the annexed and foregoing Order is truly copied from the Records of the Proceedings of the Board of County Commissioners for said Adams County, now in my office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County, at Brighton, Colorado this 27th day of January, A.D. 2015.

County Clerk and ex-officio Clerk of the Board of County Commissioners

Stan Martin:

By:

E-Signed by Erica Hannah
VERIFY authenticity with e-Sign

Deputy

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

A RESOLUTION CONCERNING THE ADAMS COUNTY
COMMUNITY SERVICES BLOCK GRANT APPLICATION AND WORK PLAN
FOR 2015-2018

Resolution 2015-032

WHEREAS, the Federal government has established the Community Services Block Grant Program (CSBG) to provide a range of services and activities designed to have an impact on the causes of poverty in local communities; and

WHEREAS, the U.S Department of Health and Human Services (HHS) allocates Community Services Block Grant funds to the State of Colorado, Department of Local Affairs through an annual formula allocation; and

WHEREAS, Adams County has received Community Services Block Grant funds since 1974; and

WHEREAS, Adams County is eligible to receive an estimated $409,846 for the 2015/16 program year from the State of Colorado, Department of Local Affairs; and

WHEREAS, the Adams County Community & Neighborhood Resources Advisory Council has provided direction for the proposed Community Services Block grants for 2015-2018 and has made their funding recommendations to the Board of County Commissioners; and

WHEREAS, public notice was provided regarding the Public Hearing for the 2015-2018 CSBG Application and Work Plan; and

WHEREAS, a Public Hearing was held on January 20, 2015, for the approval and adoption for the 2015/16 sub-grantee grant awards; and

WHEREAS, much of this information is regular and routine, and the Board of County Commissioners wishes to designate authorized representatives as signatories for any non-contractual documents as required by the various funding sources; and

WHEREAS, the Director of the Neighborhood Services Department and the Community Development Manager have been authorized to sign necessary documents to carry out the on-going activities of the program; and

NOW, THEREFORE, BE IT RESOLVED by the Adams County Board of County Commissioners, County of Adams, and State of Colorado, that the Adams County Community Services Block Grant 2015-2018 Application and Work Plan be approved.

BE IT FURTHER RESOLVED, that the Chairman of the Adams County Board of County Commissioners be authorized to sign the 2015-2018 CSBG Application and Work Plan, the 2015 CSBG Sub-Grantee Award Agreements, subgrantee option letters and any related Adams County 2015-2018 CSBG program modifications and amendments.

Upon motion duly made and seconded the foregoing resolution was adopted by the following vote:

Tedesco_____Aye
O'Dorisio_____Aye
Henry_____Aye
Hansen_____Aye
Pawlowski_____Aye
Commissioners

STATE OF COLORADO)
County of Adams)

I, Stan Martin, County Clerk and ex-officio Clerk of the Board of County Commissioners in and for the County and State aforesaid do hereby certify that the annexed and foregoing Order is truly copied from the Records of the Proceedings of the Board of County Commissioners for said Adams County, now in my office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said County, at Brighton, Colorado this 27th day of January, A.D. 2015.

County Clerk and ex-officio Clerk of the Board of County Commissioners

Stan Martin:

By:

E-Signed by Erica Hannah
VERIFY authenticity with e-Sign

Deputy

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: July 17, 2018
SUBJECT: Amendment to the Unum Life Insurance Policy
FROM: Terri Lautt, Director
AGENCY/DEPARTMENT: Human Resources
HEARD AT STUDY SESSION ON: July 10, 2018
AUTHORIZATION TO MOVE FORWARD: ☐ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners approve the 2018 Amendment to the Unum Life Insurance Policy

BACKGROUND:

The Board of County Commissioners previously entered into a contract with Unum Life Insurance Company of America ("Unum"), to provide a Life Insurance Policy for all benefit-eligible employees.

The original contract allows for Life Insurance benefits for regular full-time employees to equal their annual salary rounded to the nearest thousand dollars. The Life Insurance benefit for regular part-time (30-39 hours/week) employees is limited to seventy five hundred dollars ($7,500).

The Board of County Commissioners recognizes the importance of providing equitable Life Insurance benefits to all benefit eligible employees.

The attached 2018 Amendment to the Unum Life Insurance Policy provides for enhanced benefits for regular part-time employees to increase the Life Insurance benefit from the standard seventy five hundred dollars ($7,500) to that of regular full-time employees, to equal their annual salary rounded to the nearest thousand dollars.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Human Resources
County Manager's Office

ATTACHED DOCUMENTS:

Resolution
2018 Amendment to the Unum Life 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:

The additional expense to the county to make the recommended change would be $581 annually.

RESOLUTION APPROVING AMENDMENT NO. 4 TO THE UNUM LIFE INSURANCE POLICY

WHEREAS, the Board of County Commissioners recognizes the importance of providing equitable Life Insurance benefits to regular full-time and part-time employees; and

WHEREAS, the Adams County Board of County Commissioners previously entered into a contract with Unum Life Insurance Company of America ("Unum") to provide a Life Insurance Policy for benefit eligible employees; and

WHEREAS, the attached Summary of Benefits replaces the previous Summary of Benefits for regular full-time employees (Class 1) and regular part-time employees (Class 2) in their entirety.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Amendment No. 4 to the Unum Life Insurance Policy effective August 1, 2018, a copy of which is attached hereto and incorporated herein by reference, be approved.

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

AMENDMENT NO. 4

This amendment forms a part of Group Identification No. 420696 001 issued to the Employer/Applicant:

Adams County

The entire Summary of Benefits is replaced by the Summary of Benefits attached to this amendment.

The effective date of these changes is August 1, 2018. The changes only apply to deaths and covered losses that occur and disabilities which start on or after the effective date.

The Summary of Benefits' terms and provisions will apply other than as stated in this amendment.

Dated at Portland, Maine on June 26, 2018.

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 June 26, 2018.

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

GROUP INSURANCE
SUMMARY OF BENEFITS
NON-PARTICIPATING

IDENTIFICATION NUMBER: 420696 001

EFFECTIVE DATE OF COVERAGE: January 1, 2016

ANNIVERSARY DATE: January 1

GOVERNING JURISDICTION: Maine

Unum Life Insurance Company of America
insures the lives of

Adams County

under the
Select Group Insurance Trust
Policy No. 292000

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under this Summary of Benefits. Unum makes this promise subject to all of this Summary of Benefits' provisions.

The Employer should read this Summary of Benefits carefully and contact Unum promptly with any questions. This Summary of Benefits 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.

Signed for Unum at Portland, Maine on the Effective Date of Coverage.

President

Secretary

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

TABLE OF CONTENTS

BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan. You also have the opportunity to have coverage for your dependents.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: January 1, 2016

PLAN YEAR:

January 1, 2016 to January 1, 2017 and each following January 1 to January 1

IDENTIFICATION NUMBER: 420696 001

ELIGIBLE CLASS(ES):

All Full-Time Members, Elected Officials and Members of Adams County Economic Department, and Part-Time Employees excluding Project Designated, Temporary, Seasonal and 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 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 Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:

For You:

Basic Benefit:

Your Employer pays the cost of your coverage.

Additional Benefit:

You pay the cost of your coverage.

For Your Dependents:

You pay the cost of your dependent coverage.

ELIMINATION PERIOD:

Premium Waiver: 180 days

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

BASIC BENEFIT

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 1, to a maximum of $300,000

ADDITIONAL BENEFIT OPTIONS:

Option A

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 1

Option B

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 2

Option C

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 3

Option D

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 4

Option E

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 5

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR INSURANCE OVER:

2 x annual earnings

Evidence of Insurability **is not required** for amounts of life insurance you had in force with your Employer's prior carrier on the termination date of the prior carrier's plan.

Evidence of Insurability **is required** for amounts of life insurance in excess of the greater of:

- The amount(s) of life insurance you had in force with your Employer's prior carrier on the termination date of the prior carrier's plan; or
- The amount(s) of life insurance over the amount shown above.

MINIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

$10,000

MAXIMUM BENEFIT OF BASIC LIFE INSURANCE FOR YOU:

$300,000

MAXIMUM BENEFIT OF ADDITIONAL LIFE INSURANCE FOR YOU:

$300,000

AMOUNT OF LIFE INSURANCE FOR YOUR DEPENDENTS

Spouse:

Option A

$5,000

Option B

$10,000

Option C

$25,000

Option D

$50,000

Option E

$75,000

Option F

$100,000

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR SPOUSE'S INSURANCE OVER:

$25,000

Evidence of Insurability **is not required** for amounts of life insurance your spouse had in force with your Employer's prior carrier on the termination date of the prior carrier's plan.

Evidence of Insurability **is required** for amounts of life insurance in excess of the greater of:

- The amount(s) of life insurance your spouse had in force with your Employer's prior carrier on the termination date of the prior carrier's plan; or
- The amount(s) of life insurance over the amount shown above.

Children:

Option A

Live birth to 14 days: $5,000
14 days to 6 months: $5,000
6 months through the end of the month in which your child reaches age 19 or through the end of the month in which your child reaches age 24 if a full-time student: $5,000

Option B

Live birth to 14 days: $10,000
14 days to 6 months: $10,000
6 months through the end of the month in which your child reaches age 19 or through the end of the month in which your child reaches age 24 if a full-time student: $10,000

THE AMOUNT OF LIFE INSURANCE FOR A DEPENDENT WILL NOT BE MORE THAN 100% OF YOUR AMOUNT OF LIFE INSURANCE.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

Continuity of Coverage

Portability

NOTE: Portability under this plan is available to an insured spouse in the event of divorce from an insured employee, subject to all terms and conditions otherwise applicable to ported spouse coverage.

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

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: January 1, 2016

PLAN YEAR:

January 1, 2016 to January 1, 2017 and each following January 1 to January 1

IDENTIFICATION NUMBER: 420696 001

ELIGIBLE CLASS(ES):

All Full-Time Members, Elected Officials and Members of Adams County Economic Department, and Part-Time Employees excluding Project Designated, Temporary, Seasonal and 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 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 Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:

Basic Benefit:

Your Employer pays the cost of your coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU (FULL AMOUNT)

BASIC BENEFIT

Annual earnings, rounded to the next higher multiple of $1,000, if not already an exact multiple thereof, x 1, to a maximum of $300,000

MINIMUM BENEFIT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR YOU:

$10,000

REPATRIATION BENEFIT FOR YOU

Maximum Benefit Amount:

Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

SEATBELT(S) AND AIR BAG BENEFIT FOR YOU

Benefit Amount:

Seatbelt(s): 10% of the Full Amount of your accidental death and dismemberment insurance benefit.

Air Bag: 5% of the Full Amount of your accidental death and dismemberment insurance benefit.

Maximum Benefit Payment:

Seatbelt(s): $25,000

Air bag: $5,000

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your accidental death benefit must be paid first.

EDUCATION BENEFIT

Each Qualified Child

Benefit Amount per Academic Year for which a Qualified Child is enrolled:

6% of the Full Amount of the employee's accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments:

4 per lifetime

Maximum Benefit Amount:

$24,000

Maximum Benefit Period:

6 years from the date the first benefit payment has been made.

The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.

COMMON CARRIER BENEFIT

Maximum Benefit: The Full Amount

The Common Carrier Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Common Carrier benefit your accidental death benefit must be paid first.

EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU

Maximum Benefit Amount: The Full Amount

CHILD CARE BENEFIT

Each Qualified Child

Annual Benefit Amount:

Birth through age 13

The lesser of:

- 5% of the Full Amount of your or your spouse's accidental death and dismemberment insurance; or

- $3,000

Maximum Benefit Amount:

$12,000

Maximum Benefit Period:

4 consecutive years

If, at the time of your or your spouse's death, you have no Qualified Child eligible for the Child Care Benefit, we will pay 5% of the Full Amount to a maximum benefit of $2,000 to you, your spouse, your beneficiary or your or your spouse's authorized representative.

The Child Care Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Child Care Benefit, your or your spouse's accidental death benefit must be paid first.

This benefit will only be paid once per accident, even if you and your spouse suffers an injury in the same accident

FELONIOUS ASSAULT BENEFIT FOR YOU

Benefit Amount:

10% of the Full Amount of your accidental death and dismemberment insurance benefit

Maximum Benefit Amount:

$10,000

The Felonious Assault Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order to receive the Felonious Assault Benefit, your accidental death and dismemberment must be paid first.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Portability

Continuity of Coverage is available under this plan - refer to the **ACCIDENTAL DEATH AND DISMEMBERMENT OTHER BENEFIT FEATURES** for further details.

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

LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on your disability, written notice and proof of claim must be sent no later than 90 days after the end of the elimination period.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

If you have a disability, you must notify us immediately when you return to work in any capacity, regardless of whether you are working for your Employer.

HOW DO YOU FILE A CLAIM FOR A DISABILITY?

You or your authorized representative, 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.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

If your claim is based on your disability, your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation; and
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

If claim is based on death, proof of claim, provided at your or your authorized representative's expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim if the appropriate information is not submitted.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This $2,000 payment made in good faith satisfies Unum's legal duty to the extent of that $2,000 payment and Unum will not have to make that payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

In addition, if you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse should name a beneficiary according to the requirements specified above for you.

HOW WILL UNUM MAKE PAYMENTS?

If your or your dependent's life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, you or your beneficiary may request the life claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

If you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse's death claim will be paid to your surviving spouse's beneficiary.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

CLAIM INFORMATION

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on death or other covered loss, written notice and proof of claim must be sent no later than 90 days after the date of death or the date of any other covered loss.

If a claim is based on the Education Benefit, written notice and proof of claim must be sent no later than 60 days after the date of your death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the time proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

HOW DO YOU FILE A CLAIM FOR A COVERED LOSS?

You or your authorized representative 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.

WHAT INFORMATION IS NEEDED AS PROOF OF CLAIM?

If claim is based on death or other covered loss, proof of claim for death or covered loss, provided at your or your authorized representative's expense, must show:

- the cause of death or covered loss;
- the extent of the covered loss;
- the date of covered loss; and
- the name and address of any **hospital or institution** where treatment was received, including all attending **physicians**.

Also, in case of death, a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

If a claim is based on the Education Benefit, proof of claim, provided at your authorized representative's expense, must show:

- the date of enrollment of your qualified child in an accredited post-secondary institution of higher learning;
- the name of the institution;
- a list of courses for the current academic term; and
- the number of credit hours for the current academic term.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your accidental death and dismemberment insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This $2,000 payment made in good faith satisfies Unum's legal duty to the extent of that $2,000 payment and Unum will not have to make that payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

HOW WILL UNUM MAKE PAYMENTS?

If your accidental death or dismemberment claim is at least $10,000 Unum will make available to you or your beneficiary a **retained asset account** (the Unum Security Account).

Payment for the accidental death or dismemberment claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the accidental death or dismemberment claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, your beneficiary may request the accidental death claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

The Child Care Benefit will be paid to you, your spouse, your beneficiary or your or your spouse's authorized representative.

The Education Benefit will be paid to your qualified child or the qualified child's legal representative.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS? (Assignability Rights)

The rights provided to you by the plan(s) for accidental death insurance benefits are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

EMPLOYER PROVISIONS

WHAT DOES THIS SUMMARY OF BENEFITS CONSIST OF FOR THE EMPLOYER?

This Summary of Benefits consists of:

- all Summary of Benefits' provisions and any amendments and/or attachments issued;
- the Employer's Participation Agreement;
- each employee's application for insurance (employee retains his own copy); and
- the certificate of coverage issued for each employee of the Employer.

This Summary of Benefits 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 Summary of Benefits. No other person, including an agent, may change this Summary of Benefits or waive any part of it.

WHAT IS THE COST OF THIS INSURANCE?

LIFE INSURANCE

Premium payments are *required* for an insured while he or she is disabled under this plan.

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

PREMIUM WAIVER

Unum does not require premium payments for an insured employee's life coverage if he or she is under age 60 and disabled for 180 days. Proof of disability, provided at the insured employee's expense, must be filed by the insured employee and approved by Unum.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

WHEN IS PREMIUM DUE FOR THIS SUMMARY OF BENEFITS?

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The **Employer** 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 an insurance 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 plan year and the prior plan year. In the case of fraud, premium adjustments will be made for all plan years.

WHAT INFORMATION DOES UNUM REQUIRE FROM THE EMPLOYER?

The Employer 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.

Employer records that, in Unum's opinion, have a bearing on this Summary of Benefits 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 SUMMARY OF BENEFITS OR A PLAN UNDER THIS SUMMARY OF BENEFITS?

This Summary of Benefits or a plan under this Summary of Benefits can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify this Summary of Benefits or a plan if:

- there is less than 100% participation of those eligible employees for an Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a basic benefit plan; or

- the number of employees insured for all additional benefits is less than 15 lives or 25% of those eligible, whichever is greater; or
- the number of employees insured under a plan decreases by 25%; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to this Summary of Benefits; or
- fewer than 15 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of this Summary of Benefits that specify whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible class; or
- 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 Employer and/or its employees; or
- the Employer fails to pay any portion of the premium within the 45 day **grace period**.

If Unum cancels or modifies this Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel this Summary of Benefits or 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 this Summary of Benefits or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel this Summary of Benefits or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, this Summary of Benefits or a plan can be cancelled on an earlier date. If Unum or the Employer cancels this Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If this Summary of Benefits or a plan is cancelled, the cancellation will not affect a **payable claim**.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE UNDER THIS SUMMARY OF BENEFITS WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

We will continue the employee's coverage in accordance with the Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and the Employer approved the employee's leave in writing.

Coverage will be continued until the end of the latest of:

- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law; or

- the leave period provided to the employee for injury or sickness.

If the Employer's Human Resource policy doesn't provide for continuation of a plan for an employee 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; or
- require evidence of insurability.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

FOR LIFE INSURANCE:

NAME/LOCATION (CITY AND STATE)

Adams County Economic Development
Westminster, Colorado

FOR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE:

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 Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

The Summary of Benefits 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 Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer'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?

This plan provides different additional life benefit options in addition to the basic life benefit and the basic accidental death and dismemberment benefit. When you first become eligible for coverage, you may apply for any additional life benefit option, however, you cannot be covered under more than one option at a time.

Evidence of insurability is required for any amount of life insurance over the amount shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

Your Employer pays 100% of the cost of your coverage under the basic benefit. You will automatically be covered under the basic benefit at 12:01 a.m. on the later of:

- the date you are eligible for coverage; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

You pay 100% of the cost yourself for any additional life benefit option. You will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

WHEN CAN YOU APPLY FOR ADDITIONAL BENEFITS IF YOU APPLY MORE THAN 31 DAYS AFTER YOUR ELIGIBILITY DATE? (LATE ENTRANTS)

You can apply for additional benefits within 31 days of a **change in status**. Evidence of insurability is required for any amount of insurance.

Coverage applied for due to a change in status will begin at 12:01 a.m. on the date Unum approves your evidence of insurability form.

WHEN CAN YOU CHANGE YOUR COVERAGE BY CHOOSING ANOTHER ADDITIONAL BENEFIT OPTION? (This does not apply to Late Entrants)

You can change your coverage by applying for a different additional life benefit option anytime during the plan year.

You can decrease or increase your coverage any number of levels.

Evidence of insurability is required if you increase your coverage by any level.

If you are not approved for the increase in your coverage, you will automatically remain at the same amount you had prior to applying for the increase.

A change in coverage that is made at anytime during the plan year will begin at 12:01 a.m. on the later of:

- the date you apply for the change in coverage; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

An evidence of insurability form can be obtained from your Employer.

If you end employment and are rehired within the same plan year, you may be insured on your eligibility date for the coverage that you had under the plan when you ended employment.

An evidence of insurability form can be obtained from your Employer.

WHEN CAN YOU CANCEL YOUR ADDITIONAL COVERAGE?

You can cancel your additional coverage at anytime during the plan year. Any cancellation in coverage will take effect immediately, but will not affect a **payable claim** that occurs prior to the cancellation.

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 NOT WORKING DUE TO INJURY OR SICKNESS?

If you are not working due to injury or sickness, and if premium is paid, you may continue to be covered up to your retirement date.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

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 due to a change in your annual earnings or due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your evidence of insurability form, if evidence of insurability is required. You must be in active employment or 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 due to a change in your annual earnings or due to a plan change 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 Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date your eligible class is no longer covered; or
- the latest of:
  - the date you no longer are in an eligible class;
  - the last day of the period for which you made any required contributions; or
  - the end of the month in which you no longer are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

WHEN ARE YOU ELIGIBLE TO ELECT DEPENDENT COVERAGE?

If you elect coverage for yourself or are insured under the plan, you are eligible to elect dependent coverage for your spouse only, your dependent children only or both.

WHEN ARE YOUR DEPENDENTS ELIGIBLE FOR COVERAGE?

The date your dependents are eligible for coverage is the later of:

- the date your insurance begins; or
- the date you first acquire a dependent.

WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?

The following dependents are eligible for coverage under the plan:

- Your lawful spouse, including a legally separated spouse. You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.

"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.

- Your unmarried children from live birth through the end of the month in which they reach age 19. Stillborn children are not eligible for coverage.

- Your unmarried dependent children from the end of the month in which they reach age 19 through the end of the month in which they reach age 24, also are eligible if they are full-time students at an **accredited school**.

- Your unmarried dependent children who became **handicapped** prior to the end of the month in which they reach age 19.

- Your unmarried dependent children who became handicapped prior to the end of the month in which they reached age 24, while they were full-time students.

  Unum must receive proof within 31 days of the date the child is eligible for coverage under this Summary of Benefits, and as required during the first two years. After the first two years, Unum will ask for proof when needed, but not more than once a year.

Children include your own natural offspring, lawfully adopted children, stepchildren and children for whom you have legal guardianship. A child will be considered adopted on the date of placement in your home.

No dependent child may be covered by more than one employee in the plan.

No dependent child can be covered as both an employee and a dependent.

WHEN DOES YOUR DEPENDENT COVERAGE BEGIN?

This plan provides different benefit options for your dependents. When your dependents become eligible for coverage, you may apply for any dependent option. However, your dependents cannot be covered under more than one option at a time.

Evidence of insurability is required if you are applying for any amount of dependent life insurance over the amount shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

You pay 100% of the cost yourself for any dependent option. Your dependents will be covered at 12:01 a.m. on the later of:

- the date your dependents are eligible for coverage, if you apply for insurance on or before that date or within 31 days after your dependents eligibility date; or
- the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required.

WHEN CAN YOU APPLY FOR DEPENDENT COVERAGE IF YOU APPLY MORE THAN 31 DAYS AFTER YOUR DEPENDENTS' ELIGIBILITY DATE?

You can apply for dependent coverage within 31 days of a **change in status**. Evidence of insurability is required for any amount of insurance.

Dependent coverage applied for due to a change in status will begin at 12:01 a.m. on the date Unum approves your dependent's evidence of insurability form.

WHEN CAN YOU CHANGE YOUR DEPENDENT COVERAGE BY CHOOSING ANOTHER OPTION? (This does not apply to Late Entrants)

You can change your dependent coverage by applying for a different benefit option anytime during the plan year.

You can decrease or increase your dependent coverage any number of levels.

Evidence of insurability is required if you increase your dependent spouse coverage by any level.

A change in coverage that is made at anytime during the plan year will begin at 12:01 a.m. on the later of:

- the date you apply for the change in coverage; or
- the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required.

An evidence of insurability form for your dependents can be obtained from your Employer.

WHEN CAN YOU CANCEL YOUR DEPENDENT COVERAGE?

You can cancel your dependent coverage at anytime during the plan year. Any cancellation in dependent coverage will take effect immediately, but will not affect a **payable claim** that occurs prior to the cancellation.

WHEN WILL CHANGES TO YOUR DEPENDENT'S COVERAGE TAKE EFFECT?

Once your dependent's coverage begins, any increased or additional dependent coverage due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required, provided your dependent is not totally disabled. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional dependent coverage due to a plan change will begin on the date you return to active employment.

If your dependent is totally disabled, any increased or additional dependent coverage will begin on the date your dependent is no longer totally disabled.

Any decreased coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHEN DOES YOUR DEPENDENT'S COVERAGE END?

Your dependent's coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date your eligible class is no longer covered; or
- the latest of:
  - the date you no longer are in an eligible class;
  - the date of your death;
  - the last day of the period for which you made any required contributions; or
  - the end of the month in which you no longer are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Coverage for any one dependent will end on the earliest of:

- the date your coverage under a plan ends;
- the date your dependent ceases to be an eligible dependent;
- for a spouse, the date of divorce or annulment;
- for a civil union, registered domestic partnership or similar legal relationship, the date of dissolution.

Unum will provide coverage for a payable claim which occurs while your dependents are covered under the Summary of Benefits or plan.

WILL COVERAGE CONTINUE FOR A HANDICAPPED CHILD INSURED UNDER THE PLAN AFTER THE END OF THE MONTH IN WHICH THEY REACH AGE 19 OR IF A FULL-TIME STUDENT AGE 24?

Coverage will continue for a child age 24 who is handicapped, provided:

- the child is currently insured under the plan; and
- the child is unmarried; and
- you are the main source of support and maintenance.

Unum must receive proof within 31 days of the end of the month in which the child reaches age 19 or if a full-time student, age 24 and as required during the first two years. After the first two years, Unum will ask for proof when needed, but not more than once a year.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal 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 or an evidence of insurability form 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 or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

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 SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The Summary of Benefits 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 the purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOU IF UNUM APPROVES YOUR DEPENDENT'S DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer, including shift differential and car allowance, in effect just prior to the date of loss. 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 ANNUAL 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 annual earnings from your Employer in effect just prior to the date your absence began.

WHAT HAPPENS TO YOUR LIFE INSURANCE COVERAGE IF YOU BECOME DISABLED?

Your life insurance coverage may be continued for a specific time and your life insurance premium will be waived if you qualify as described below.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO HAVE LIFE PREMIUMS WAIVED?

You must be disabled through your **elimination period**.

Your elimination period is 180 days.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?

Your life insurance premium waiver will begin when we approve your claim, if the elimination period has ended and you meet the following conditions. Your Employer may continue premium payments until Unum notifies your Employer of the date your life insurance premium waiver begins.

Your life insurance premium will be waived if you meet these conditions:

- you are less than 60 and insured under the plan.
- you become disabled and remain disabled during the elimination period.
- you meet the notice and proof of claim requirements for disability while your life insurance is in effect or within three months after it ends.
- your claim is approved by Unum.

After we approve your claim, Unum does not require further premium payments for you while you remain disabled according to the terms and provisions of the plan.

Your life insurance amount will not increase while your life insurance premiums are being waived. Your life insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER END?

The life insurance premium waiver will automatically end if:

- you recover and you no longer are disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by Unum;
- you reach age 70; or
- premium has been waived for 12 months and you are considered to reside outside the United States or Canada. You will be considered to reside outside the United States or Canada when you have been outside these countries for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- during the elimination period, you are not working in any occupation due to your **injury** or **sickness**; and
- after the elimination period, due to the same injury or sickness, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by training, education 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.

We may require you to be examined by a physician, other medical practitioner 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 be interviewed by an authorized Unum Representative.

APPLYING FOR LIFE INSURANCE PREMIUM WAIVER

Ask your Employer for a life insurance premium waiver claim form.

The form has instructions on how to complete and where to send the claim.

WHAT INSURANCE IS AVAILABLE WHILE YOU ARE SATISFYING THE DISABILITY REQUIREMENTS? (See Conversion Privilege)

You may use this life conversion privilege when your life insurance terminates while you are satisfying the disability requirements. Please refer to the conversion privilege below. You are not eligible to apply for this life conversion if you return to work and, again, become covered under the plan.

If an individual life insurance policy is issued to you, any benefit for your death under this plan will be paid only if the individual policy is returned for surrender to Unum. Unum will refund all premiums paid for the individual policy.

The amount of your death benefit will be paid to your named beneficiary for the plan. If, however, you named a different beneficiary for the individual policy and the policy is returned to Unum for surrender, that different beneficiary will not be paid.

If you want to name a different beneficiary for this group plan, you must change your beneficiary as described in the Beneficiary Designation page of this group plan.

WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)

When coverage ends under the plan, you and your dependents can convert your coverages to individual life policies, without evidence of insurability. The maximum amounts that you can convert are the amounts you and your dependents are insured for under the plan. You may convert a lower amount of life insurance.

You and your dependents must apply for individual life insurance under this life conversion privilege and pay the first premium within 90 days after the date:

- your employment terminates; or
- you or your dependents no longer are eligible to participate in the coverage of the plan.

If you convert to an individual life policy, then return to work, and, again, become insured under the plan, you are not eligible to convert to an individual life policy

again. However, you do not need to surrender that individual life policy when you return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. The person may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)

You and your dependents may convert a limited amount of life insurance if you have been insured under your Employer's group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum for each of you will be the lesser of:

- $10,000; or
- your or your dependent's coverage amounts under the plan less any amounts that become available under any other group life plan offered by your Employer within 90 days after the date the Summary of Benefits or the plan is cancelled.

PREMIUMS

Premiums for the converted insurance will be based on:

- the person's then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum's customary rates in use at that time; and
- the class of risk to which the person belongs.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

DEATH DURING THE NINETY DAY CONVERSION APPLICATION PERIOD

If you or your dependents die within the 90 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

APPLYING FOR CONVERSION

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350

1-800-343-5406

WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL? (Accelerated Benefit)

If you or your dependent becomes terminally ill while you or your dependent is insured by the plan, Unum will pay you a portion of your or your dependent's life insurance benefit one time. The payment will be based on 50% of your or your dependent's life insurance amount. However, the one-time benefit paid will not be greater than $750,000.

Your or your dependent's right to exercise this option and to receive payment is subject to the following:

- you or your dependent requests this election, in writing, on a form acceptable to Unum;
- you or your dependent must be terminally ill at the time of payment of the Accelerated Benefit;
- your or your dependent's physician must certify, in writing, that you or your dependent is terminally ill and your or your dependent's life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit is available on a voluntary basis. Therefore, you or your dependent is not eligible for benefits if:

- you or your dependent is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you or your dependent is required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance unless you qualify to have your life premium waived.

Also, premium payments must continue to be paid on the full amount of your dependent's life insurance.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Summary of Benefits subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you or your dependent should consult your personal tax advisor to assess the impact of this benefit.

WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 12 months after your or your dependent's initial effective date of insurance; and
- suicide occurring within 12 months after the date any increases or additional insurance become effective for you or your dependent.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you or your dependent applied for at that time.

LIFE INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you and your dependent(s) if you and your dependent(s) are covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you and your dependent(s) under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits 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 the prior carrier is liable.

Coverage for you and your dependent(s) are subject to payment of required premium and all other terms of this Summary of Benefits, except that the portable insurance coverage terms of this Summary of Benefits will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Class(es) in this plan, you may elect portable coverage for yourself and your dependents.

In case of your death, your insured dependents also may elect portable coverage for themselves. However, children cannot become insured for portable coverage unless the spouse also becomes insured for portable coverage.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you and your dependents are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of life insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for your spouse will not be more than:

- the highest amount of life insurance available for spouses under the plan; or
- 100% of your amount of portable coverage; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for a child will not be more than:

- the highest amount of life insurance available for children under the plan; or
- 100% of your amount of portable coverage; or
- $20,000,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000 for you and $1,000 for your dependents. If the current amounts under the plan are less than $5,000 for you and $1,000 for your dependents you and your dependents may port the lesser amounts.

Your or your dependent's amount of life insurance will reduce or cease at any time it would reduce or cease for your eligible class if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and your dependents and pay the first premium within 90 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Class(es) in this plan.

Your dependents must apply for portable coverage and pay the first premium within 90 days after the date you die.

You are not eligible to apply for portable coverage for yourself if:

- you have an **injury** or **sickness**, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

You are not eligible to apply for portable coverage for a dependent if:

- you do not elect portable coverage for yourself;
- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your dependent has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

In case of your death, your spouse is not eligible to apply for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your spouse.

In case of your death, your child is not eligible for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse is insured under this plan and chooses not to elect portable coverage;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your child has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your child.

If we determine that because of an injury or sickness, which has a material effect on life expectancy, you or your dependents were not eligible for portability at the time you or your dependents elected portable coverage, the benefit will be adjusted to the amount of whole life coverage the premium would have purchased under the Conversion Privilege.

APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You or your dependents may increase or decrease the amount of life insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of life insurance coverage cannot be decreased below $5,000 for you and $1,000 for your dependents. All increases are subject to evidence of insurability. Portable coverage will reduce at the ages and amounts shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

ADDING PORTABLE COVERAGE FOR DEPENDENTS

If you choose not to enroll your dependents when your dependents were first eligible for portable coverage, you may enroll your dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

You may enroll newly acquired dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a spouse will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a child will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium;
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates);
- the date your child no longer qualifies as a dependent; or
- the date the surviving spouse dies.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or

- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

APPLYING FOR CONVERSION, IF PORTABLE COVERAGE ENDS OR IS NOT AVAILABLE

If you or your dependent is not eligible to apply for portable coverage or portable coverage ends, then you or your dependent may qualify for conversion coverage. Refer to Conversion Privilege under this plan.

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT IN THE EVENT OF YOUR DEATH IF YOUR DEATH IS THE DIRECT RESULT OF AN ACCIDENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim providing you meet certain conditions.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF ACCIDENTAL DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

WHEN WILL YOU RECEIVE PAYMENT IN THE EVENT OF CERTAIN OTHER COVERED LOSSES IF THE LOSS IS THE DIRECT RESULT OF AN ACCIDENT?

You will receive payment when Unum approves the claim.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR CERTAIN OTHER COVERED LOSSES?

If Unum approves the claim, Unum will determine the payment according to the Covered Losses and Benefits List below. The benefit Unum will pay is listed opposite the corresponding covered loss.

The benefit will be paid only if an **accidental bodily injury** results in one or more of the covered losses listed below within 365 days from the date of the accident.

Also, the accident must occur while you are insured under the plan.

Covered Losses	**Benefit Amounts**
Life	The Full Amount
Both Hands or Both Feet or Sight of Both Eyes	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and Sight of One Eye	The Full Amount
One Foot and Sight of One Eye	The Full Amount
Speech and Hearing	The Full Amount
Quadriplegia	The Full Amount
Triplegia	Three Quarters The Full Amount

Paraplegia	Three Quarters The Full Amount
One Hand or One Foot	One Half The Full Amount
Sight of One Eye	One Half The Full Amount
Speech or Hearing	One Half The Full Amount
Hemiplegia	One Half The Full Amount
Thumb and Index Finger of Same Hand	One Quarter The Full Amount
Uniplegia	One Quarter The Full Amount

The most Unum will pay for any combination of Covered Losses from any one accident is the full amount.

The Full Amount is the amount shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer, including shift differential and car allowance, in effect just prior to the date of loss. 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 ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you have an accidental bodily injury that results in one or more of the covered losses while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT REPATRIATION BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit for the preparation and transportation of your body to a mortuary chosen by you or your authorized representative. Payment will be made if, as the result of a covered accident, you suffer loss of life at least 100 miles away from your principal place of residence.

However, when combined with two or more Unum accidental death and dismemberment insurance plans, the combined overall maximum for these plans together cannot exceed the actual expenses for the preparation and transportation of your body to a mortuary.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT SEATBELT(S) AND AIR BAG BENEFIT WILL UNUM PROVIDE?

Unum will pay you or your authorized representative an additional benefit if you sustain an accidental bodily injury which causes your death while you are driving or riding in a **Private Passenger Car**, provided:

For Seatbelt(s):

- the Private Passenger Car is equipped with seatbelt(s); and
- the seatbelt(s) were in actual use and properly fastened at the time of the covered accident; and
- the position of the seatbelt(s) are certified in the official report of the covered accident, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that you were properly wearing seatbelt(s), then we will pay the additional seatbelt benefit.

However, if such certification is not available, and it is unclear whether you were properly wearing seatbelt(s), then we will pay a fixed benefit of $1,000.

An automatic harness seatbelt will not be considered properly fastened unless a lap belt is also used.

For Air Bag:

- the Private Passenger Car is equipped with an air bag for the seat in which you are seated; and
- the seatbelt(s) must be in actual use and properly fastened at the time of the covered accident.

No benefit will be paid if you are the driver of the Private Passenger Car and do not hold a current and valid driver's license.

No benefit will be paid if Unum is able to verify that the air bag(s) had been disengaged prior to the accident.

The accident causing your death must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT EDUCATION BENEFIT WILL UNUM PROVIDE FOR YOUR QUALIFIED CHILDREN?

Unum will pay your authorized representative on behalf of each of your qualified children a lump sum payment if:

- you lose your life:
  - as a result of an accidental bodily injury; and

- within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your accidental bodily injury occurred while you were insured under the plan;
- proof is furnished to Unum that the child is a **qualified child**; and
- the qualified child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level.

The benefit amount per academic year, maximum benefit payments, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN WILL THE EDUCATION BENEFIT END FOR EACH QUALIFIED CHILD?

The education benefit will terminate for each qualified child on the earliest of the following dates:

- the date your qualified child fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

WHAT COVERAGE FOR EXPOSURE AND DISAPPEARANCE BENEFIT WILL UNUM PROVIDE?

Unum will pay a benefit if you sustain an accidental bodily injury and are unavoidably exposed to the elements and suffer a loss.

We will presume you suffered loss of life due to an accident if:

- you are riding in a common public passenger carrier that is involved in an accident covered under the Summary of Benefits; and
- as a result of the accident, the common public passenger carrier is wrecked, sinks, is stranded, or disappears; and
- your body is not found within 1 year of the accident.

Also, the accident must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT COMMON CARRIER BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit if you die from an accidental bodily injury received in an accident which is not an **occupational injury** and occurs while you are riding as a passenger in a common public passenger carrier.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT CHILD CARE BENEFIT WILL UNUM PROVIDE?

Unum will pay you, your spouse or your or your spouse's authorized representative on behalf of each of your qualified children an annual benefit amount for child care if:

- you or your spouse die:
  - as a result of an accidental bodily injury; and
  - within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your or your spouse's accidental bodily injury occurred while you or your spouse was insured under the plan;
- proof is furnished to Unum that the child is a qualified child.

This benefit will only be paid once per accident, even if you and your spouse suffers an injury in the same accident.

The annual benefit amount, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN WILL THE CHILD CARE BENEFIT END FOR EACH QUALIFIED CHILD?

The child care benefit will terminate for each qualified child on the earliest of the following dates:

- the date you, your spouse or your or your spouse's authorized representative fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

WHAT FELONIOUS ASSAULT BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit if you sustain a loss which is caused directly by a felonious act of violence. The felonious act of violence must occur while you are working for your Employer, at your Employer's usual place of business, at an alternative work site at the direction of the Employer, including your home, or a location to which your job requires you to travel.

A felonious act of violence means an act that is considered a felony where the act occurred. The benefit is not payable if the loss occurred while you were committing a felonious act.

Felonious acts of violence include, but are not limited to: robbery, theft, hijacking, assault and battery, sniping, murder or civil disturbance.

Also, the loss must occur while you are insured under the plan.

The benefit amount and maximum benefit amount are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any accidental losses caused by, contributed to by, or resulting from:

- suicide, self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane.
- active participation in a riot.
- an attempt to commit or commission of a crime.

- the use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your physician. This exclusion will not apply to you if the chemical substance is ethanol.
- disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- being **intoxicated**.
- war, declared or undeclared, or any act of war.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you if you were covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits 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 the prior carrier is liable.

Coverage for you is subject to payment of required premium and all other terms of this Summary of Benefits, except that the portable insurance coverage terms of this Summary of Benefits will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Class(es) in this plan, you may elect portable coverage for yourself.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of accidental death and dismemberment insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000. If the current amounts under the plan are less than $5,000, you may port the lesser amounts.

Your amount of AD&D insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and pay the first premium within 90 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Class(es) in this plan.

You are not eligible to apply for portable coverage for yourself if:

- you have an **injury** or **sickness**, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You may increase or decrease the amount of AD&D insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of accidental death and dismemberment insurance coverage cannot be decreased below $5,000. Portable coverage will reduce at the ages and amounts shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

GLOSSARY

ACCIDENTAL BODILY INJURY means bodily harm caused solely by external, violent and accidental means and not contributed to by any other cause.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

ACCREDITED SCHOOL means an accredited post-secondary institution of higher learning for full-time students beyond the 12th grade level.

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.

ANNUAL EARNINGS means your annual income received from your Employer as defined in the plan.

CHANGE IN STATUS means a change in status as defined in the regulations under Internal Revenue Code section 125, unless your Employer's cafeteria plan document or human resource policy contains more restrictive provisions. In that event, your Employer may restrict the situations where you can change your coverage.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to have your life premium waived by Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Employer/Applicant named in the Application For Participation in the Select Group Insurance Trust, on the first page of the Summary of Benefits and in all amendments. It includes any division, subsidiary or affiliated company named in the Summary of Benefits.

EVIDENCE OF INSURABILITY means a statement of your or your dependent's medical history which Unum will use to determine if you or your dependent is approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

HANDICAPPED means permanently and continuously incapable of self sustaining support by reason of mental or physical incapacity.

HEMIPLEGIA means total and irreversible paralysis of both limbs on either side of the body (i.e. the right arm and right leg or the left arm and left leg).

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means:

- **for purposes of Portability**, a bodily injury that is the direct result of an accident and not related to any other cause.
- **for all other purposes**, a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

INTOXICATED means that your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.

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.

LIFE INSURANCE BENEFIT means the total benefit amount for which an individual is insured under this plan subject to the maximum benefit.

LOSS OF A FOOT means that all of the foot is cut off at or above the ankle joint.

LOSS OF A HAND means that all four fingers are cut off at or above the knuckles joining each to the hand.

LOSS OF HEARING means the total and irrecoverable loss of hearing in both ears.

LOSS OF SIGHT means the eye is totally blind and that no sight can be restored in that eye.

LOSS OF SPEECH means the total and irrecoverable loss of speech.

LOSS OF THUMB AND INDEX FINGER means that all of the thumb and index finger are cut off at or above the joint closest to the wrist.

OCCUPATIONAL INJURY means an injury that was caused by or aggravated by any employment for pay or profit or otherwise occurring within the course of employment.

PARAPLEGIA means total and irreversible paralysis of both lower limbs.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the Summary of Benefits.

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 Summary of Benefits.

PRIVATE PASSENGER CAR means a validly registered four-wheel private passenger car (including Employer-owned cars), station wagons, jeeps, pick-up trucks, and vans that are used only as private passenger cars.

QUADRIPLEGIA means total and irreversible paralysis of all four limbs.

QUALIFIED CHILD means:

- **for purposes of the Education Benefit**, any of your unmarried dependent children under age 25 who, on the date of your death as a result of an accidental bodily injury, was either:

  - enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level; or
  - at the 12th grade level and enrolls as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level within 365 days following the date of your death.

- **for purposes of the Child Care Benefit**, any of your unmarried dependent children under age 14 who, were enrolled in a licensed day care facility, school facility, or other similar program for 90 continuous days before the date of the accident causing your death. The Child Care Benefit will not be extended to any of your children born after the date of your death unless pregnancy commenced prior to the date of your death.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

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.

RETAINED ASSET ACCOUNT is an interest bearing account established through an intermediary bank in the name of you or your beneficiary, as owner.

SICKNESS means:

- **for purposes of Portability**, an illness, disease or symptoms for which a person, in the exercise of ordinary prudence, would have consulted a health care provider.
- **for all other purposes**, an illness or disease. Disability must begin while you are covered under the plan.

TRIPLEGIA means total and irreversible paralysis of three limbs.

TRUST means the policyholder trust named on the first page of the Summary of Benefits and all amendments to the policy.

UNIPLEGIA means total and irreversible paralysis of one limb.

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.

YOU means an employee who is eligible for Unum coverage.

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY THE STATE OF WASHINGTON. PLEASE READ CAREFULLY.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia.
Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

If you had group life coverage in place with your employer through another carrier when your employer changed carriers to Unum, your prior coverage may be continued under the Unum plan to the extent the laws of your resident state require such right to continue and within the design limits of the Unum plan.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

For residents of Washington

The definition for **ACTIVE EMPLOYMENT** in the **GLOSSARY** section is amended to include the following:

> A period of up to 6 months during which you are not working due to a strike, lockout or other labor dispute is considered active employment. Your employer may require you to pay premium during this period of time.

The ***WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL?*** (Accelerated Benefit) in the **Life Insurance Benefit Information** section is amended by changing the life expectancy requirement to 24 months or less, or such longer period as stated in the policy.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **Life Insurance Benefit Information** section is amended to remove any exclusion for death caused by suicide.

Additional Claim and Appeal Information
Relative to the Summary of Benefits issued by
Unum Life Insurance Company of America ("Unum")

APPLICABILITY OF ERISA

If the Summary of Benefits 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 Summary of Benefits, including your certificate of coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the Summary of Benefits, 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

If a claim is based on death, a covered loss not based on disability or for the Education Benefit

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

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.

If a claim is based on your disability

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

If an appeal is based on death, a covered loss not based on disability or for the Education Benefit

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt

of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

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.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

If an appeal is based on your disability

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);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

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.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or summary of benefits 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 summary of benefits 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.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: July 17, 2018
SUBJECT: 2018 Delta Dental Benefits Contracts
FROM: Terri Lautt, Director
AGENCY/DEPARTMENT: Human Resources
HEARD AT STUDY SESSION ON: August 22, 2017
AUTHORIZATION TO MOVE FORWARD: ☒ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners Approves the 2018 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 and riders outline the current benefits, administrative fees and premiums for the 2018 contracts with Delta Dental of Colorado as approved through Study Session.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Human Resources
County Manager's Office
Budget Office

ATTACHED DOCUMENTS:

Resolution
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 and riders thereof, constitute the entire contracts with Delta Dental of Colorado in effect through December 31, 2018.

NOW, THEREFORE, BE IT RESOLVED, that the Board of County Commissioners, County of Adams, State of Colorado, that the attached Delta Dental Benefits contracts be approved, effective January 1, 2018.

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

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 attached appendices and riders constitute the entire Contract of the parties and will become binding upon the parties and their respective successors and assigns effective the 1st day of January, 2018 for a one year period and for successive one-year periods thereafter unless terminated as herein provided. This contract is issued and delivered in the State of Colorado, is governed by the laws of Colorado and is subject to the terms and conditions recited on the subsequent pages of this contract, and may not be changed, altered or terminated except in accordance with Article VII, RENEWAL AND TERMINATION of this Contract.

This DECLARATIONS PAGE supersedes any contrary provision of the subsequent sections of this contract.

DECLARATION PAGE

Group: ADAMS COUNTY GOVERNMENT

Type of Contract: Delta Dental PPO, Exclusive Panel Option (EPO)

Group Number: 7195/77195/97195

Contract Effective Date: January 1, 2018

Contract Anniversary Date: January 1st

	*PPO Dentist
Covered Services	**Plan Pays**
Diagnostic & Preventive Services	
Oral Exams and Cleanings	**Co-Payment is based on Appendix A- Patient Co-Payments (EPO 1B)**
X-Rays	
Sealants	
Fluoride Treatments	
Basic Services	
Basic Restorative (Fillings)	**Co-Payment is based on Appendix A- Patient Co-Payments (EPO 1B)**
Oral Surgery	
Endodontics (Root Canal Therapy)	
Periodontics (Gum Disease Treatment)	
Major Services	
Special Restorative (Crowns, Onlays)	**Co-Payment is based on Appendix A- Patient Co-Payments (EPO 1B)**
Prosthodontics (Dentures, Bridges)	
Orthodontic Services	
Orthodontics (All Ages)	**Co-Payment is based on Appendix A- Patient Co-Payments (EPO 1B)**

Orthodontia is a covered benefit. See the Delta Dental Benefits Rider for details of all benefits and limitations.

*** If you do not use a PPO Dentist, you will be responsible for all charges.**

Age

Type	Age Limit	Coverage Thru
Dependent Child	26	Month

Eligibility Waiting Period

Active Subscribers working the minimum number of hours as required by the Employer will become eligible on the first day of the month or coinciding with 45 days of employment.

Enrollment Type

The enrollment type is Open Enrollment. Open Enrollment means a period of time each Contract Year occurring prior to the Anniversary Date during which eligible Subscribers may choose to enroll themselves and/or their eligible Dependents in the Plan, or change from one coverage option to another if the Contract issued to the Group permits them to do so. Coverage will become effective on the Group's Anniversary Date.

Where two Subscribers who are spouses and are both eligible for coverage under this contract, they may be enrolled together or separately, but not both. Dependent children may be enrolled under one parent.

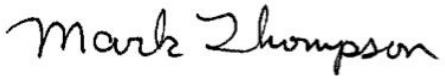
Rate Coverage

Coverage Tier	Rate Amt
SUBSCRIBER	$ 32.33
SUBSCRIBER /SPOUSE	$ 61.20
SUBSCRIBER /CHILDREN	$ 79.96
SUBSCRIBER /FAMILY	$ 124.12

These rates are contingent upon the minimum percent enrollment as stated in the original quote, in accordance with the eligibility provisions in Article III.

Riders or Appendices Attached

Countersigned:
Delta Dental of Colorado



Signature

_____
Date
Accepted:
ADAMS COUNTY GOVERNMENT (EPO SCHEDULE 1B) – 7195/77195/97195

_____
Signature

_____
Date

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ARTICLE I. DEFINITIONS

The terms below apply to this Contract:

1.01 ALTERNATE BENEFIT means the amount allowed based on the least costly, commonly accepted Service used to treat a dental problem when a Covered Person selects more costly treatment options.

1.02 APPLICANT means the Group or Employer wishing to provide dental benefits.

1.03 BENEFITS means the Services described in this Contract in the Benefits Rider, BENEFITS, LIMITATIONS and EXCLUSIONS.

1.04 COINSURANCE means the percent of a Covered Amount which Delta Dental will pay. The Coinsurance for each type of Covered Service appears in the Declaration Page. The Coinsurance that applies to a Subscriber may vary by type of dental Service.

1.05 COMPLETED means:

- For Root Canal Therapy, the date the canals are permanently filled.
- For Fixed Bridges (fixed partial dentures), Crowns, Inlays, Onlays, and other laboratory prepared restorations: The date the restoration is cemented in place.
- For Dentures and Partial Dentures (removable partial dentures): The date that the final appliance is first inserted in the mouth.
- For all other Services: The date the procedure is Started.

A Benefit is only payable once Completed.

1.06 The **CONTRACT ANNIVERSARY DATE or ANNIVERSARY DATE** is noted on the Declaration Page of this Contract. The anniversary date is the first day of each Contract Year following the initial Contract Year.

1.07 CONTRACT means the agreement between Delta Dental and the Applicant. It includes attached appendices, exhibits and riders, if any. This Contract is the whole agreement between the parties.

1.08 CONTRACT TERM means the time from the Effective Date of the Contract until it is terminated.

1.09 CONTRACT YEAR is the 365 days beginning on the Effective Date of this Contract, and each year after unless the contract is terminated. The contract year is 366 days in a leap year.

1.10 COVERED AMOUNT means:

- For PPO Providers, the lesser of the PPO Provider's Allowable fee or the fee actually charged.
- For Premier Participating Providers, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.
- For all other Providers, the lesser of the non-participating Maximum Plan Allowance, or the fee actually charged.

1.11 COVERED SERVICES means the Services described in this Contract or attachments, subject to the limitations and exclusions noted.

1.12 DEDUCTIBLE means the amount the Member must pay before Delta Dental pays. The Deductible is shown on the Declaration Page. If there is a limit to the deductible that a family must pay, that will be shown on the Declaration Page.

1.13 DEPENDENT means:

- The Subscriber's lawful spouse, including civil union partner.
- Civil Union partner must meet each of the requirements listed below:
  - ❖ They must be at least 18 years old.
  - ❖ They must be of the same or opposite sex.
  - ❖ They must not be a partner in another civil union.
  - ❖ They must not be married to another person.
  - ❖ They must not be related.
  - ❖ They must have entered into a civil union based on the guidelines of Article 15 of Title 14, C.R.S. recognized pursuant to Colorado Law.
- A child under the Dependent Age Limit shown on the Declaration Page.
- A child who reaches the Dependent Age Limit stated on the Declaration Page and is incapable of self-support because of physical or mental disabilities that began before reaching the Dependent Age Limit, and is dependent on the Subscriber. Delta Dental may annually request proof of such disability and dependency. Failure to submit such proof will terminate coverage.

If the Group chooses whether to cover a Civil Union Partner that option will be noted on the Declaration Page.

Eligible children are natural children, stepchildren, children under court-ordered guardianship, adopted children, and children of a civil union.

No one may be covered as a Dependent and also as a Subscriber under this Contract. If both parents are covered as Subscribers, children may be covered as Dependents of one parent only.

Persons in active military service are not eligible Dependents.

1.14 EFFECTIVE DATE is the date coverage begins.

1.15 ELIGIBLE CLASS is a group of Subscribers who are allowed to enroll under the Contract. A list of Eligible Classes is on the Declaration Page.

1.16 ELIGIBILITY WAITING PERIOD means the time that a person must be employed before they may enroll. The Eligibility Waiting Period is chosen by the Applicant and may differ by Eligible Classes. The Eligibility Waiting Period, if any, is noted on the Declaration Page and in Article III.

1.17 EMPLOYEE means someone who works the minimum number of hours defined by the Employer.

1.18 EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES means those services not generally accepted in the dental community as being safe and effective, as defined by Delta Dental.

1.19 GROUP means the Applicant or Employer contracting for dental benefits.

1.20 LATE ENROLLMENT means to enroll after first becoming eligible. A Late Enrollee must be enrolled for 12 months before Covered Services beyond those noted on the Declaration Page are covered.

The exceptions to this rule are:

- A Subscriber or Dependent who loses coverage through another group plan. (Loss of coverage is defined as loss due to death, divorce, loss of job, or termination of benefits by the employer.) Such Subscriber or Dependent will be allowed to enroll within 31 days of the loss of coverage with proof of loss. The person will not be a Late Enrollee.
- A Dependent child under age four may be added on any Contract Anniversary Date. The child will not be a Late Enrollee.

If the Applicant chooses Late Enrollment, the option will be noted on the Declaration Page.

1.21 MAXIMUM PLAN ALLOWANCE means the most that a Provider is allowed to charge for a procedure. Delta Dental reviews the limits twice a year. We may increase or decrease fees for any procedure.

1.22 MEMBER means any person eligible and enrolled for coverage under this plan.

1.23 NECESSARY means a Service that Delta Dental decides, using accepted standards of dental care and Delta Dental's processing policies, is needed and fitting for treatment of the Members's dental condition.

1.24 **NON-PARTICIPATING PROVIDER** means a Provider who does not contract with Delta Dental.

1.25 **OPEN ENROLLMENT** means a period prior to the Anniversary Date when eligible Subscribers and their Dependents may enroll. They may also change from one plan to another if the Contract permits them to do so. Coverage is effective on the Applicant's Anniversary Date.

If the Applicant chooses an Open Enrollment period, the option will be noted on the Declaration Page.

1.26 **PARTICIPATING PROVIDER** means a Provider who contracts with Delta Dental.

- **Premier Participating Provider** means a Provider who has a Premier Participating Provider Agreement with Delta Dental.
- **PPO Participating Provider** means a Provider who has a PPO Provider Agreement with Delta Dental.

1.27 **PREMIUM** means the amount of money paid for each Subscriber to buy the Benefits provided in this Contract.

1.28 **PRE-TREATMENT ESTIMATE** is a review of a Provider's plan of care to decide what is covered under this Contract.

1.29 **PROVIDER** means a person licensed to provide dental Services.

1.30 **SERVICE** means a procedure or supply provided by a Provider.

1.31 **STARTED** means:

- For Full Dentures or Partial Dentures (removable partial dentures): The date the final impression is taken.
- For Fixed Bridges (fixed partial dentures), Crowns, Inlays, Onlays and other laboratory prepared restorations: The date the teeth are first prepared (i.e., drilled down) to receive the restoration.
- For Root Canal Therapy: The date the pulp chamber is first opened.
- For Periodontal Surgery: The date the surgery is performed.
- For All Other Services: The date the Service is performed.

1.32 **SUBSCRIBER** means:

- An enrolled Subscriber for whom the monthly Premium is paid.
- A person who elects continued coverage and for whom the monthly Premium is paid.

1.33 **TIED-TO-MEDICAL** means dental benefits linked to the medical plan that the Applicant offers. Only those who enroll in a medical plan may be Subscribers under a dental plan that is tied-to-medical.

If the Applicant chooses Tied-To-Medical, the option will be noted on the Declaration Page.

ARTICLE II. MONTHLY PREMIUM

2.01 PREMIUM DUE DATE. The Group agrees to pay Delta Dental the Monthly Premium for each Member on or before the first day of the month for which the premium is due.

2.02 MONTHLY PREMIUM. The Monthly Premium for each Subscriber is noted on the Declaration Page.

2.03 INITIAL PREMIUM. This Contract is not effective until Delta Dental receives the initial Premium. Future Premiums are due on the first day of each month.

2.04 PREMIUMS AT TERMINATION. If this Contract terminates for any reason, the Applicant must pay all Premiums due but not paid.

2.05 CHANGE OF PREMIUM RATES. Absent an amendment agreed to by Applicant and Delta Dental, Premiums will not change during a Contract Year except as noted in Section 2.06.

2.06 EFFECT OF PREMIUM TAX CHANGES. If a new tax is imposed on Delta Dental on the amount of Premium or the number of persons covered, the Monthly Premium will be increased by the amount of any such new tax. If the rate of an existing tax on the amount of Premium or the number of persons covered is increased, the Monthly Premium will be increased by the amount of the increased tax.

2.07 CLERICAL ERRORS. Clerical errors or delays in data related to coverage will not affect coverage that would otherwise be in force. Upon discovery of such errors or delays, charges will be adjusted.

2.08 GRACE PERIOD. Except for the initial Premium, a Grace Period until the 45 day grace period of 15th day of each month for the previous month's fees. Coverage remains in force during the Grace Period unless cancelled by the Group. If the Premium is not paid by the end of the Grace Period, the Contract will terminate as of the last day of the Grace Period. Premiums are due through the last day of the Grace Period.

2.09 REFUNDS. Group must provide timely notice to Delta Dental when a Subscriber is no longer eligible. Group must pay the Monthly Premium through the date that notice is given. If Premium is paid for a Person who is no longer eligible and timely notice was given, Delta Dental will refund the Premium for the period paid in error. The refund will be paid for up to three months or to the last Contract Anniversary, whichever is less. If Benefits were paid for a person after coverage terminated, the full amount of the Benefits paid in error must be repaid to Delta Dental before any Premium will be refunded.

ARTICLE III. ELIGIBILITY

3.01 ELIGIBILITY. Subject to eligibility rules set forth in Section 3.02 below and/or on the Declarations Page, a Subscriber in an Eligible Class may enroll within 31 days after the Eligibility Waiting Period. They may also enroll during an Open Enrollment period if offered by the Employer.

a) **BECOMING COVERED.** Delta Dental must receive enrollment data for each Subscriber in a format acceptable to Delta Dental. The enrollment data must be received within 31 days of a Subscriber or Dependent's enrollment. The enrollment data must include the Subscriber's address, gender, social security number, date of birth and effective date. If the Subscriber chooses to enroll Dependents, each Dependent's name (including surname if different from Subscriber's), relationship to the Subscriber, address, gender, social security number and date of birth must be submitted.

- Coverage is effective after the eligibility waiting period shown on the Declaration Page.
- A Subscriber not enrolled in the plan may not enroll Dependents.

b) **ENROLLMENT TYPE. The Group's enrollment type is set forth on the Declaration Page. It will be one of the following:**
- Late Enrollment. A Member who does not enroll within the period described in Article III Section 3.01a will be considered a Late Enrollee.
- Open Enrollment. A Member who fails to enroll within the period described in Article III, Section 3.01a may enroll at the next Open Enrollment.
- Tied-to-Medical. Eligibility for the dental plan will be the same as that required by the medical plan.

c) **MAINTAINING COVERAGE.** The Group will give Delta Dental a list of any plan additions, changes, or terminations on or before the first day of each month. Delta Dental is not required to provide Benefits for a Subscriber or Dependent not on the list and for whom the monthly Premium is not paid.

3.02 SUBSCRIBER ELIGIBILITY. Subscribers may enroll within 31 days of the date they first become eligible.

a) Depending on the Enrollment Type of the group, eligible Subscribers who do not enroll as described above may enroll
- For Open Enrollment Groups, only during Open Enrollment. Eligible Subscribers who enroll and later drop the plan may enroll only during Open Enrollment.
- For Late Enrollment Groups, they may be able to enroll as a Late Enrollee.

b) Eligible Subscribers who lose coverage through another source may enroll with proof of loss. (Loss of coverage is defined as loss due to death, divorce, job loss, or termination of benefits by the employer.) They must enroll within 31 days of the loss of coverage.

3.03 DEPENDENT ELIGIBILITY. Dependents of an eligible Subscriber may enroll within 31 days of the following:

- The date the Subscriber becomes eligible to enroll. The effective date is that of the Subscriber.
- New Dependents must be enrolled within 31 days of a life event and will be covered the day immediately following the event. Newborns and adopted children will be covered on the date of birth or date of placement for adoption.
- The date the Contract is amended to provide Dependent coverage. The Plan becomes effective on the first day of the month following this change.

a) If the group's Enrollment Type is Tied-to-Medical and Dependent enrollment is desired, the Dependents must be the same as those on the medical plan.
   - If the group's Enrollment Type is Open Enrollment, the Dependent can be added during the Open Enrollment period.
   - If the group's Enrollment Type is Late Enrollment, a Dependent can be added as a Late Enrollee.

b) Depending on the Enrollment Type of the group, Eligible Dependents who do not enroll as described above may enroll
   - For Open Enrollment Groups, only during Open Enrollment. Dependents who enroll and later drop the plan may enroll only during Open Enrollment.
   - For Late Enrollment Groups, they may be able to enroll as a Late Enrollee.

c) Eligible Dependents who lose coverage through another source may enroll with proof of loss. (Loss of coverage is defined as loss due to death, divorce, loss of job, or termination of benefits by the employer.) They must enroll within 31 days of the loss.

3.04 TERMINATION OF COVERAGE. A Member's plan will terminate at the earliest of:

- The date Delta Dental receives a written request to cancel;
- The last day of the month the Subscriber is not eligible for coverage;
- The date the Contract terminates;
- The end of the period for which Premium is paid;
- The last day of the end of the month the Member enters full-time military service of any country; or
- As to any Dependent, the last day of the end of the month the person no longer qualifies as a Dependent.

Delta Dental must be notified within 60 days if a Member is no longer eligible.

Family and Medical Leave ACT (FMLA) -

If coverage ends during an Employer approved FMLA leave, coverage may be reinstated upon return to work within the terms of the FMLA leave. Pre-existing conditions, limitations and other waiting periods will not be imposed unless they were in effect for the Subscriber and/or his or her Dependents when coverage terminated.

3.05 INVOLUNTARY LOSS OF COVERAGE DUE TO STRIKE, LEAVE OF ABSENCE OR LAYOFF. If a Subscriber loses coverage due to strike, lay-off or leave of absence, and returns to work within 30 days, he may re-enroll on the first day of the month after his return to work. If the absence exceeds 30 days, he will be treated as a new Subscriber. Contract provisions relating to the Deductible, Coinsurance, Contract Year Maximum, and Waiting Periods, if any, will apply as to new coverage. The following exception applies:

Delta Dental of Colorado complies with the Uniformed Services Employment and Reemployment Rights Act (USERRA). Subscribers called to active duty may enroll as if there had been no leave of absence if they are still in an Eligible Class of Subscriber when they return to work. USERRA allows Subscribers to elect continuation of coverage when coverage would terminate due to an absence to serve in the uniformed services.

Services received by a person who is not eligible due to leave of absence are not covered unless the person elects continued coverage as provided in Article VIII or according to USERRA where applicable.

3.06 INVOLUNTARY LOSS OF "OTHER COVERAGE". A person who loses dental coverage from another source will be allowed to enroll with proof of the loss. (Loss of coverage is defined as loss due to death, divorce, loss of job, or termination of benefits by the employer.) The person must enroll within 31 days of the loss. Coverage will begin the date immediately following the loss of coverage date.

3.07 VOLUNTARY TERMINATION OF COVERAGE. In groups with Open Enrollment, a Member who cancels his plan may only re-enroll at the next Open Enrollment. In groups not offering Open Enrollment, a Member who cancels his plan and wants to re-enroll will be a Late Enrollee. The requirements of Late Enrollment will apply.

3.08 REVIEW OF RECORDS. Applicant will permit Delta Dental, with advance written notice, to inspect records of Applicant in order to confirm the lists of Members prepared by Applicant. Delta Dental may verify Applicant's compliance with Article II. Delta Dental may use auditors or other agents for this purpose.

ARTICLE IV. COORDINATION OF BENEFITS

4.01 DEFINITIONS. Coordination of Benefits means taking into account other Plans when paying Benefits.

"Allowable expense" is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering a Member. 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 Member 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 Member is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) If a Member is covered by 2 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.

(2) If a Member is covered by 2 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.

(3) If a Member 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.

(4) The amount of any benefit reduction by the primary plan because a covered Member 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.

Plan means a Plan that provides benefits or Services for dental care on a group basis. This includes group and blanket insurance, self-insured and prepaid plans, automobile fault or no-fault insurance and government plans (except Medicaid).

Primary Coverage means Coverage that must pay first. The Primary Plan must pay up to its full liability.

Secondary Coverage means Coverage that pays a claim after the Primary Plan pays.

4.02 WHEN COORDINATION OF BENEFITS APPLIES.

Coordination of Benefits applies when a Subscriber is covered under more than one Plan. The Benefits of this Plan will be coordinated with the other Plan(s).

4.03 RULES FOR COORDINATION OF BENEFITS.

The rules for the order of payment are shown below.

- The Plan covering a Subscriber as an Employee is primary to a policy on which the Member is a Dependent.
- For Dependent children, primacy will be determined as follows.

  The Plan of the parent whose birthday occurs earlier in a year will be primary.

  If the parents are separated or divorced, the Plan of the parent who is ordered by court decree to pay for dental expenses will be primary. If the court decree orders parents to share, the decree governs and these rules shall apply to decide the primary plan.

  The Plan of the parent with custody is Primary. If the custodial parent has remarried, the stepparent's Plan is Secondary and the Plan of the parent without custody pays third.

  If the above rules do not establish an order of benefit payment, the Plan that has covered the Person the longest will be Primary. If a Plan covers a person who has been laid off or is retired, it will be Secondary to any other Plan.
- A group Plan that does not have a Coordination of Benefits clause is primary.

If this Plan is Primary, we will pay claims without regard to benefits provided by any other Plan. If this Plan is Secondary, it shall calculate the benefits it would have paid on the claim 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 reduce its payment by that 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 100 percent of 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.

ARTICLE V. CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

5.01 PAYMENT OF CLAIMS. Covered services will not include, and payment will not be made for claims for dental Services not listed in this Contract and any Appendix, Amendment, or Rider. Claims submitted to Delta Dental must use terms of the American Dental Association Current Dental Terminology (Code on Dental Procedures and Nomenclature).

5.02 APPEAL OF AN ADVERSE DETERMINATION OF A CLAIM.

A. Internal Appeal Process - First Level Appeals

A Member may appeal an adverse claim decision within 180 days of the date of the original Explanation of Benefits by writing to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

A Member may submit additional information in support of the appeal.

Appeals are reviewed by an impartial Provider of the same or similar specialty as would typically manage the case being reviewed. The reviewing provider will not have been involved in the initial decision.

The decision will be sent to the Member with the rationale for the decision. The decision will be made within 15 calendar days for pre-service denials. Post-service decisions will be made within 30 calendar days.

B. Internal Appeal Process - Second Level Appeals (Not available for Self-Funded Groups)

If a denial is upheld at the first level, a Member may request a second level appeal. The request must be received within 30 days of the First Level Appeal decision. It must be submitted to the address noted in 5.02A. Additional information may be submitted. Second level appeals will be reviewed by an impartial provider with the appropriate expertise. The reviewer will not have been involved in the first appeal. The Member, or a designated representative, may request to appear before the reviewer in person or may present by conference call.

A Second Level Appeal decision will be issued within 7 days of the review meeting.

C. Internal Appeal Process - Expedited Appeals

Members may request an expedited appeal when the time for a standard review would seriously jeopardize the life or health of the Member, would jeopardize the Member's ability to regain maximum function, or, for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently.

Expedited review decisions will be issued within 72 hours.

D. Independent External Review (Not available for Self-Funded or Federal Groups)
Where Delta Dental makes an Adverse Determination and the Member exhausts the internal appeals process, the Member has the right to request an external review. Delta Dental will notify the Member of the right, if any, to request an external review after the First Level appeal.

Requests for an independent external review must be in writing. They must include a completed external review request form as specified by the Colorado Division of Insurance. The Member must submit the request within four months of the completion or exhaustion of the internal appeals process. The internal appeals process is completed or exhausted upon Member's receipt of notice of the adverse determination or upon Delta Dental's failure to comply with Colorado Revised Statues §§ 10-16-113, 10-16-113.5, or Colorado Insurance Regulations 4-2-17 or 4-2-21.

Member may request expedited external review. All requests must be submitted to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

A signed consent authorizing Delta Dental to disclose protected health information pertinent to the external review is also required.

Delta Dental adheres to timeframes set forth by Colorado Regulation 4-2-21 in the processing of Independent External Reviews. Within 45 days after the receipt of the request for external review (72 hours for expedited external review), the external review entity shall deliver a written decision to the Member, Delta Dental, the provider, and the Commissioner.

5.03 CLAIMS FROM NON-PARTICIPATING PROVIDERS. Payment for Completed Covered Services from a Non-Participating Provider will be based on the non-participating Maximum Plan Allowance. The Member will be responsible for the full cost of Service.

5.04 CLAIMS FROM PARTICIPATING PROVIDERS. Payment for Completed Covered Services provided by a Participating Provider will be made directly to the Provider. The patient does not have to pay any amount above what Delta Dental allows. For PPO Participating Providers, the amount Delta Dental allows is set forth in the PPO Schedule of Allowances. For Premier Participating Providers, the amount Delta Dental allows is the Premier Maximum Plan Allowance. If the Participating Provider charges more for a Service than Delta Dental allows, that amount is not chargeable to the patient.

5.05 TIME FRAME FOR SUBMISSION OF CLAIM. Delta Dental will not pay claims submitted more than 12 months after the date the Service is Completed. If a Participating Provider failed to submit a claim within this time, the Member will not be liable for the amount that Delta Dental would have paid.

5.06 AVAILABILITY OF PROVIDER. A Member may elect the Service of any licensed Provider, but neither Delta Dental nor Applicant guarantees the availability of any Provider.

5.07 RIGHT TO INFORMATION AND RECORDS. Delta Dental may receive records related to the treatment of a Member from any Provider. Delta Dental may require a Member to be examined by a dental consultant retained by Delta Dental. Delta Dental will maintain records in a confidential manner in accordance with federal and state law.

5.08 EXTENDED COVERAGE. Delta Dental benefits will end if this Contract is terminated or if a person's coverage is cancelled. Delta Dental will cover no further Services except as described below.

If a Covered Service Started before coverage ends, but the Covered Service is Completed after it ends, Delta Dental will pay Benefits for the Covered Service as follows:

- Benefits will be paid in the amount that would have been paid and subject to the same terms as would have applied if the Person's coverage were still in effect.
- Benefits will be paid only if the Covered Service is Completed within 60 days after the date the Person's coverage ended.

No benefit will be paid if the Covered Service is Started after coverage ends.

5.09 PRE-TREATMENT ESTIMATE. Before starting treatment that may cost $400 or more, Members may request an estimate from Delta Dental of what is covered. Pre-treatment estimates are not required.

5.10 SUBROGATION. Delta Dental may pursue on its own or with a Member a claim against a third party. If Delta Dental pays a claim for injuries to a Member and the Member settles with a third party for an amount that includes such costs, the Member must refund Delta Dental the amount equal to the benefit payment made to, or on behalf of, the Member.

ARTICLE VI. GENERAL TERMS AND CONDITIONS

6.01 NOTICES. Any notice under this Contract will be valid if given by either the Applicant or Delta Dental to the other. In the case of the Applicant, notice may be given to a designated agent. The notice will be effective upon the date of mailing.

6.02 NOTICES TO SUBSCRIBERS. Notice to a Subscriber will be in writing and sent by regular US mail to the current address in Delta Dental's records. If agreed to by Delta Dental and the Subscriber, notices may be sent via email.

6.03 LEGAL ACTION. No action at law or in equity may be filed in order to recover on this Contract prior to the expiration of 60 days after final notice of claim has been filed in accordance with the requirements of this Contract.

6.04 REPRESENTATIONS. All statements made by the Group or by an individual will be deemed representations and not warranties.

6.05 ENTIRE CONTRACT; AMENDMENTS. This Contract is the complete agreement between Delta Dental and the Group. This Contract may not be orally amended or changed. This Contract may at any time be amended and changed by written agreement between Delta Dental and the Group. Any such amendment will be binding on all Members regardless of the date their coverage became effective or the date treatment was Started.

6.06 CONTRACT CHANGES. No agent or employee of Delta Dental may change the Contract or waive any of its provisions. No change in the Contract will be valid unless approved in writing by an authorized Delta Dental employee.

6.07 GROUP'S ACCESS TO RECORDS. Delta Dental agrees that Group or its designated representative may access all files and records pertinent to the Group in accordance with federal and state laws. The group must give 14 days written advance notice.

6.08 SETTLEMENT OF DISPUTES. Any dispute between Delta Dental, a Participating Provider, and Member, or any combination of these, must be settled by arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association. Except for ERISA covered claims, disputes include adverse claim decisions not settled by the appeals process. Judgment on the award rendered by the Arbitrator(s) may be entered in any Court having jurisdiction. Arbitration may be initiated by any party to a dispute by giving notice to each party, by filing two copies of such notice with the American Arbitration Association and by complying with other applicable provisions of the Association's rule.

6.09 PARTICIPATING PROVIDER. Delta Dental will make reasonable efforts to provide Applicant a list of Participating Providers. The list may be provided in different formats. The Providers may change from time to time, and Delta Dental reserves the right to change the list without prior notice to the Applicant.

Neither Delta Dental nor Applicant is liable for any act or omission by Providers or their agents or employees who provide or contract to provide dental Services under this Contract. Providers who participate with Delta Dental are independent contractors. They are neither agents nor employees of Delta Dental. Nor is Delta Dental an agent or employee of any Participating Provider. Delta Dental will not be responsible for any claim or demand for damages arising out of any injuries suffered by a Member while receiving care from any Participating provider or in any Participating provider's facilities.

6.10 SUBSCRIBER BENEFIT BOOKLET. Delta Dental will give an Subscriber Benefit Booklet to the Group. The Group will make the booklet available to each Subscriber. If an amendment to this Contract will materially affect the Benefits in the booklet, we will give a revised Subscriber Benefit Booklet or inserts showing the change to the Group.

6.11 PHYSICAL EXAMINATION. Delta Dental, at its own expense, may examine an individual for whom a claim or request for pre-estimation of Benefits is pending under this Contract.

6.12 GENDER. The use of the singular will include the plural and the plural the singular. Use of any gender will include all genders.

6.13 NON-DISCRIMINATION. Delta Dental does not use individual health factors to determine benefits or premium rates. Health factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability.

6.14 HIPAA PRIVACY & SECURITY. Delta Dental complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security regulations.

6.15 AGREEMENT WITH STATE LAW. Any requirement in this Contract which on its effective date is in conflict with the laws of the state in which any Member lives is hereby changed to the minimum requirement of such laws.

ARTICLE VII. RENEWAL AND TERMINATION

7.01 RENEWAL. The Contract will renew for one-year periods unless either party elects not to renew by giving the other party written notice. Notice must be received at least 60 days before the end of the current Contract year. If there are changes to the rates or other terms of this Contract effective on an Anniversary Date, Delta Dental will provide notice of the proposed changes with the notice of renewal.

7.02 TERMINATION. This Contract may be terminated as follows:

a) By either the Group or Delta Dental at the end of the initial Contract or at the end of any contract year if the required notice of non-renewal is given.
b) If Premium is not paid within **30** days of the due date, Delta Dental will give notice that payment is past due. If payment is not received by the last day of the Grace Period, Delta Dental may terminate the Contract.
c) The Group may terminate if Delta Dental fails to provide the Benefits under the Contract and does not correct the failure within 60 days.
d) Delta Dental may terminate if enrollment falls below the required percent shown on the quote. Delta Dental may propose to the Group adjustments in rates, Benefits, or copayments to correct adverse group experience that could result from a reduction in size. Within 30 days, the Group will select an alternative in writing. If an alternative is not selected, Delta Dental may terminate the Contract.
e) Group may terminate by written notice of intent to terminate as of any date other than the end of the Contract Term. The termination date will be the last day of the month during which Delta Dental received the Group's written notice of intent to terminate.
f) Delta Dental may terminate if the number of enrolled Subscribers drops below the required number in the quote. Delta Dental may propose to the Group alternative rates, Benefits, or copayments necessary to correct adverse group experience that could result from such reduction in size. Within 30 days, the Group will select an alternative by written notice to Delta Dental. If an alternative is not selected, Delta Dental may terminate the Contract.
g) Delta Dental may terminate upon any fraud or misrepresentation by the Applicant. With respect to coverage of a Member, fraud or misrepresentation by the Member or such person's representative may result in termination.

7.03 In the event of termination by Delta Dental, all Benefits will end and Delta Dental will have no further obligations as of the last day of the month in which written notice of termination is effective. Premium must be paid through that period. Delta Dental will pay for Services Started while a person was covered under the Contract but Completed after the person's coverage ends pursuant to Section 5.08, Extended Coverage.

7.04 If Group has not paid Premiums to Delta Dental for a period up to and including the termination date, Group will remit such Premium within 30 days of termination.

7.05 REINSTATEMENT.

Delta Dental, at its sole discretion, may reinstate a Contract that was terminated for non-payment of Premium. If Delta Dental reinstates a Contract, the following rules will apply:

a) All Premiums then due and unpaid must be paid, including the Premium for the Grace Period.
b) Interest on past due Premiums must be paid at a rate of 1.5% per month or the highest rate allowed by state law if less.
c) Delta Dental may review the claim experience for the group and, based on its analysis, offer to reinstate the group at a different Premium rate than was in force at the time the Contract lapsed.
d) A Contract Reinstatement Fee of $50.00 must be paid.

ARTICLE VIII. CONTINUATION COVERAGE

8.01 COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) generally applies to Groups with 20 or more Subscribers.

Under COBRA, Members who have a qualifying event may be able to continue coverage for a period of time. The benefits will be the same as those of active Subscribers. The Member must pay the Premium, which cannot exceed 102% of the cost for an active Subscriber with the same plan. Qualifying events govern if a person may elect COBRA and the length of coverage. The employer or Group must administer COBRA according to federal requirements.

COBRA Continuation coverage will end on the earliest of the following:

a) the last day of the month in which COBRA Continuation ends;
b) the day the Contract terminates;
c) the last day of the month for which premium has been paid;
d) the last day of the month the person becomes entitled to Medicare;
e) the last day of the month the person is eligible for coverage under another group plan.

8.02 Continued Health Coverage required by the State of Colorado (State Continuation) applies to Groups not subject to COBRA.

Members covered under this Contract, or a similar contract it replaces, for at least 6 months may be able to continue coverage for up to 18 months under State Continuation. Their premium and benefits will be the same as those for active Subscribers, except that the Member will be responsible for the Premium. The Employer or Group must administer State Continuation according to state law.

State Continuation coverage is effective upon loss of coverage. Within 60 days of the loss, the Group must send enrollment information and premium to Delta Dental for the Member's benefits to continue.

State Continuation coverage will terminate on the earliest of the following:

a) the last day of the month after 18 months of continued coverage;
b) the day the Contract terminates;
c) the last day of the month that premium is paid;
d) the day the person becomes entitled to Medicare;
e) the day the person is eligible for coverage under another group plan; or
f) in the case of a Dependent child, the day he no longer meets the definition of Dependent.

RIDERS and APPENDICES

COVERED DENTAL SERVICES

Subject to the limitations and exclusions included in this Contract, the Completed dental Services are Benefits when provided by a Provider (or other person legally permitted to perform such Services by authority of license) and are determined under the standards of generally accepted dental practice to be Necessary and appropriate. Benefits will be determined based on the terms of this Contract and Delta Dental's Processing Policies.

DIAGNOSTIC & PREVENTIVE SERVICES

Diagnostic: Certain Services performed to assist the Provider in evaluating the existing conditions and determining the dental care required.

Preventive: Certain Services performed to prevent the occurrence of dental abnormalities or disease.

Adjunctive: Certain additional Services, including emergency palliative treatment, performed as a temporary measure that does not affect a definitive cure.

PROCEDURE	BENEFIT DESCRIPTION
Oral Exam (All exam types)	Two exams in a 12 month period are covered. There is no separate benefit for diagnosis, treatment planning or consultation by the treating provider
Dental Cleaning	Two cleanings in any 12 month period are covered. An adult cleaning is not covered for persons under age 14. For those with any condition(s) listed below, 2 additional cleanings (or any procedure that includes cleaning) will be provided during a 12 month period. • Diabetes with documented gum conditions, • Pregnancy with documented gum conditions, • Cardiovascular disease with documented gum conditions, • Kidney failure with dialysis, and • Suppressed immune system due to chemotherapy or radiation treatment, HIV Positive status, Organ Transplant or stem cell (bone marrow) transplant.
Bitewing X-rays	Covered one time in a 12 month period.
Full Mouth Survey or Panoramic X-ray	Covered one time in a 60 month period.
Individual Periapical X-rays **Intraoral Occlusal X-rays** **Extraoral X-rays**	Limited to the allowance for a full mouth survey or panoramic x-ray. If the fee meets or exceeds the allowance for a full mouth survey, it will be processed as a full mouth survey.

Sealants	Covered one time per tooth in a 36 month period. Allowed for the occlusal (chewing) surface of decay-free unrestored permanent molars. Covered for children through age 14. There is no separate benefit for preparation of the tooth or any other procedure associated with the sealant application.
Preventive Resin Restoration	Covered as a sealant above.
Fluoride Treatment	Covered twice in a 12 month period for children through age 15.
Space Maintainer	Covered for children through age 13 to maintain space left by prematurely lost baby back teeth.
Adjunctive Services	Services related to another category of covered services will be covered at the same percentage as the related category of covered services.
Palliative Treatment	Covered as a separate benefit only if no other service is provided during the visit except an exam and/or x-rays.
Oral Pathology Lab Procedures	Covered with a pathology report.

BASIC SERVICES

Basic Restorative: Fillings and preformed shell crowns, for treatment of tooth decay which results in visible destruction of hard tooth structure or loss of tooth structure due to fracture.

Oral Surgery: Extractions and certain other surgical Services and associated covered anesthesia and/or related Covered Services.

Endodontic: Certain Services for treatment of non-vital tooth pulp resulting from disease or trauma.

Periodontic: Certain Services for treatment of gum tissue and bone supporting teeth.

PROCEDURE	**BENEFIT DESCRIPTION**
Amalgam Fillings (silver fillings)	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam filling is allowed if at least 12 months have passed since the existing amalgam was placed.
Composite Resin (white plastic) Fillings	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing composite resin filling is allowed if at least 12 months have passed since the filling was placed.
Stainless Steel Crowns Resin Crowns	Covered when the tooth cannot be restored by a filling and then 1 time in a 12 month period.
Protective Filling	Covered if no other restorative service is performed on the same tooth on the same date. Not covered during a course of endodontic therapy.

Pin Retention	Covered with a basic (amalgam or composite) filling. A benefit one time per filling.
Extraction - Coronal Remnants Deciduous Tooth	Includes local anesthesia and routine post-operative care, which are not covered separately.
Extraction - Erupted Tooth or Exposed Root	Includes local anesthesia and routine post-operative care, which are not covered separately.
Therapeutic Pulpotomy	Covered for baby teeth.
Root Canal Therapy	Covered once per tooth. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Repeat Root Canal therapy	Covered if the first root canal procedure on the same tooth was performed at least 24 months earlier.
Apicoectomy	Covered once per root each 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Retrograde Filling (per root)	Covered once per root each 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not covered separately.
Root Amputation (per root)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Periodontal Scaling and Root Planing - Per Quadrant	Covered one time per quadrant of the mouth in any 24 month period.
Periodontal Maintenance Procedures Following Active Therapy	Periodontal maintenance procedures or any combination of periodontal maintenance procedures and prophylaxis (adult and child cleanings) are limited to 4 in any 12 month period.
Gingivectomy	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Gingival Flap Procedure	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Root planing, local anesthesia and routine post-operative care are not separately covered.
Osseous Surgery, Guided Tissue Regeneration (includes surgery and re-entry), Pedicle Soft Tissue Graft, Free Soft Tissue Graft (including donor site)	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Surgical Extractions of Teeth or Tooth Roots	Local anesthesia and routine post-operative care are not separately allowed as benefits.

Oral Surgery Services	Includes fistula closure, sinus perforation closure, tooth reimplantation, surgical access to expose teeth, biopsies, soft-tissue lesion removal, excision of bone tissue, excision of hyperplastic gum tissue, surgical incisions, and cyst removal. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Alveoloplasty	Not allowed as a separate benefit when performed on the same date as extractions. Includes local anesthesia and routine post-operative care.
General Anesthesia **Analgesia (Nitrous Oxide)** **I.V. Sedation**	Only one type of anesthesia procedure per date of service is allowed as a separate benefit when provided for covered oral surgical procedures.

MAJOR SERVICES

Special Restorative: Buildups (which may or may not include a post) and laboratory processed restorations (crowns, onlays) for treatment of tooth decay which results in visible destruction of hard tooth structure, or loss of tooth structure due to fracture, which cannot be restored with amalgam or composite restorations.

Prosthodontics: Services for construction or repair of fixed partial dentures (bridges), cast or acrylic removable partial dentures, acrylic complete dentures, and removable temporary partial dentures to replace completely extracted or avulsed natural permanent teeth.

PROCEDURE	BENEFIT DESCRIPTION
Re-Cement Crowns, Inlays and Onlays	Covered after 6 months from initial insertion.
Repairs to Crowns	Subject to Delta Dental's consultant review.
Re-Cement Fixed Bridges	Covered after 6 months from initial insertion of fixed bridge.
Repairs to Fixed Bridges	Subject to Delta Dental's consultant review.
Denture Adjustments	Covered after 6 months from the insertion of the full or partial denture.
Repairs to Full and Partial Dentures	Covered after 6 months from the insertion of the full or partial denture.
Tissue Conditioning per Denture Unit	Covered two times in a 36 month period.
Relining Dentures **Rebasing Dentures**	Relining or rebasing is covered at least 6 months after the initial insertion of a full or partial denture and then not more than one time in a 36 month period.

Inlays	An alternate benefit allowance for an amalgam filling will be made for the same number of surfaces. Any difference in fee is chargeable to the patient. It will be covered if 60 months have passed since the last placement. Not covered for children under age 12.
Crowns	Covered when the tooth cannot be restored by an amalgam or composite filling and if more than 60 months since the last placement. Not covered for children under age 12.
Core (Crown) Buildup including any Pins	Covered when needed to retain a crown or onlay and only when need is due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 12.
Post and Core (in conjunction with a Crown or Onlay)	Covered for endodontically treated teeth. Must be needed to retain a crown or onlay, and only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 12.
Fixed Bridges	Initial fixed bridge is covered. Replacement of an existing fixed bridge is covered if the existing fixed bridge is more than 60 months old, is not serviceable, and cannot be repaired, and there is no prior payment of covered Special Restorative or Prosthodontic benefits for the same tooth. Not covered for children under age 16.
Core (Bridge) Buildup including any Pins (in conjunction with a Bridge Abutment or a Fixed Bridge)	Covered when needed to retain a fixed bridge or endodontically treated teeth. Only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 16.
Full Dentures	Initial full dentures are covered. Replacement is covered after 60 months from the last placement. Dentures must not be able to be repaired. Personalized dentures, overdentures or associated procedures are not covered.
Partial Dentures	Initial partial dentures are covered. Replacement is covered after 60 months have elapsed since the last placement. Dentures must not be able to be repaired. Precision or semi-precision attachments are not covered. The benefit for a partial denture includes any clasps and rests and all teeth. Metal based partial dentures are not covered for children under age 16.

Temporary Removable Partial Dentures	Initial temporary removable partial dentures are covered to replace missing permanent front teeth. Replacement is covered only after 60 months have elapsed since the last placement.

ORTHODONTIC SERVICES

PROCEDURE	**BENEFIT DESCRIPTION**
Orthodontic Treatment	Orthodontics are defined as the services provided by a licensed Provider involving orthognathic surgery or appliance therapy for movement of teeth and post-treatment retention for treatment of malalignment of teeth and/or jaws including any related interceptive services.
Limitations on Orthodontic Benefits	a) No benefits will be provided for: • Replacement or repair of appliances. • Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint or related conditions. b) Periodic Orthodontic payments will end upon termination of treatment for any reason prior to completion of the case, or upon termination of the Covered Person's eligibility. c) We will make periodic payments based on the provider's treatment plan. Total case fees include active treatment and post treatment retention or stabilization. We will not make separate benefit for post treatment stabilization. d) For comprehensive orthodontic treatment in progress that began prior to eligibility in the plan, Delta Dental will reduce periodic payments using its applicable processing policies.

LIMITATIONS/EXCLUSIONS (What Is Not Covered)
GENERAL LIMITATIONS – ALL SERVICES

a. Temporary services will be covered as part of the final service. The benefit allowed for such service and the final service is limited to the benefit allowed for the final service
b. Services are covered when provided by a person legally permitted to perform such Services and are determined to be Necessary and appropriate. Benefits will be based on the terms of this plan and Delta Dental's Processing Policies, even if no monies are paid.
c. Pre- and post-operative procedures are considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.
d. Local anesthesia is considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.

EXCLUSIONS

a) Services for injuries or conditions which are covered under Worker's Compensation or employer's liability laws. Services provided by any federal or state agency. Services provided without cost by any city, county or other political subdivision. Any Services for which the person would not have to pay if not insured, except if such exclusion may be prohibited by law.
b) Any Service Started when the person was not covered under this Contract. This includes any Service Started during an applicable Waiting Period.
c) Services for treatment of birth or developmental defects, ***except*** **dental Services within the mouth for treatment of a condition related to cleft lip and/or cleft palate**.
d) Services to treat tooth structure lost from wear, erosion, attrition, abrasion or abfraction.
e) Services resulting from improper alignment, occlusion or contour.
f) Services related to periodontal stabilization of teeth (splinting).
g) Habit appliances, night guards, occlusal guards, athletic mouth guards and gnathological (jaw function) services, bite registration or analysis, or any related services.
h) Patient management services (***except*** covered anesthetic services).
i) Charges for prescribed drugs.
j) Any Experimental or Investigational treatment.
k) Services that may otherwise be covered, but due to the patient's condition would not prove successful to improve the patient's oral health.
l) Any treatment done in anticipation of future need (***except*** covered preventive services).
m) Hospital costs or any charges for use of any facility.
n) Any anesthesia service not included in Covered Services.
o) Grafts done in the mouth where teeth are not present.
p) Grafts of tissues from outside the mouth into the mouth.
q) Therapy for speech or the function of the tongue or face.
r) Treatment of any temporomandibular joint (TMJ) problems, including facial pain, or any related conditions. Any related diagnostic, preventive or treatment Services.
s) Services not performed in accordance with Colorado state laws. Services by any person other than a person licensed to perform them. Services to treat any condition, other than an oral or dental disease, abnormality or condition.
t) Teaching services.
u) Completion of forms. Providing diagnostic information. Copying of other records.

v) Replacement of lost, stolen or damaged items.
w) Repair of items altered by someone other than a Provider.
x) Any Services not included in Covered Services.
y) Services for which charges would not have been made but for this coverage, except for Services as provided under Medicaid.
z) Missed appointment charges.
aa) Preventive control programs, including home care items.
bb) Plaque control programs.
cc) Self-injury.
dd) Provisional splinting.
ee) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.
ff) Services provided for treatment of teeth retained in relation to an Overdenture.
gg) Any Prosthodontic service provided within 60 months of Special Restorative services involving the same teeth.
hh) Any Special Restorative service provided within 60 months of fixed Prosthodontic Services involving the same teeth.
ii) Fixed and removable Prosthodontic appliances (bridges and partials) are not a benefit in the same arch except when the fixed denture (bridge) replaces front teeth. Allowance is limited to the allowance for the removable partial denture.
jj) Services from a Provider other than a PPO Participating Provider.
kk) Any services not listed on the EPO Co-Payment schedule.

Delta Dental of Colorado
4582 South Ulster Street
Denver, Colorado 80237

DELTA DENTAL BENEFITS CONTRACT

The parties of this Contract are ADAMS COUNTY COLORADO, herein called the "Group," "Applicant," or "Employer" and Colorado Dental Service Inc., d/b/a Delta Dental of Colorado, herein called "Delta Dental." The attached appendices and riders constitute the entire Contract of the parties and will become binding upon the parties and their respective successors and assigns effective the 1st day of January, 2018 for a one year period and for successive one-year periods thereafter unless terminated as herein provided. This contract is issued and delivered in the State of Colorado, is governed by the laws of Colorado and is subject to the terms and conditions recited on the subsequent pages of this contract, and may not be changed, altered or terminated except in accordance with Article VII, RENEWAL AND TERMINATION of this Contract.

This DECLARATIONS PAGE supersedes any contrary provision of the subsequent sections of this contract.

DECLARATION PAGE

Group: ADAMS COUNTY COLORADO - RETIREES

Type of Contract: Delta Dental PPO

Group Number: 7738

Contract Effective Date: January 1, 2018

Contract Anniversary Date: January 1st

	PPO Provider	Delta Dental Premier Provider	*Non-Participating Provider
Covered Services	**Plan Pays**	**Plan Pays**	**Plan Pays**
Diagnostic & Preventive Services			
Oral Exams and Cleanings	100%	100%	100%
Sealants	100%	100%	100%
Fluoride Treatment	100%	100%	100%
All X-rays	80%	80%	80%
Basic Services			
Basic Restorative (Fillings)	80%	80%	80%
Simple Extractions	80%	80%	80%
Major Services			
Complex Oral Surgery	50%	50%	50%
Denture Repair/Relines/Rebases	50%	50%	50%
Endodontics (Root Canal Therapy)	50%	50%	50%
Special Restorative (Crowns, Onlays)	50%	50%	50%
Prosthodontics (Dentures, Bridges)	50%	50%	50%
Periodontics (Gum Disease Treatment)	50%	50%	50%

Orthodontia is not a covered benefit. See Delta Dental Benefits Rider DDCO-SPEC Voluntary for details of all benefits and limitations.

***Important: Non-Participating Providers are allowed to balance bill. Subscribers and/or Dependents are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Provider.**

Age

Type	Age Limit	Coverage Thru
Dependent Child	26	Month

Deductible (January 1st - December 31st)

Class	Type	Network	Amount
All Covered Classes	Individual coverage amount	PPO and Non-PPO	$75

Maximum (January 1st - December 31st)

Class	Type	Network	Amount
All Covered Classes	Individual coverage amount	PPO and Non-PPO	$2000

Eligibility Waiting Period
Within 60 days of retirement.

Enrollment Type
The enrollment type is Late Enrollment. (A Late Enrollee must be enrolled for 12 consecutive months before any Basic Benefits will be covered and 24 months before any Major Benefits will be covered.) LATE ENROLLMENT means enrollment occurring after the period of initial eligibility. The exceptions to this rule are:

- A Subscriber or Dependent who involuntarily loses coverage through another group insurance plan. Involuntary loss of coverage is defined as loss due to death, divorce, loss of job, or termination of benefits by employer. Such Subscriber or Dependent will be allowed to enroll within 31 days of the loss of coverage with satisfactory proof of coverage loss and will not be considered a Late Enrollee upon enrollment.
- A dependent child prior to their 4th birthday may be added on any Contract Anniversary Date. Such child will not be considered a Late Enrollee upon enrollment.

Eligible Participants – All county retirees are eligible within 60 days of retirement. Also eligible at your option are your spouse and dependent children to the end of the month in which they attain age 26.

Where two Subscribers who are spouses and are both eligible for coverage under this contract, they may be enrolled together or separately, but not both. Dependent children may be enrolled under one parent.

Rate Coverage

Coverage Tier	Rate Amount
SUBSCRIBER	$ 35.99
SUBSCRIBER/ONE	$ 72.00
SUBSCRIBER/TWO+	$ 108.01

These rates are contingent upon the minimum percent enrollment as stated in the original quote, in accordance with the eligibility provisions in Article III.

Riders or Appendices Attached

Countersigned:
Delta Dental of Colorado

Signature

_____
Date

Accepted:
ADAMS COUNTY COLORADO - #7738 - RETIREES

_____
Signature

_____
Date

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ARTICLE I. DEFINITIONS

The terms below apply to this Contract:

1.01 **ALTERNATE BENEFIT** means the amount allowed based on the least costly, commonly accepted Service used to treat a dental problem when a Covered Person selects more costly treatment options.

1.02 **APPLICANT** means the Group or Employer wishing to provide dental benefits.

1.03 **BENEFITS** means the Services described in this Contract in the Benefits Rider, BENEFITS, LIMITATIONS and EXCLUSIONS.

1.04 **COINSURANCE** means the percent of a Covered Amount which Delta Dental will pay. The Coinsurance for each type of Covered Service appears in the Declaration Page. The Coinsurance that applies to a Subscriber may vary by type of dental Service.

1.05 **COMPLETED** means:

- For Root Canal Therapy, the date the canals are permanently filled.
- For Fixed Bridges (fixed partial dentures), Crowns, Inlays, Onlays, and other laboratory prepared restorations: The date the restoration is cemented in place.
- For Dentures and Partial Dentures (removable partial dentures): The date that the final appliance is first inserted in the mouth.
- For all other Services: The date the procedure is Started.

For benefit payment purposes, the date a Covered Service is incurred is the date Completed.

1.06 The **CONTRACT ANNIVERSARY DATE or ANNIVERSARY DATE** is noted on the Declaration Page of this Contract. The anniversary date is the first day of each Contract Year following the initial Contract Year.

1.07 **CONTRACT** means the agreement between Delta Dental and the Applicant. It includes attached appendices, exhibits and riders, if any. This Contract is the whole agreement between the parties.

1.08 **CONTRACT TERM** means the time from the Effective Date of the Contract until it is terminated.

1.09 **CONTRACT YEAR** is the 365 days beginning on the Effective Date of this Contract, and each year after unless the contract is terminated. The contract year is 366 days in a leap year.

1.10 **COVERED AMOUNT** means:

- For PPO Providers, the lesser of the PPO Provider's Allowable fee or the fee actually charged.
- For Premier Participating Providers, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.
- For all other Providers, the lesser of the non-participating Maximum Plan Allowance, or the fee actually charged.

1.11 **COVERED PERSON** means:

- An enrolled Retiree or Dependent for whom the monthly Premium is paid.
- A person who elects continued coverage and for whom the monthly Premium is paid.

1.12 **COVERED SERVICES** means the Services described in this Contract or attachments, subject to the limitations and exclusions noted.

1.13 **DEDUCTIBLE** means the amount the Subscriber must pay before Delta Dental pays. The Deductible is shown on the Declaration Page. If there is a limit to the deductible that a family must pay, that will be shown on the Declaration Page.

1.14 **DELTA DENTAL PPO** is a preferred provider plan. PPO Providers provide services at the PPO Discounted Fee Schedule.

1.15 **DENTAL INJURY** is an injury to a Sound Natural Tooth (other than a chewing injury) sustained while covered under the Contract, which is caused solely by a sudden violent act, or accident that could not be predicted in advance or avoided. A chewing injury is any injury that occurs during the act of biting or chewing regardless of whether the injury is caused by biting food or a foreign object.

1.16 DEPENDENT means:

- The Subscriber's lawful spouse, including civil union partner.
- Civil Union partner must meet each of the requirements listed below:
  - ❖ They must be at least 18 years old.
  - ❖ They must be of the same or opposite sex.
  - ❖ They must not be a partner in another civil union.
  - ❖ They must not be married to another person.
  - ❖ They must not be related.
  - ❖ They must have entered into a civil union based on the guidelines of Article 15 of Title 14, C.R.S. recognized pursuant to Colorado Law.
- A child under the Dependent Age Limit shown on the Declaration Page.
- A child who reaches the Dependent Age Limit stated on the Declaration Page and is incapable of self-support because of physical or mental disabilities that began before reaching the Dependent Age Limit, and is dependent on the Subscriber. Delta Dental may annually request proof of such disability and dependency. Failure to submit such proof will terminate coverage.

Eligible children are natural children, stepchildren, children under court-ordered guardianship, adopted children, and children of a civil union.

No one may be covered as a Dependent and also as a Subscriber under this Contract. If both parents are covered as Subscribers, children may be covered as Dependents of one parent only.

Persons in active military service are not eligible Dependents.

If the Group chooses whether to cover a Civil Union Partner or a Domestic Partner that option will be noted on the Declaration Page.

1.17 EFFECTIVE DATE is the date coverage begins.

1.18 ELIGIBLE CLASS is a group of Retirees who are allowed to enroll under the Contract. A list of Eligible Classes is on the Declaration Page.

1.19 ELIGIBILITY WAITING PERIOD means the time that a person must be employed before they may enroll. The Eligibility Waiting Period is chosen by the Applicant and may differ by Eligible Classes. The Eligibility Waiting Period, if any, is noted on the Declaration Page and in Article III.

1.20 EMERGENCY TREATMENT OR EMERGENCY SERVICE means any necessary Service that is rendered as the direct result of an unforeseen occurrence or combination of circumstances that requires immediate, urgent action or remedy

1.21 **EMPLOYEE** means someone who works the minimum number of hours defined by the Employer.

1.22 **EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES** means those services not generally accepted in the dental community as being safe and effective, as defined by Delta Dental.

1.23 **FUNCTIONING NATURAL TOOTH:** A permanent (adult) Natural Tooth which is performing its normal role in the masticating (i.e. chewing) process in the Subscriber's upper or lower arch and which is opposed in the Subscriber's other arch by another Natural Tooth or prosthodontics (i.e. artificial) replacement. Third molars are not considering Functioning Natural Teeth.

1.24 **GROUP** means the Applicant or Employer contracting for dental benefits.

1.25 **LATE ENROLLMENT** means to enroll after first becoming eligible. A Late Enrollee must be enrolled for 12 months before Covered Services beyond those noted on the Declaration Page are covered.

The exceptions to this rule are:

- A Subscriber or Dependent who loses coverage through another group plan. (Loss of coverage is defined as loss due to death, divorce, loss of job, or termination of benefits by the employer.) Such Subscriber or Dependent will be allowed to enroll within 31 days of the loss of coverage with proof of loss. The person will not be a Late Enrollee.
- A Dependent child under age four may be added on any Contract Anniversary Date. The child will not be a Late Enrollee.

If the Applicant chooses Late Enrollment, the option will be noted on the Declaration Page.

1.26 **MAXIMUM PLAN ALLOWANCE** means the most that will be allowed for a procedure. Delta Dental reviews the limits twice a year. We may increase or decrease fees for any procedure.

1.27 **MEMBER** means any person eligible and enrolled for coverage under this plan.

1.28 **NATURAL TOOTH** means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e., not manufactured). Organic portions of a tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).

1.29 **NECESSARY** means a Service that Delta Dental decides, using accepted standards of dental care, is needed and fitting for treatment of the Subscriber's dental condition.

1.30 **NON-PARTICIPATING PROVIDER** means a Provider who does not contract with Delta Dental.

1.31 **OPEN ENROLLMENT** means a period prior to the Anniversary Date when eligible Subscribers and their Dependents may enroll. They may also change from one plan to another if the Contract permits them to do so. Coverage is effective on the Applicant's Anniversary Date.

If the Applicant chooses an Open Enrollment period, the option will be noted on the Declaration Page.

1.32 **OUT-OF-POCKET MAXIMUM** means the maximum amount you will have to pay for allowable covered expenses under this plan.

1.33 **PARTICIPATING PROVIDER** means a Provider who contracts with Delta Dental.

- **Premier Participating Provider** means a Provider who has a Premier Participating Provider Agreement with Delta Dental.
- **PPO Participating Provider** means a Provider who has a PPO Provider Agreement with Delta Dental.

1.34 **PPO PROVIDER'S ALLOWABLE FEE** means the lesser of the fee from the PPO Discounted Fee Schedule that the PPO Provider has agreed to or the fee actually charged for a single procedure.

1.35 **PREMIUM** means the amount of money paid for each Subscriber to buy the Benefits provided in this Contract.

1.36 **PRE-TREATMENT ESTIMATE** is a review of a Provider's plan of care to decide what is covered under this Contract.

1.37 **PROVIDER** means a person licensed in dentistry.

1.38 **SERVICE** means a procedure or supply provided by a Provider.

1.39 **SOUND NATURAL TOOTH** means a Natural Tooth that is fully restored to function, does not have any decay, is not more susceptible to injury than a virgin tooth, and is without periodontal disease.

1.40 **STARTED** means:

- For Full Dentures or Partial Dentures (removable partial dentures): The date the final impression is taken.

- For Fixed Bridges (fixed partial dentures), Crowns, Inlays, Onlays and other laboratory prepared restorations: The date the teeth are first prepared (i.e., drilled down) to receive the restoration.
- For Root Canal Therapy: The date the pulp chamber is first opened.
- For Periodontal Surgery: The date the surgery is performed.
- For All Other Services: The date the Service is performed.

1.41 SUBSCRIBER means:

- An enrolled Retiree or Dependent for whom the monthly Premium is paid.
- A person who elects continued coverage and for whom the monthly Premium is paid.

1.42 TIED-TO-MEDICAL means dental benefits linked to the medical plan that the Applicant offers. Only those who enroll in a medical plan may be Subscribers under a dental plan that is tied-to-medical.

If the Applicant chooses Tied-To-Medical, the option will be noted on the Declaration Page.

1.43 WAITING PERIOD means the time from a Subscriber's Effective Date until certain Services are covered. If a Service is Completed before the Waiting Period for that Service ends, that Service is not covered. If a Person's coverage ends and the Person becomes covered again, the Effective Date is the most recent Effective Date unless stated otherwise in the Contract.

If Waiting Periods apply, they are noted on the Declaration Page.

ARTICLE II. MONTHLY PREMIUM

2.01 PREMIUM DUE DATE. The Group agrees to pay Delta Dental the Monthly Premium for each Subscriber on or before the first day of the month for which the premium is due.

2.02 MONTHLY PREMIUM. The Monthly Premium for each Subscriber is noted on the Declaration Page.

2.03 INITIAL PREMIUM. This Contract is not effective until Delta Dental receives the initial Premium. Future Premiums are due on the first day of each month.

2.04 PREMIUMS AT TERMINATION. If this Contract terminates for any reason, the Applicant must pay all Premiums due but not paid.

2.05 CHANGE OF PREMIUM RATES. Absent an amendment agreed to by Applicant and Delta Dental, Premiums will not change during a Contract Year except as noted in Section

2.06 EFFECT OF PREMIUM TAX CHANGES. If a new tax is imposed on Delta Dental on the amount of Premium or the number of persons covered, the Monthly Premium will be increased by the amount of any such new tax. If the rate of an existing tax on the amount of Premium or the number of persons covered is increased, the Monthly Premium will be increased by the amount of the increased tax.

2.07 CLERICAL ERRORS. Clerical errors or delays in data related to coverage will not affect coverage that would otherwise be in force. Upon discovery of such errors or delays, charges will be adjusted.

2.08 GRACE PERIOD. Except for the initial Premium, a Grace Period until the 45 day grace period Premium is due is allowed. Coverage remains in force during the Grace Period unless cancelled by the Group. If the Premium is not paid by the end of the Grace Period, the Contract will terminate as of the last day of the Grace Period. Premiums are due through the last day of the Grace Period.

2.09 REFUNDS. Group must provide timely notice to Delta Dental when a Subscriber is no longer eligible. Group must pay the Monthly Premium through the date that notice is given. If Premium is paid for a Person who is no longer eligible and timely notice was given, Delta Dental will refund the Premium for the period paid in error. The refund will be paid for up to three months or to the last Contract Anniversary, whichever is less. If Benefits were paid for a person after coverage terminated, the full amount of the Benefits paid in error must be repaid to Delta Dental before any Premium will be refunded.

ARTICLE III. ELIGIBILITY

3.01 ELIGIBILITY. A Subscriber in an Eligible Class may enroll 60 days after the Eligibility Waiting Period. They may also enroll during an Open Enrollment period if offered by the Employer.

a) **BECOMING COVERED.** Delta Dental must receive enrollment data for each Subscriber in a format acceptable to Delta Dental. The enrollment data must be received within 60 days of a Subscriber or Dependent's enrollment. The enrollment data must include the Subscriber's address, gender, social security number, date of birth and effective date. If the Subscriber chooses to enroll Dependents, each Dependent's name (including surname if different from Subscriber's), relationship to the Subscriber, address, gender, social security number and date of birth must be submitted.

- Coverage is effective after the eligibility waiting period shown on the Declaration Page.
- A Subscriber not enrolled in the plan may not enroll Dependents.

b) **LATE ENROLLMENT**

- Late Enrollment. A Subscriber who does not enroll within the period described in Article III Section 3.01a will be considered a Late Enrollee.
- Open Enrollment. A Subscriber who fails to enroll within the period described in Article III, Section 3.01a may enroll at the next Open Enrollment.
- Tied-to-Medical. Eligibility for the dental plan will be the same as that required by the medical plan.

c) **MAINTAINING COVERAGE.** The Group will give Delta Dental a list of any plan additions, changes, or terminations on or before the first day of each month. Delta Dental is not required to provide Benefits for a Subscriber or Dependent not on the list and for whom the monthly Premium is not paid.

3.02 SUBSCRIBER ELIGIBILITY. Subscribers may enroll within 60 days of the date they first become eligible.

a) Depending on the Enrollment Type of the group, Eligible Subscribers who do not enroll as described above may enroll

- For Open Enrollment Groups, only during Open Enrollment. Eligible Subscribers who enroll and later drop the plan may enroll only during Open Enrollment.
- For Late Enrollment Groups, they may be able to enroll as a Late Enrollee.

b) Eligible Subscribers who lose coverage through another source may enroll with proof of loss. (Loss of coverage is defined as loss due to death, divorce, job loss, or termination of benefits by the employer.) They must enroll within 31 days of the loss of coverage.

3.03 DEPENDENT ELIGIBILITY. Dependents of an eligible Subscriber may enroll within 31 days of the following:

- The date the Employee become eligible to enroll (within 60 days of retirement). The effective date is that of the Subscriber.
- New Dependents must be enrolled within 31 days and will be covered immediately following loss of coverage. Newborns and adopted children will be covered on the date of birth or date of placement for adoption.
- The date the Contract is amended to provide Dependent coverage. The Plan becomes effective on the first day of the month following this change.

a) If the group's Enrollment Type is Tied-to-Medical and Dependent enrollment is desired, the Dependents must be the same as those on the medical plan.
b) New Dependents must be added within 31 days. If not added during this time:
   - If the group's Enrollment Type is Open Enrollment, the Dependent can be added during the Open Enrollment period.
   - If the group's Enrollment Type is Late Enrollment, a Dependent can be added as a Late Enrollee.
c) Depending on the Enrollment Type of the group, Eligible Dependents who do not enroll as described above may enroll
   - For Open Enrollment Groups, only during Open Enrollment. Dependents who enroll and later drop the plan may enroll only during Open Enrollment.
   - For Late Enrollment Groups, they may be able to enroll as a Late Enrollee.
d) Eligible Dependents who lose coverage through another source may enroll with proof of loss. (Loss of coverage is defined as loss due to death, divorce, loss of job, or termination of benefits by the employer.) They must enroll within 31 days of the loss.

3.04 TERMINATION OF COVERAGE. A Subscriber's plan will terminate at the earliest of:

- The last day of the month Delta Dental receives a written request to cancel;
- The last day of the month the Subscriber is not eligible for coverage;
- The last day of the month the Contract terminates;
- The last day of the month of the period for which Premium is paid;
- The last day of the month the Subscriber enters full-time military service of any country; or as to any Dependent, the last day of the month the person no longer qualifies as a Dependent.

Delta Dental must be notified within 60 days if a Dependent or Subscriber is no longer eligible.

Family and Medical Leave ACT (FMLA) -
If coverage ends during an Employer approved FMLA leave, coverage may be reinstated upon return to work within the terms of the FMLA leave. Pre-existing conditions, limitations and other waiting periods will not be imposed unless they were in effect for the Subscriber and/or his or her Dependents when coverage terminated.

3.05 INVOLUNTARY LOSS OF COVERAGE DUE TO STRIKE, LEAVE OF ABSENCE OR LAYOFF. If a Subscriber loses coverage due to strike, lay-off or leave of absence, and returns to work within 6 months, he may re-enroll on the first day of the month after his return to work. If the absence exceeds 6 months, he will be treated as a new Subscriber. Contract provisions relating to the Deductible, Coinsurance, Contract Year Maximum, and Waiting Periods, if any, will apply as to new coverage. The following exception applies:

Delta Dental of Colorado complies with the Uniformed Services Employment and Reemployment Rights Act (USERRA). Subscribers called to active duty may enroll as if there had been no leave of absence if they are still in an Eligible Class of Subscriber when they return to work. USERRA allows Subscribers to elect continuation of coverage when coverage would terminate due to an absence to serve in the uniformed services.

Services received by a person who is not eligible due to leave of absence are not covered unless the person elects continued coverage as provided in Article VIII or according to USERRA where applicable.

3.06 INVOLUNTARY LOSS OF "OTHER COVERAGE". A person who loses dental coverage from another source will be allowed to enroll with proof of the loss. (Loss of coverage is defined as loss due to death, divorce, loss of job, or termination of benefits by the employer.) The person must enroll within 31 days of the loss. Coverage will begin immediately following loss of coverage date.

3.07 VOLUNTARY TERMINATION OF COVERAGE. In groups with Open Enrollment, a Subscriber who cancels his plan may only re-enroll at the next Open Enrollment. In groups not offering Open Enrollment, a Subscriber who cancels his plan and wants to reenroll will be a Late Enrollee. The requirements of Late Enrollment will apply.

3.08 REVIEW OF RECORDS. Applicant will permit Delta Dental, with advance written notice, to inspect records of Applicant in order to confirm the lists of Subscribers prepared by Applicant. Delta Dental may verify Applicant's compliance with Article II. Delta Dental may use auditors or other agents for this purpose.

ARTICLE IV. COORDINATION OF BENEFITS

4.01 DEFINITIONS. Coordination of Benefits means taking into account other Plans when paying Benefits.

Plan means a Plan that provides benefits or Services for dental care on a group or individual basis. This includes group and blanket insurance, self-insured and prepaid plans, automobile fault or no-fault insurance and government plans (except Medicaid).

Primary Coverage means Coverage that must pay first. The Primary Plan must pay up to its full liability.

Secondary Coverage means Coverage that pays a claim after the Primary Plan pays.

4.02 WHEN COORDINATION OF BENEFITS APPLIES.

Coordination of Benefits applies when a Subscriber is covered under more than one Plan. The Benefits of this Plan will be coordinated with the other Plan(s).

4.03 RULES FOR COORDINATION OF BENEFITS.

The rules for the order of payment are shown below.

- The Plan covering a Subscriber as an Employee is primary to a policy on which the Covered Person is a Dependent.
- For Dependent children, primacy will be determined as follows.

The Plan of the parent whose birthday occurs earlier in a year will be primary.

If the parents are separated or divorced, the Plan of the parent who is ordered by court decree to pay for dental expenses will be primary.

The Plan of the parent with custody is Primary. If the custodial parent has remarried, the stepparent's Plan is Secondary and the Plan of the parent without custody pays third.

If the above rules do not establish an order of benefit payment, the Plan that has covered the Person the longest will be Primary. If that Plan covers a person who has been laid off or is retired, it will be Secondary to any other Plan.

A group Plan that does not have a Coordination of Benefits clause is primary.

If this Plan is Primary, we will pay claims without regard to benefits provided by any other Plan. If this Plan is Secondary, we will pay claims so that together with the other Plan payment will not exceed 100% of the allowable expense or this Plan's maximum benefit.

ARTICLE V. CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

5.01 PAYMENT OF CLAIMS. Covered services will not include, and payment will not be made for claims for dental Services not listed in this Contract and any Appendix, Amendment, or Rider. Claims submitted to Delta Dental must use terms of the American Dental Association Current Dental Terminology (Code on Dental Procedures and Nomenclature).

5.02 APPEAL OF AN ADVERSE DETERMINATION OF A CLAIM.

A. Internal Appeal Process - First Level Appeals

A Subscriber may appeal an adverse claim decision within 180 days of the date of the original Explanation of Benefits by writing to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

A Subscriber may submit additional information in support of the appeal.

Appeals are reviewed by an impartial Provider of the same or similar specialty as would typically manage the case being reviewed. The reviewing provider will not have been involved in the initial decision.

The decision will be sent to the Subscriber with the rationale for the decision. The decision will be made within 15 calendar days for pre-service denials. Post-service decisions will be made within 30 calendar days.

B. Internal Appeal Process - Second Level Appeals (Not available for Self-Funded Groups)

If a denial is upheld at the first level, a Subscriber may request a second level appeal. The request must be received within 30 days of the First Level Appeal decision. It must be submitted to the address noted in 5.02A. Additional information may be submitted. Second level appeals will be reviewed by an impartial provider with the appropriate expertise. The reviewer will not have been involved in the first appeal. The Subscriber, or a designated representative, may request to appear before the reviewer in person or may present by conference call.

A Second Level Appeal decision will be issued within 7 days of the review meeting.

C. Internal Appeal Process - Expedited Appeals

Subscribers may request an expedited appeal when the time for a standard review would seriously jeopardize the life or health of the Subscriber, would jeopardize the Subscriber's ability to regain maximum function, or, for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently.

Expedited review decisions will be issued within 72 hours.

D. Independent External Review (Not available for Self-Funded or Federal Groups)
Where Delta Dental makes an Adverse Determination and the Subscriber exhausts the internal appeals process, the Subscriber has the right to request an external review. Delta Dental will notify the Subscriber of the right, if any, to request an external review after the First Level appeal.

Requests for an independent external review must be in writing. They must include a completed external review request form as specified by the Colorado Division of Insurance. The Subscriber must submit the request within four months of the completion or exhaustion of the internal appeals process. The internal appeals process is completed or exhausted upon Subscriber's receipt of notice of the adverse determination or upon Delta Dental's failure to comply with Colorado Revised Statues §§ 10-16-113, 10-16-113.5, or Colorado Insurance Regulations 4-2-17 or 4-2-21.

Subscriber may request expedited external review. All requests must be submitted to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

A signed consent authorizing Delta Dental to disclose protected health information pertinent to the external review is also required.

Delta Dental adheres to timeframes set forth by Colorado Regulation 4-2-21 in the processing of Independent External Reviews. Within 45 days after the receipt of the request for external review (72 hours for expedited external review), the external review entity shall deliver a written decision to the Subscriber, Delta Dental, the provider, and the Commissioner.

5.03 CLAIMS FROM NON-PARTICIPATING PROVIDERS. Payment for Completed Covered Services from a Non-Participating Provider will be based on the non-participating Maximum Plan Allowance. The Subscriber will be responsible for the full cost of Service.

5.04 CLAIMS FROM PARTICIPATING PROVIDERS. Payment for Completed Covered Services provided by a Participating Provider will be made directly to the Provider. The patient does not have to pay any amount above what Delta Dental allows. If the Participating Provider charges more for a Service than Delta Dental allows, that amount is not chargeable to the patient.

5.05 TIME FRAME FOR SUBMISSION OF CLAIM. Delta Dental may not pay claims submitted more than 12 months after the date the Service is Completed. If a Participating Provider failed to submit a claim within this time, the Subscriber will not be liable for the amount that Delta Dental would have paid.

5.06 AVAILABILITY OF PROVIDER. A Subscriber may elect the Service of any licensed Provider, but neither Delta Dental nor Applicant guarantees the availability of any Provider.

5.07 RIGHT TO INFORMATION AND RECORDS. Delta Dental may receive records related to the treatment of a Subscriber from any Provider. Delta Dental may require a Subscriber to be examined by a dental consultant retained by Delta Dental. Delta Dental will maintain records in a confidential manner in accordance with federal and state law.

5.08 EXTENDED COVERAGE. Delta Dental benefits will end if this Contract is terminated or if a person's coverage is cancelled. Delta Dental will cover no further Services except as described below.

If a Covered Service Started before coverage ends, but the Covered Service is Completed after it ends, Delta Dental will pay Benefits for the Covered Service as follows:

- Benefits will be paid in the amount that would have been paid and subject to the same terms as would have applied if the Person's coverage were still in effect.
- Benefits will be paid only if the Covered Service is Completed within 60 days after the date the Person's coverage ended.

No benefit will be paid if the Covered Service is Started after coverage ends.

5.09 PRE-TREATMENT ESTIMATE. Before starting treatment that may cost $400 or more, Subscribers may request an estimate from Delta Dental of what is covered. Pretreatment estimates are not required.

5.10 SUBROGATION. Delta Dental may pursue on its own or with a Covered Person a claim against a third party. If Delta Dental pays a claim for injuries to a Covered Person and the Covered Person settles with a third party for an amount that includes such costs, the Covered Person must refund Delta Dental the amount equal to the benefit payment made to, or on behalf of, the Covered Person.

ARTICLE VI. GENERAL TERMS AND CONDITIONS

6.01 NOTICES. Any notice under this Contract will be valid if given by either the Applicant or Delta Dental to the other. In the case of the Applicant, notice may be given to a designated agent. The notice will be effective upon the date of mailing.

6.02 NOTICES TO SUBSCRIBERS. Notice to a Subscriber will be in writing and sent by regular US mail to the current address in Delta Dental's records. If agreed to by Delta Dental and the Subscriber, notices may be sent via email.

6.03 LEGAL ACTION. No action at law or in equity may be filed in order to recover on this Contract prior to the expiration of 60 days after final notice of claim has been filed in accordance with the requirements of this Contract.

6.04 REPRESENTATIONS. All statements made by the Group or by an individual will be deemed representations and not warranties.

6.05 ENTIRE CONTRACT; AMENDMENTS. This Contract is the complete agreement between Delta Dental and the Group. This Contract may not be orally amended or changed. This Contract may at any time be amended and changed by written agreement between Delta Dental and the Group. Any such amendment will be binding on all Subscribers regardless of the date their coverage became effective or the date treatment was Started.

6.06 CONTRACT CHANGES. No agent or employee of Delta Dental may change the Contract or waive any of its provisions. No change in the Contract will be valid unless approved in writing by an authorized Delta Dental employee.

6.07 GROUP'S ACCESS TO RECORDS. Delta Dental agrees that Group or its designated representative may access all files and records pertinent to the Group in accordance with federal and state laws. The group must give written advance notice.

6.08 SETTLEMENT OF DISPUTES. Any dispute between Delta Dental, a Participating Provider, and Subscriber, or any combination of these, must be settled by arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association. Except for ERISA covered claims, disputes include adverse claim decisions not settled by the appeals process. Judgment on the award rendered by the Arbitrator(s) may be entered in any Court having jurisdiction. Arbitration may be initiated by any party to a dispute by giving notice to each party, by filing two copies of such notice with the American Arbitration Association and by complying with other applicable provisions of the Association's rule.

6.09 PARTICIPATING PROVIDER. Delta Dental will make reasonable efforts to provide Applicant a list of Participating Providers. The list may be provided in different formats. The Providers may change from time to time, and Delta Dental reserves the right to change the list without prior notice to the Applicant.

Neither Delta Dental nor Applicant is liable for any act or omission by Providers or their agents or employees who provide or contract to provide dental Services under this Contract. Providers who participate with Delta Dental are independent contractors. They are neither agents nor employees of Delta Dental. Nor is Delta Dental an agent or employee of any Participating Provider. Delta Dental will not be responsible for any claim or demand for damages arising out of any injuries suffered by a Subscriber while receiving care from any Participating provider or in any Participating provider's facilities.

6.10 SUBSCRIBER BENEFIT BOOKLET. Delta Dental will give a Subscriber Benefit Booklet to the Group. The Group will make the booklet available to each Subscriber. If an amendment to this Contract will materially affect the Benefits in the booklet, we will give a revised Subscriber Benefit Booklet or inserts showing the change to the Group.

6.11 PHYSICAL EXAMINATION. Delta Dental, at its own expense, may examine an individual for whom a claim or request for pre-estimation of Benefits is pending under this Contract.

6.12 GENDER. The use of the singular will include the plural and the plural the singular. Use of any gender will include all genders.

6.13 NON-DISCRIMINATION. Delta Dental does not use health factors to determine benefits or premium rates. Health factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability.

6.14 HIPAA PRIVACY & SECURITY. Delta Dental complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security regulations.

6.15 AGREEMENT WITH STATE LAW. Any requirement in this Contract which on its effective date is in conflict with the laws of the state in which any Covered Person lives is hereby changed to the minimum requirement of such laws.

ARTICLE VII. RENEWAL AND TERMINATION

7.01 RENEWAL. The Contract will renew for one-year periods unless either party elects not to renew by giving the other party written notice. Notice must be received at least 60 days before the end of the current Contract year. If there are changes to the rates or other terms of this Contract effective on an Anniversary Date, Delta Dental will provide notice of the proposed changes with the notice of renewal.

7.02 TERMINATION. This Contract may be terminated as follows:

a) By either the Group or Delta Dental at the end of the initial Contract or at the end of any contract year if the required notice of non-renewal is given.
b) If Premium is not paid within **30** days of the due date, Delta Dental will give notice that payment is past due. If payment is not received by the last day of the Grace Period, Delta Dental may terminate the Contract.
c) The Group may terminate if Delta Dental fails to provide the Benefits under the Contract and does not correct the failure within 60 days.
d) Delta Dental may terminate if enrollment falls below the required percent shown on the quote. Delta Dental may propose to the Group adjustments in rates, Benefits, or copayments to correct adverse group experience that could result from a reduction in size. Within 30 days, the Group will select an alternative in writing. If an alternative is not selected, Delta Dental may terminate the Contract.
e) Group may terminate by written notice of intent to terminate as of any date other than the end of the Contract Term. The termination date will be the last day of the month during which Delta Dental received the Group's written notice of intent to terminate.
f) Delta Dental may terminate if the number of enrolled Subscribers drops below the required number in the quote. Delta Dental may propose to the Group alternative rates, Benefits, or copayments necessary to correct adverse group experience that could result from such reduction in size. Within 30 days, the Group will select an alternative by written notice to Delta Dental. If an alternative is not selected, Delta Dental may terminate the Contract.
g) Delta Dental may terminate upon any fraud or misrepresentation by the Applicant. With respect to coverage of a Subscriber, fraud or misrepresentation by the Subscriber or such person's representative may result in termination.

7.03 In the event of termination by Delta Dental, all Benefits will end and Delta Dental will have no further obligations as of the last day of the month in which written notice of termination is effective. Premium must be paid through that period. Delta Dental will pay for Services Started while a person was covered under the Contract but Completed after the person's coverage ends pursuant to Section 5.08, Extended Coverage.

7.04 If Group has not paid Premiums to Delta Dental for a period up to and including the termination date, Group will remit such Premium within 30 days of termination.

7.05 REINSTATEMENT.

Delta Dental, at its sole discretion, may reinstate a Contract that was terminated for non-payment of Premium. If Delta Dental reinstates a Contract, the following rules will apply:

a) All Premiums then due and unpaid must be paid, including the Premium for the Grace Period.
b) Interest on past due Premiums must be paid at a rate of 1.5% per month or the highest rate allowed by state law if less.
c) Delta Dental may review the claim experience for the group and, based on its analysis, offer to reinstate the group at a different Premium rate than was in force at the time the Contract lapsed.
d) A Contract Reinstatement Fee of $50.00 must be paid.

ARTICLE VIII. CONTINUATION COVERAGE

8.01 Continued Health Coverage required by the State of Colorado (State Continuation) applies to Groups not subject to COBRA.

Subscribers covered under this Contract, or a similar contract it replaces, for at least 6 months may be able to continue coverage for up to 18 months under State Continuation. Their premium and benefits will be the same as those for active Subscribers, except that the Subscriber will be responsible for the Premium. The Employer or Group must administer State Continuation according to state law.

State Continuation coverage is effective upon loss of coverage. Within 60 days of the loss, the Group must send enrollment information and premium to Delta Dental for the Subscriber's benefits to continue.

State Continuation coverage will terminate on the earliest of the following:

a) the last day of the month after 18 months of continued coverage;
b) the day the Contract terminates;
c) the last day of the month that premium is paid;
d) the day the person becomes entitled to Medicare;
e) the day the person is eligible for coverage under another group plan; or
f) in the case of a Dependent child, the day he no longer meets the definition of Dependent.

COVERED DENTAL SERVICES

Subject to the limitations and exclusions included in this Contract, the Completed dental Services are Benefits when provided by a Provider (or other person legally permitted to perform such Services by authority of license) and are determined under the standards of generally accepted dental practice to be Necessary and appropriate. Benefits will be determined based on the terms of this Contract and Delta Dental's Processing Policies.

DIAGNOSTIC & PREVENTIVE SERVICES

Diagnostic: Certain Services performed to assist the Provider in evaluating the existing conditions and determining the dental care required.

Preventive: Certain Services performed to prevent the occurrence of dental abnormalities or disease.

PROCEDURE	BENEFIT DESCRIPTION
Oral Exam (All exam types)	One exam in any 12 month period is covered. One comprehensive oral exam is covered per covered person per dental office. There is no separate benefit for diagnosis, treatment planning or consultation by the treating provider.
Dental Cleaning	One cleaning in any 6 month period is covered. Not covered within 6 months of a periodontal maintenance procedure. An adult cleaning is not covered for persons under age 14. For those with any condition(s) listed below, 2 additional cleanings (or any procedure that includes cleaning) will be provided during a 12 month period. • Diabetes with documented gum conditions, • Pregnancy with documented gum conditions, • Cardiovascular disease with documented gum conditions, • Kidney failure with dialysis, and • Suppressed immune system due to chemotherapy or radiation treatment, HIV Positive status, Organ Transplant or stem cell (bone marrow) transplant.
Sealants	Covered one time per tooth in a 36 month period. Allowed for the occlusal (chewing) surface of decay-free unrestored permanent first and second molars. Covered for children to age 15. There is no separate benefit for preparation of the tooth or any other procedure associated with the sealant application.
Preventive Resin Restoration	Covered as a sealant above.

Fluoride Treatment	Covered up to two times in a 12 month period for children to age 16.
Space Maintainer	Covered for children to age 14 to maintain space left by prematurely lost baby back teeth.
Bitewing X-rays	Covered two times in a 12 month period.
Full Mouth Survey or Panoramic X-ray	Covered one time in a 60 month period.
Individual Periapical Xrays **Intraoral Occlusal X-rays** **Extraoral X-rays**	A maximum of 4 periapical x-rays are covered in a 12-month period when submitted separately. Limited to the allowance for a full mouth survey or panoramic x-ray. If the fee for any combination of individually submitted x-rays meets or exceeds the allowance for a full mouth survey, it will be processed as a full mouth survey.
Oral Pathology Lab Procedures	Covered with a pathology report.

BASIC SERVICES

Adjunctive: Certain additional Services, including emergency palliative treatment, performed as a temporary measure that does not affect a definitive cure.

Basic Restorative: Fillings and preformed shell crowns, for treatment of tooth decay which results in visible destruction of hard tooth structure or loss of tooth structure due to fracture.

PROCEDURE	BENEFIT DESCRIPTION
Amalgam Fillings (silver fillings)	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam filling is allowed if at least 24 months have passed since the existing amalgam was placed.
Composite Resin (white plastic) Fillings	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing composite resin filling is allowed if at least 24 months have passed since the filling was placed. Composite resin fillings on back teeth will be covered up to the cost of an amalgam filling.
Protective Filling	Covered if no other restorative service is performed on the same tooth on the same date. Not covered during a course of endodontic therapy.
Pin Retention	Covered with a basic (amalgam or composite) filling. A benefit one time per filling.

Extraction - coronal remnants deciduous tooth	Includes local anesthesia and routine post-operative care, which are not covered separately.
Extraction - erupted tooth or exposed root	Includes local anesthesia and routine post-operative care, which are not covered separately.
Adjunctive Services	Services related to another category of covered services will be covered at the same percentage as the related category of covered services.
Palliative Treatment	Covered as a separate benefit if no other service is performed during the visit except an exam and/or x-rays.

MAJOR – ENDODONTIC SERVICES

Endodontic: Certain Services for treatment of non-vital tooth pulp resulting from disease or trauma.

PROCEDURE	BENEFIT DESCRIPTION
Therapeutic Pulpotomy	Covered for baby teeth.
Root Canal Therapy	Covered once per tooth. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Repeat Root Canal Therapy	Covered if the first root canal procedure on the same tooth was performed at least 36 months earlier.
Apexification/Recalcification (apical closure/calcific repair of perforations, root resorption, etc.)	Covered once per tooth. A course of treatment includes initial, interim and final visits. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Apicoectomy	Covered once per root each 36 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Retrograde Filling (per root)	Covered once per root each 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not covered separately.
Root Amputation (per root)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Hemisection (includes any root removal)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.

MAJOR – PERIODONTIC SERVICES

Periodontic: Certain Services for treatment of gum tissue and bone supporting teeth.

PROCEDURE	BENEFIT DESCRIPTION
Periodontal Scaling and Root Planing - Per Quadrant	Covered one time per quadrant of the mouth in any 24 month period.
Periodontal Maintenance Procedures Following Active Therapy	Covered if 3 months have passed since the completion of active periodontal therapy (gum surgery or scaling and root planing). Then one time in any 6 month period. Not covered if performed within 6 months of a routine cleaning.
Gingivectomy	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Gingival Flap Procedure	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Root planning, local anesthesia and routine post-operative care are not separately covered.
Crown lengthening-hard tissue, by report	Not covered if performed on the same date as surgery to bone structures, crown preparation or other restoration.
Osseous Surgery, Guided Tissue Regeneration (includes surgery and reentry), Pedicle Soft Tissue Graft, Free Soft Tissue Graft (including donor site)	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.

MAJOR – COMPLEX ORAL SURGERY SERVICES

Oral Surgery: Extractions and certain other surgical Services and associated covered anesthesia and/or related Covered Services.

PROCEDURE	BENEFIT DESCRIPTION
Surgical Extractions of teeth, or tooth roots	Local anesthesia and routine post-operative care are not separately allowed as benefits.
Oral Surgery Services	Includes fistula closure, sinus perforation closure, tooth reimplantation, surgical access to expose teeth, biopsies, soft-tissue lesion removal, excision of bone tissue, excision of hyperplastic gum tissue, surgical incisions, and cyst removal. Local anesthesia and routine post-operative care are not separately covered.
Alveoloplasty	Not allowed as a separate benefit when performed on the same date as extractions. Includes local anesthesia and routine postoperative care.

MAJOR – PAIN MANAGEMENT SERVICES

PROCEDURE	BENEFIT DESCRIPTION
General Anesthesia **Analgesia (Nitrous Oxide)** **I.V. Sedation**	Only one type of anesthesia procedure per date of service is allowed as a separate benefit when provided for covered oral surgical procedures.

MAJOR – ADJUSTMENT AND REPAIR SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Re-Cement Crowns, Inlays and Onlays	Covered after 6 months from initial insertion.
Repairs to Crowns	Subject to Delta Dental's consultant review.
Re-Cement Fixed Bridges	Covered after 6 months from initial insertion of fixed bridge.
Repairs to Fixed Bridges	Subject to Delta Dental's consultant review.

MAJOR – DENTURE ADJUSTMENT, REPAIR, RELINE AND REBASE SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Denture Adjustments	Covered after 6 months from the insertion of the full or partial denture.
Repairs to Full and Partial Dentures	Covered after 6 months from the insertion of the full or partial denture.
Tissue Conditioning Per Denture Unit	Covered two times in a 36 month period.
Relining Dentures Rebasing Dentures	Relining or rebasing is covered at least 6 months after the initial insertion of a full or partial denture and then not more than one time in a 36 month period.

MAJOR – INLAY, ONLAY, AND CROWN SERVICES (Temporary restorations and appliances are not covered separately.)

Special Restorative: Buildups (which may or may not include a post) and laboratory processed restorations (crowns, onlays) for treatment of tooth decay which results in visible destruction of hard tooth structure, or loss of tooth structure due to fracture, which cannot be restored with amalgam or composite restorations.

PROCEDURE	BENEFIT DESCRIPTION
Metallic Inlays	An alternate benefit allowance for an amalgam filling will be made for the same number of surfaces. Any difference in fee is chargeable to the patient. It will be covered if 84 months have passed since the last placement. Not covered for children under age 16.
Crowns and Metallic Onlays	Covered when the tooth cannot be restored by an amalgam or composite filling and if more than 84 months since the last placement. Not covered for children under age 16.
Stainless Steel Crowns, Resin Crowns	Covered once in 36 months when the tooth cannot be restored by a filling. Covered only for children to age 16. Prefabricated resin crowns are a benefit only on front teeth. Replacement of a prefabricated crown is not covered within 36 months of placement of an existing prefabricated crown.
Core (Crown) Buildup including any Pins	Covered when needed to retain a crown or onlay and when need is due to extensive loss of tooth structure caused by decay or fracture. Covered only if 84 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 16.

Post and Core (in conjunction with a Crown or Onlay)	Covered for endodontically treated teeth. Must be needed to retain a crown or onlay, and only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 84 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 16.

MAJOR – FIXED BRIDGEWORK SERVICES

Prosthodontics: Services for construction or repair of fixed partial dentures (bridges), cast or acrylic removable partial dentures, acrylic complete dentures, and removable temporary partial dentures to replace completely extracted or avulsed natural permanent teeth.

PROCEDURE	BENEFIT DESCRIPTION
Fixed Bridges (covered to replace a Functioning Natural Tooth that was pulled while the patient was covered under this Plan.)	Initial fixed bridge is covered. Replacement of an existing fixed bridge is covered if the existing fixed bridge is more than 84 months old, is not serviceable, and cannot be repaired, and there is no prior payment of covered Special Restorative or Prosthodontic benefits for the same tooth. Not covered for children under age 16.
Core (Bridge) Buildup including any Pins (in conjunction with a Bridge Abutment or a Fixed Bridge)	Covered when needed to retain a fixed bridge or endodontically treated teeth. Only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 84 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 16.

MAJOR – DENTURES AND PARTIAL DENTURE SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Full Dentures (A benefit if it includes the replacement of at least one Functioning Natural Tooth that was extracted while the patient was covered under this Plan.)	Initial full dentures are covered. Replacement is covered after 60 months from the last placement. Dentures must not be able to be repaired. Personalized dentures, overdentures or associated procedures are not covered.
Partial Dentures (A benefit to replace a Functioning Natural Tooth that was extracted while the patient was covered under this Plan.)	Initial partial dentures are covered. Replacement is covered after 60 months have elapsed since the last placement. Dentures must not be able to be repaired. Precision or semiprecision attachments are not covered. The benefit for a partial denture includes any clasps and rests and all teeth. Metal based partial dentures are not covered for children under age 16.

LIMITATIONS/EXCLUSIONS (What Is Not Covered)

GENERAL LIMITATIONS – ALL SERVICES

a. Alternate Benefits - Often more than one service or supply can be used for treatment. In deciding the amount allowed on a claim, Plan will consider other materials and methods of treatment. Payment will be limited to the Covered Amount for the least costly Covered Service that meets accepted standards of dental care as determined by Delta Dental. The covered person and his Provider may decide on a more costly treatment. Delta Dental will pay toward the cost of the selected procedure at the Coinsurance level shown on the Declaration Page. Payment will be limited to the Covered Amount for the least costly treatment. **Only covered services will receive alternate benefits.**
b. The benefit allowed for a temporary service and the final service is limited to the benefit allowed for the final dental service, unless the temporary service is specifically included as a Covered Service in this Contract.
c. Dental procedures performed at the same time and as part of a primary procedure will be paid at the amount allowed for the primary procedure.
d. Services are covered when provided by a person legally permitted to perform such Services and are determined to be Necessary and appropriate. Benefits will be based on the terms of this plan and Delta Dental's Processing Policies, even if no monies are paid.
e. Pre- and post-operative procedures are considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.
f. Local anesthesia is considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.
g. The Covered Amount for a Covered Service Started but not Completed will be limited to the amount determined by Delta Dental.

h. Allowance for an assistant surgeon, when determined by Delta Dental to be a Covered Service, will not exceed 20% of the surgeon's fee for the same Covered Service.
i. Services related to another category of Covered Services will be covered at the same percentage as the related category of Covered Services.

EXCLUSIONS

a) Services for injuries or conditions which are covered under Worker's Compensation or employer's liability laws. Services provided by any federal or state agency. Services provided without cost by any city, county or other political subdivision. Any Services for which the person would not have to pay if not insured, except if such exclusion may be prohibited by law.
b) Any Service Started when the person was not covered under this Contract. This includes any Service Started during an applicable Waiting Period.
c) Services for treatment of birth or developmental defects, ***except*** dental Services within the mouth for treatment of a condition related to cleft lip and/or cleft palate.
d) Any treatment provided primarily for cosmetic purposes. Veneers on teeth and facings or veneers placed on crowns or bridge units for teeth after the first molar will always be considered cosmetic. Delta Dental will limit their allowance to a Covered Service without facings or veneers and the patient is responsible for the remainder of the Provider's approved fee.
e) Services to treat tooth structure lost from wear, erosion, attrition, abrasion or abfraction.
f) Services resulting from improper alignment, occlusion or contour.
g) Services related to periodontal stabilization of teeth (splinting).
h) Habit appliances, night guards, occlusal guards, athletic mouth guards and gnathological (jaw function) services, bite registration or analysis, or any related services.
i) Patient management services (***except*** covered anesthetic services).
j) Charges for prescribed drugs.
k) Any Experimental or Investigational treatment.
l) Services that may otherwise be covered, but due to the patient's condition would not prove successful to improve the patient's oral health.
m) Any treatment done in anticipation of future need (***except*** covered preventive services).
n) Hospital costs or any charges for use of any facility.
o) Any anesthesia service not included in Covered Services.
p) Grafts done in the mouth where teeth are not present.
q) Grafts of tissues from outside the mouth into the mouth.
r) Therapy for speech or the function of the tongue or face.
s) Orthodontic Services unless shown as a covered benefit on the Declaration Page.
t) Implant Services unless shown as a covered benefit on the Declaration Page.
u) Treatment of any temporomandibular joint (TMJ) problems, including facial pain, or any related conditions. Any related diagnostic, preventive or treatment Services.
v) Services not performed in accordance with Colorado state laws. Services by any person other than a person licensed to perform them. Services to treat any condition, other than an oral or dental disease, abnormality or condition.
w) Teaching services.

x) Completion of forms. Providing diagnostic information. Copying of other records.
y) Replacement of lost, stolen or damaged items.
z) Repair of items altered by someone other than a Provider.
aa) Any Services not included in Covered Services.
bb) Services for which charges would not have been made but for this coverage, except for Services as provided under Medicaid.
cc) Missed appointment charges. bb)
dd) Preventive control programs, including home care items.
ee) Plaque control programs.
ff) Self-injury.
gg) Initial placement of a denture unless needed to replace at least one Functioning Natural Tooth pulled while the Person was covered under this Plan. One full or partial denture is covered per arch in any 60-month period.
hh) The first fixed bridge unless it is needed to replace a Functioning Natural Tooth pulled while the Person was insured under this Plan, and if that tooth was not an abutment to an existing fixed bridge which is less than 84-months old. If a bridge replaces more than one pulled permanent Natural Tooth, benefit will be limited to the replacement of those teeth which were pulled while the Person was covered under the Plan.

ii) Replacement of a complete denture, partial denture, or fixed bridge is not a Covered Service unless:
    1. replacement of the current denture occurs at least 60 months after the date of insertion, even if the existing appliance was not provided under this Plan; or
    2. replacement of an existing fixed bridge occurs at least 84 months after the date of insertion, even if the existing appliance was not provided under this Plan; or
    3. the replacement appliance is required by the Necessary extraction of a Functioning Natural Tooth while the Person is covered; or
    4. the replacement is made Necessary by a covered Dental Injury to Sound Natural Teeth provided the treatment is Started within 60 days of the injury. (Chewing injuries are not considered covered Dental Injuries).

jj) The replacement of a fixed bridge unless the existing fixed bridge is at least 84 months old, cannot be serviced, and cannot be repaired. This requirement applies even if the existing fixed bridge was not provided under this Plan. ii) The replacement of an existing crown, inlay, onlay or other cast restoration, unless the existing cast restoration is at least 84 months old, is not serviceable and cannot be repaired. The time requirement applies even if the existing cast restoration was not provided under this Plan.
kk) The replacement of an existing crown, inlay, onlay or other cast restoration, unless the existing cast restoration is at least 84 months old, is not serviceable and cannot be repaired. The time requirement applies even if the existing cast restoration was not provided under this plan.
ll) Prefabricated stainless steel and resin crowns are a benefit for covered children who are under the age of 16, subject to any Waiting Period or reduced Coinsurance which might apply. Prefabricated resin crowns are a benefit on front teeth. Replacement of a

prefabricated crown is not covered within 36 months of the placement of an existing prefabricated crown.

mm) No benefit will be provided for temporary partial dentures. Charges for temporary partial dentures are not covered.

nn) Provisional splinting.

oo) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.

pp) Services provided for treatment of teeth retained in relation to an Overdenture.

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 attached appendices and riders constitute the entire Contract of the parties and will become binding upon the parties and their respective successors and assigns effective the 1st day of January, 2018 for a one year period and for successive one-year periods thereafter unless terminated as herein provided. This contract is issued and delivered in the State of Colorado, is governed by the laws of Colorado and is subject to the terms and conditions recited on the subsequent pages of this contract, and may not be changed, altered or terminated except in accordance with Article VII, RENEWAL AND TERMINATION of this Contract.

This DECLARATIONS PAGE supersedes any contrary provision of the subsequent sections of this contract.

DECLARATION PAGE

Group: ADAMS COUNTY GOVERNMENT

Type of Contract: Delta Dental PPO

Group Number: 1200/71200/91200

Contract Effective Date: January 1, 2018

Contract Anniversary Date: January 1st

	PPO Provider	Delta Dental Premier Provider	*Non-Participating Provider
Covered Services	**Plan Pays**	**Plan Pays**	**Plan Pays**
Diagnostic & Preventive Services			
Sealants	100%	100%	100%
Oral Exams and Cleanings	100%	100%	100%
X-Rays	100%	100%	100%
Fluoride Treatment	100%	100%	100%
Basic Services			
Simple Extractions	80%	80%	80%
Complex Oral Surgery	80%	80%	80%
Basic Restorative (Fillings)	80%	80%	80%
Endodontics (Root Canal Therapy)	80%	80%	80%
Periodontics (Gum Disease Treatment)	80%	80%	80%
Major Services			
Denture Repair/Relines/Rebases	50%	50%	50%
Prosthodontics (Dentures, Bridges)	50%	50%	50%
Special Restorative (Crowns, Onlays)	50%	50%	50%
Implant Services	50%	50%	50%
Orthodontic Services			
Orthodontics (Child to age 19)	50%	50%	50%

Orthodontia is a covered benefit. See the Delta Dental Benefits Rider for details of all benefits and limitations.

*** Important: Non-Participating Providers are allowed to balance bill. Subscribers and/or Dependents are responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Provider.**

Age

Type	Age Limit	Coverage Thru
Dependent Child	26	Month
End Dependent Ortho	19	Month

Deductible (January 1st - December 31st)

Class	Type	Network	Amount
All Covered Classes Except D&P and Ortho	Individual coverage amount	PPO and Non-PPO	$50
All Covered Classes Except D&P and Ortho	Family coverage amount	PPO and Non-PPO	$150

Maximum (January 1st - December 31st)

Class	Type	Network	Amount
All Covered Classes Except Ortho	Individual coverage amount	PPO and Non-PPO	$2000
Orthodontic Classes	Individual lifetime	PPO and Non-PPO	$2000

Eligibility Waiting Period

Active Subscribers working the minimum number of hours as required by the employer will become eligible on the first day of the month or coinciding with 45 days of employment.

Enrollment Type

The enrollment type is Open Enrollment. Open Enrollment means a period of time each Contract Year occurring prior to the Anniversary Date during which eligible Subscribers may choose to enroll themselves and/or their eligible Dependents in the Plan, or change from one coverage option to another if the Contract issued to the Group permits them to do so. Coverage will become effective on the Group's Anniversary Date.

Where two Subscribers who are spouses and are both eligible for coverage under this contract, they may be enrolled together or separately, but not both. Dependent children may be enrolled under one parent.

Rate Coverage

Composite	Admin Fee
PER MONTH PER SUBSCRIBER	$ 3.79

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.

Riders or Appendices Attached

Countersigned:
Delta Dental of Colorado

Signature

_____

Date
Accepted:
ADAMS COUNTY GOVERNMENT – 1200

_____

Signature

_____

Date

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ARTICLE I. DEFINITIONS

The terms below apply to this Contract:

1.01 ALTERNATE BENEFIT means the amount allowed based on the least costly, commonly accepted Service used to treat a dental problem when a Covered Person selects more costly treatment options.

1.02 APPLICANT means the Group or Employer wishing to provide dental benefits.

1.03 BENEFITS means the Services described in this Contract in the Benefits Rider, BENEFITS, LIMITATIONS and EXCLUSIONS.

1.04 COINSURANCE means the percent of a Covered Amount which Delta Dental will pay. The Coinsurance for each type of Covered Service appears in the Declaration Page. The Coinsurance that applies to a Subscriber may vary by type of dental Service.

1.05 COMPLETED means:

- For Root Canal Therapy, the date the canals are permanently filled.
- For Fixed Bridges (fixed partial dentures), Crowns, Inlays, Onlays, and other laboratory prepared restorations: The date the restoration is cemented in place.
- For Dentures and Partial Dentures (removable partial dentures): The date that the final appliance is first inserted in the mouth.
- For all other Services: The date the procedure is Started.

A Benefit is only payable once Completed.

1.06 The **CONTRACT ANNIVERSARY DATE or ANNIVERSARY DATE** is noted on the Declaration Page of this Contract. The anniversary date is the first day of each Contract Year following the initial Contract Year.

1.07 CONTRACT means the agreement between Delta Dental and the Applicant. It includes attached appendices, exhibits and riders, if any. This Contract is the whole agreement between the parties.

1.08 CONTRACT TERM means the time from the Effective Date of the Contract until it is terminated.

1.09 CONTRACT YEAR is the 365 days beginning on the Effective Date of this Contract, and each year after unless the contract is terminated. The contract year is 366 days in a leap year.

1.10 COVERED AMOUNT means:

- For PPO Providers, the lesser of the PPO Provider's Allowable fee or the fee actually charged.
- For Premier Participating Providers, the lesser of the Premier Maximum Plan Allowance, or the fee actually charged.
- For all other Providers, the lesser of the non-participating Maximum Plan Allowance, or the fee actually charged.

1.11 COVERED SERVICES means the Services described in this Contract or attachments, subject to the limitations and exclusions noted.

1.12 DEDUCTIBLE means the amount the Member must pay before Delta Dental pays. The Deductible is shown on the Declaration Page. If there is a limit to the deductible that a family must pay, that will be shown on the Declaration Page.

1.13 DEPENDENT means:

- The Subscriber's lawful spouse, including civil union partner.
- Civil Union partner must meet each of the requirements listed below:
  - ❖ They must be at least 18 years old.
  - ❖ They must be of the same or opposite sex.
  - ❖ They must not be a partner in another civil union.
  - ❖ They must not be married to another person.
  - ❖ They must not be related.
  - ❖ They must have entered into a civil union based on the guidelines of Article 15 of Title 14, C.R.S. recognized pursuant to Colorado Law.
- A child under the Dependent Age Limit shown on the Declaration Page.
- A child who reaches the Dependent Age Limit stated on the Declaration Page and is incapable of self-support because of physical or mental disabilities that began before reaching the Dependent Age Limit, and is dependent on the Subscriber. Delta Dental may annually request proof of such disability and dependency. Failure to submit such proof will terminate coverage.

If the Group chooses whether to cover a Civil Union Partner that option will be noted on the Declaration Page.

Eligible children are natural children, stepchildren, children under court-ordered guardianship, adopted children, and children of a civil union.

No one may be covered as a Dependent and also as a Subscriber under this Contract. If both parents are covered as Subscribers, children may be covered as Dependents of one parent only.

Persons in active military service are not eligible Dependents.

1.14 EFFECTIVE DATE is the date coverage begins.

1.15 ELIGIBLE CLASS is a group of Subscribers who are allowed to enroll under the Contract. A list of Eligible Classes is on the Declaration Page.

1.16 ELIGIBILITY WAITING PERIOD means the time that a person must be employed before they may enroll. The Eligibility Waiting Period is chosen by the Applicant and may differ by Eligible Classes. The Eligibility Waiting Period, if any, is noted on the Declaration Page and in Article III.

1.17 EMPLOYEE means someone who works the minimum number of hours defined by the Employer.

1.18 EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES means those services not generally accepted in the dental community as being safe and effective, as defined by Delta Dental.

1.19 GROUP means the Applicant or Employer contracting for dental benefits.

1.20 LATE ENROLLMENT means to enroll after first becoming eligible. A Late Enrollee must be enrolled for 12 months before Covered Services beyond those noted on the Declaration Page are covered.

The exceptions to this rule are:

- A Subscriber or Dependent who loses coverage through another group plan. (Loss of coverage is defined as loss due to death, divorce, loss of job, or termination of benefits by the employer.) Such Subscriber or Dependent will be allowed to enroll within 31 days of the loss of coverage with proof of loss. The person will not be a Late Enrollee.
- A Dependent child under age four may be added on any Contract Anniversary Date. The child will not be a Late Enrollee.

If the Applicant chooses Late Enrollment, the option will be noted on the Declaration Page.

1.21 MAXIMUM PLAN ALLOWANCE means the most that a Provider is allowed to charge for a procedure. Delta Dental reviews the limits twice a year. We may increase or decrease fees for any procedure.

1.22 MEMBER means any person eligible and enrolled for coverage under this plan.

1.23 NECESSARY means a Service that Delta Dental decides, using accepted standards of dental care and Delta Dental's processing policies, is needed and fitting for treatment of the Members's dental condition.

1.24 NON-PARTICIPATING PROVIDER means a Provider who does not contract with Delta Dental.

1.25 OPEN ENROLLMENT means a period prior to the Anniversary Date when eligible Subscribers and their Dependents may enroll. They may also change from one plan to another if the Contract permits them to do so. Coverage is effective on the Applicant's Anniversary Date.

If the Applicant chooses an Open Enrollment period, the option will be noted on the Declaration Page.

1.26 PARTICIPATING PROVIDER means a Provider who contracts with Delta Dental.

- **Premier Participating Provider** means a Provider who has a Premier Participating Provider Agreement with Delta Dental.
- **PPO Participating Provider** means a Provider who has a PPO Provider Agreement with Delta Dental.

1.27 PREMIUM means the amount of money paid for each Subscriber to buy the Benefits provided in this Contract.

1.28 PRE-TREATMENT ESTIMATE is a review of a Provider's plan of care to decide what is covered under this Contract.

1.29 PROVIDER means a person licensed to provide dental Services.

1.30 SERVICE means a procedure or supply provided by a Provider.

1.31 SERVICE FEE means the amount of money paid to Delta Dental for each Subscriber to purchase the Administrative Services provided by this Contract, as provided in Article II.

CLAIMS REIMBURSEMENT mans the amount of money the Group must pay Delta Dental for the total amount of Providers' statements paid or otherwise discharged by Delta Dental for services rendered for all Subscribers.

1.32 STARTED means:

- For Full Dentures or Partial Dentures (removable partial dentures): The date the final impression is taken.
- For Fixed Bridges (fixed partial dentures), Crowns, Inlays, Onlays and other laboratory prepared restorations: The date the teeth are first prepared (i.e., drilled down) to receive the restoration.
- For Root Canal Therapy: The date the pulp chamber is first opened.
- For Periodontal Surgery: The date the surgery is performed.
- For All Other Services: The date the Service is performed.

1.33 SUBSCRIBER means:

- An enrolled Subscriber for whom the monthly Premium is paid.
- A person who elects continued coverage and for whom the monthly Premium is paid.

1.34 TIED-TO-MEDICAL means dental benefits linked to the medical plan that the Applicant offers. Only those who enroll in a medical plan may be Subscribers under a dental plan that is tied-to-medical.

If the Applicant chooses Tied-To-Medical, the option will be noted on the Declaration Page.

ARTICLE II. SERVICE FEE AND MONTH CLAIMS REIMBURSEMENT

2.01 CLAIMS REIMBURSEMENT

Claims Reimbursement - On the 2nd, 12th and 22nd day or the last business day closest to such date of each month, Delta Dental will notify the Group of the total amount of Providers' statements paid or otherwise discharged by Delta Dental for services rendered.

Using one of the options described below, a prompt transfer of funds is made to Delta Dental to cover such disbursements as they become due and payable upon receipt of said notification.

a) **Automated Clearing House Transfer (ACH Transfer)**
Once the Group is notified of the total claims paid, Delta Dental has authorization from the Group to initiate an electronic transfer of funds from the Group's account to cover the total claims paid by Delta Dental. The ACH Transfer will occur 2 business days following the Group's receipt of the total claims paid by Delta Dental.

b) **Wire Transfer**
Once the Group is notified of the total claims paid, the Group initiates the electronic transfer of funds from their account to cover the total claims paid by Delta Dental. The electronic fund transfer must be completed within 5 business days of the Group receiving the invoice.

2.02 MONTHLY SERVICE FEE. The Monthly Service Fee for each Subscriber is as noted on the Declaration Page. The Group agrees to remit to Delta Dental during the Contract Term a monthly Service Fee for each subscriber. This is due and payable on the 15th day of each month for the previous month's Service fee.

2.03 SERVICE FEE AND CLAIMS REIMBURSEMENT AT TERMINATION. In the event this Contract terminates for any reason, the Applicant will be liable for all Service Fees due but unpaid, as well as Claims Reimbursement.

2.04 CHANGE OF SERVICE FEE. In the absence of an amendment mutually agreed upon between Applicant and Delta, no change in the Service Fee will be made during a Contract Year.

2.05 CLERICAL ERRORS. Clerical errors or delays in maintaining or exchanging data relative to coverage will not validate or invalidate coverage that would otherwise be in force. Upon discovery of such errors or delays, an adjustment of charges will be made.

2.06 GRACE PERIOD.

- Service Fee. The Contract has a Grace Period of 15 days after the due date of the Service Fee bill.
- Claims Reimbursement. The Contract has a Grace Period extending to the following bill of claims reimbursement. When Delta Dental has notified the Group of the total claims paid on the 2nd, the grace period is until the 12th day of the month; when Delta Dental has notified the Group of the total claims paid on the 12th, the grace period is until the 22nd day of the month; and when Delta Dental has notified the Group of the total claims paid on the 22nd calendar day, the grace period is until the 2nd of the following month.

The coverage remains in force during this Grace Period unless terminated by the Group. If either the Service Fee or Claims Reimbursement are not paid by the end of the Grace Period, the Contract will be placed on a hold status, where no claims will be paid and no eligibility will be guaranteed. If the Group does not pay after this Grace period, they may be terminated as of the last date of the earliest Grace Period at the discretion of Delta Dental. Service Fees and Claim Reimbursement are due through the last day of the Grace Period, including the Grace Period.

2.07 TIMELY NOTICE. Delta Dental must be informed when any Subscriber is no longer eligible. Failure to provide timely notice does not continue a Subscriber's coverage past the time it would otherwise have ended.

ARTICLE III. ELIGIBILITY

3.01 ELIGIBILITY. Subject to eligibility rules set forth in Section 3.02 below and/or on the Declarations Page, a Subscriber in an Eligible Class may enroll within 31 days after the Eligibility Waiting Period. They may also enroll during an Open Enrollment period if offered by the Employer.

a) **BECOMING COVERED.** Delta Dental must receive enrollment data for each Subscriber in a format acceptable to Delta Dental. The enrollment data must be received within 31 days of a Subscriber or Dependent's enrollment. The enrollment data must include the Subscriber's address, gender, social security number, date of birth and effective date. If the Subscriber chooses to enroll Dependents, each Dependent's name (including surname if different from Subscriber's), relationship to the Subscriber, address, gender, social security number and date of birth must be submitted.
- Coverage is effective after the eligibility waiting period shown on the Declaration Page.
- A Subscriber not enrolled in the plan may not enroll Dependents.

b) **ENROLLMENT TYPE. The Group's enrollment type is set forth on the Declaration Page. It will be one of the following:**
- Late Enrollment. A Member who does not enroll within the period described in Article III Section 3.01a will be considered a Late Enrollee.
- Open Enrollment. A Member who fails to enroll within the period described in Article III, Section 3.01a may enroll at the next Open Enrollment.
- Tied-to-Medical. Eligibility for the dental plan will be the same as that required by the medical plan.

c) **MAINTAINING COVERAGE.** The Group will give Delta Dental a list of any plan additions, changes, or terminations on or before the first day of each month. Delta Dental is not required to provide Benefits for a Subscriber or Dependent not on the list and for whom the monthly Premium is not paid.

3.02 SUBSCRIBER ELIGIBILITY. Subscribers may enroll within 31 days of the date they first become eligible.

a) Depending on the Enrollment Type of the group, eligible Subscribers who do not enroll as described above may enroll

- For Open Enrollment Groups, only during Open Enrollment. Eligible Subscribers who enroll and later drop the plan may enroll only during Open Enrollment.
- For Late Enrollment Groups, they may be able to enroll as a Late Enrollee.

b) Eligible Subscribers who lose coverage through another source may enroll with proof of loss. (Loss of coverage is defined as loss due to death, divorce, job loss, or termination of benefits by the employer.) They must enroll within 31 days of the loss of coverage.

3.03 DEPENDENT ELIGIBILITY. Dependents of a eligible Subscriber may enroll within 31 days of the following:

- The date the Subscriber becomes eligible to enroll. The effective date is that of the subscriber.
- New Dependents must be enrolled within 31 days and will be covered on the date of the event. Newborns and adopted children will be covered on the date of birth or date of placement for adoption.
- The date the Contract is amended to provide Dependent coverage. The Plan becomes effective on the first day of the month following this change.

a) If the group's Enrollment Type is Tied-to-Medical and Dependent enrollment is desired, the Dependents must be the same as those on the medical plan.

- If the group's Enrollment Type is Open Enrollment, the Dependent can be added during the Open Enrollment period.
- If the group's Enrollment Type is Late Enrollment, a Dependent can be added as a Late Enrollee.

c) Depending on the Enrollment Type of the group, Eligible Dependents who do not enroll as described above may enroll

- For Open Enrollment Groups, only during Open Enrollment. Dependents who enroll and later drop the plan may enroll only during Open Enrollment.
- For Late Enrollment Groups, they may be able to enroll as a Late Enrollee.

d) Eligible Dependents who lose coverage through another source may enroll with proof of loss. (Loss of coverage is defined as loss due to death, divorce, loss of job, or termination of benefits by the employer.) They must enroll within 31 days of the loss.

3.04 TERMINATION OF COVERAGE. A Member's plan will terminate, the end of the month, at the earliest of:

- The date Delta Dental receives a written request to cancel;
- The last day of the month the Subscriber is not eligible for coverage;
- The date the Contract terminates;
- The end of the period for which Premium is paid;
- The last day of the month the Member enters full-time military service of any country; or
- As to any Dependent, the last day of the month the person no longer qualifies as a Dependent.

Delta Dental must be notified within 60 days if a Member is no longer eligible.

Family and Medical Leave ACT (FMLA) -

If coverage ends during an Employer approved FMLA leave, coverage may be reinstated upon return to work within the terms of the FMLA leave. Pre-existing conditions, limitations and other waiting periods will not be imposed unless they were in effect for the Subscriber and/or his or her Dependents when coverage terminated.

3.05 INVOLUNTARY LOSS OF COVERAGE DUE TO STRIKE, LEAVE OF ABSENCE OR LAYOFF. If a Subscriber loses coverage due to strike, lay-off or leave of absence, and returns to work within 30 days, he may re-enroll on the first day of the month after his return to work. If the absence exceeds 30 days, he will be treated as a new Subscriber. Contract provisions relating to the Deductible, Coinsurance, Contract Year Maximum, and Waiting Periods, if any, will apply as to new coverage. The following exception applies:

Delta Dental of Colorado complies with the Uniformed Services Employment and Reemployment Rights Act (USERRA). Subscribers called to active duty may enroll as if there had been no leave of absence if they are still in an Eligible Class of Subscriber when they return to work. USERRA allows Subscribers to elect continuation of coverage when coverage would terminate due to an absence to serve in the uniformed services.

Services received by a person who is not eligible due to leave of absence are not covered unless the person elects continued coverage as provided in Article VIII or according to USERRA where applicable.

3.06 INVOLUNTARY LOSS OF "OTHER COVERAGE". A person who loses dental coverage from another source will be allowed to enroll with proof of the loss. (Loss of coverage is defined as loss due to death, divorce, loss of job, or termination of benefits by the employer.) The person must enroll within 31 days of the loss. Coverage will begin the first day of the month following a loss of coverage.

3.07 VOLUNTARY TERMINATION OF COVERAGE. In groups with Open Enrollment, a Member who cancels his plan may only re-enroll at the next Open Enrollment. In groups not offering Open Enrollment, a Member who cancels his plan and wants to re-enroll will be a Late Enrollee. The requirements of Late Enrollment will apply.

3.08 REVIEW OF RECORDS. Applicant will permit Delta Dental, with advance written notice, to inspect records of Applicant in order to confirm the lists of Members prepared by Applicant. Delta Dental may verify Applicant's compliance with Article II. Delta Dental may use auditors or other agents for this purpose.

ARTICLE IV. COORDINATION OF BENEFITS

4.01 DEFINITIONS. Coordination of Benefits means taking into account other Plans when paying Benefits.

"Allowable expense" is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering a Member. 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 Member 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 Member is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) If a Member is covered by 2 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.

(2) If a Member is covered by 2 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.

(3) If a Member 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.

(4) The amount of any benefit reduction by the primary plan because a covered Member 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.

Plan means a Plan that provides benefits or Services for dental care on a group basis. This includes group and blanket insurance, self-insured and prepaid plans, automobile fault or no-fault insurance and government plans (except Medicaid).

Primary Coverage means Coverage that must pay first. The Primary Plan must pay up to its full liability.

Secondary Coverage means Coverage that pays a claim after the Primary Plan pays.

4.02 WHEN COORDINATION OF BENEFITS APPLIES.

Coordination of Benefits applies when a Subscriber is covered under more than one Plan. The Benefits of this Plan will be coordinated with the other Plan(s).

4.03 RULES FOR COORDINATION OF BENEFITS.

The rules for the order of payment are shown below.

- The Plan covering a Subscriber as an Employee is primary to a policy on which the Member is a Dependent.
- For Dependent children, primacy will be determined as follows.
  The Plan of the parent whose birthday occurs earlier in a year will be primary.

If the parents are separated or divorced, the Plan of the parent who is ordered by court decree to pay for dental expenses will be primary. If the court decree orders parents to share, the decree governs and these rules shall apply to decide the primary plan.

The Plan of the parent with custody is Primary. If the custodial parent has remarried, the stepparent's Plan is Secondary and the Plan of the parent without custody pays third.

If the above rules do not establish an order of benefit payment, the Plan that has covered the Person the longest will be Primary. If a Plan covers a person who has been laid off or is retired, it will be Secondary to any other Plan.

- A group Plan that does not have a Coordination of Benefits clause is primary.

If this Plan is Primary, we will pay claims without regard to benefits provided by any other Plan. If this Plan is Secondary, it shall calculate the benefits it would have paid on the claim 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 reduce its payment by that 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 100 percent of 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.

ARTICLE V. CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

5.01 PAYMENT OF CLAIMS. Covered services will not include, and payment will not be made for claims for dental Services not listed in this Contract and any Appendix, Amendment, or Rider. Claims submitted to Delta Dental must use terms of the American Dental Association Current Dental Terminology (Code on Dental Procedures and Nomenclature).

5.02 APPEAL OF AN ADVERSE DETERMINATION OF A CLAIM.

A. Internal Appeal Process - First Level Appeals

A Member may appeal an adverse claim decision within 180 days of the date of the original Explanation of Benefits by writing to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

A Member may submit additional information in support of the appeal.

Appeals are reviewed by an impartial Provider of the same or similar specialty as would typically manage the case being reviewed. The reviewing provider will not have been involved in the initial decision.

The decision will be sent to the Member with the rationale for the decision. The decision will be made within 15 calendar days for pre-service denials. Post-service decisions will be made within 30 calendar days.

B. Internal Appeal Process - Second Level Appeals (Not available for Self-Funded Groups)

If a denial is upheld at the first level, a Member may request a second level appeal. The request must be received within 30 days of the First Level Appeal decision. It must be submitted to the address noted in 5.02A. Additional information may be submitted. Second level appeals will be reviewed by an impartial provider with the appropriate expertise. The reviewer will not have been involved in the first appeal. The Member, or a designated representative, may request to appear before the reviewer in person or may present by conference call.

A Second Level Appeal decision will be issued within 7 days of the review meeting.

C. Internal Appeal Process - Expedited Appeals

Members may request an expedited appeal when the time for a standard review would seriously jeopardize the life or health of the Member, would jeopardize the Member's ability to regain maximum function, or, for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently.

Expedited review decisions will be issued within 72 hours.

D. Independent External Review (Not available for Self-Funded or Federal Groups)

Where Delta Dental makes an Adverse Determination and the Member exhausts the internal appeals process, the Member has the right to request an external review. Delta Dental will notify the Member of the right, if any, to request an external review after the First Level appeal.

Requests for an independent external review must be in writing. They must include a completed external review request form as specified by the Colorado Division of Insurance. The Member must submit the request within four months of the completion or exhaustion of the internal appeals process. The internal appeals process is completed or exhausted upon Member's receipt of notice of the adverse determination or upon Delta Dental's failure to comply with Colorado Revised Statues §§ 10-16-113, 10-16-113.5, or Colorado Insurance Regulations 4-2-17 or 4-2-21.

Member may request expedited external review. All requests must be submitted to:

Delta Dental of Colorado
Appeals Analyst
P.O. Box 172528
Denver, CO 80217-2528

A signed consent authorizing Delta Dental to disclose protected health information pertinent to the external review is also required.

Delta Dental adheres to timeframes set forth by Colorado Regulation 4-2-21 in the processing of Independent External Reviews. Within 45 days after the receipt of the request for external review (72 hours for expedited external review), the external review entity shall deliver a written decision to the Member, Delta Dental, the provider, and the Commissioner.

5.03 CLAIMS FROM NON-PARTICIPATING PROVIDERS. Payment for Completed Covered Services from a Non-Participating Provider will be based on the non-participating Maximum Plan Allowance.

5.04 CLAIMS FROM PARTICIPATING PROVIDERS. Payment for Completed Covered Services provided by a Participating Provider will be made directly to the Provider. The patient does not have to pay any amount above what Delta Dental allows. For PPO Participating Providers, the amount Delta Dental allows is set forth in the PPO Schedule of Allowances. For Premier Participating Providers, the amount Delta Dental allows is the Premier Maximum Plan Allowance. If the Participating Provider charges more for a Service than Delta Dental allows, that amount is not chargeable to the patient.

5.05 TIME FRAME FOR SUBMISSION OF CLAIM. Delta Dental will not pay claims submitted more than 12 months after the date the Service is Completed. If a Participating Provider failed to submit a claim within this time, the Member will not be liable for the amount that Delta Dental would have paid.

5.06 AVAILABILITY OF PROVIDER. A Member may elect the Service of any licensed Provider, but neither Delta Dental nor Applicant guarantees the availability of any Provider.

5.07 RIGHT TO INFORMATION AND RECORDS. Delta Dental may receive records related to the treatment of a Member from any Provider. Delta Dental may require a Member to be examined by a dental consultant retained by Delta Dental. Delta Dental will maintain records in a confidential manner in accordance with federal and state law.

5.08 EXTENDED COVERAGE. Delta Dental benefits will end if this Contract is terminated or if a person's coverage is cancelled. Delta Dental will cover no further Services except as described below.

If a Covered Service Started before coverage ends, but the Covered Service is Completed after it ends, Delta Dental will pay Benefits for the Covered Service as follows:

- Benefits will be paid in the amount that would have been paid and subject to the same terms as would have applied if the Person's coverage were still in effect.
- Benefits will be paid only if the Covered Service is Completed within 60 days after the date the Person's coverage ended.

No benefit will be paid if the Covered Service is Started after coverage ends.

5.09 PRE-TREATMENT ESTIMATE. Before starting treatment that may cost $400 or more, Members may request an estimate from Delta Dental of what is covered. Pre-treatment estimates are not required.

5.10 SUBROGATION. Delta Dental may pursue on its own or with a Member a claim against a third party. If Delta Dental pays a claim for injuries to a Member and the Member settles with a third party for an amount that includes such costs, the Member must refund Delta Dental the amount equal to the benefit payment made to, or on behalf of, the Member.

ARTICLE VI. GENERAL TERMS AND CONDITIONS

6.01 NOTICES. Any notice under this Contract will be valid if given by either the Applicant or Delta Dental to the other. In the case of the Applicant, notice may be given to a designated agent. The notice will be effective upon the date of mailing.

6.02 NOTICES TO SUBSCRIBERS. Notice to a Subscriber will be in writing and sent by regular US mail to the current address in Delta Dental's records. If agreed to by Delta Dental and the Subscriber, notices may be sent via email.

6.03 **LEGAL ACTION.** No action at law or in equity may be filed in order to recover on this Contract prior to the expiration of 60 days after final notice of claim has been filed in accordance with the requirements of this Contract.

6.04 REPRESENTATIONS. All statements made by the Group or by an individual will be deemed representations and not warranties.

6.05 ENTIRE CONTRACT; AMENDMENTS. This Contract is the complete agreement between Delta Dental and the Group. This Contract may not be orally amended or changed. This Contract may at any time be amended and changed by written agreement between Delta Dental and the Group. Any such amendment will be binding on all Members regardless of the date their coverage became effective or the date treatment was Started.

6.06 CONTRACT CHANGES. No agent or employee of Delta Dental may change the Contract or waive any of its provisions. No change in the Contract will be valid unless approved in writing by an authorized Delta Dental employee.

6.07 GROUP'S ACCESS TO RECORDS. Delta Dental agrees that Group or its designated representative may access all files and records pertinent to the Group in accordance with federal and state laws. The group must give 14 days written advance notice.

6.08 SETTLEMENT OF DISPUTES. Any dispute between Delta Dental, a Participating Provider, and Member, or any combination of these, must be settled by arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association. Except for ERISA covered claims, disputes include adverse claim decisions not settled by the appeals process. Judgment on the award rendered by the Arbitrator(s) may be entered in any Court having jurisdiction. Arbitration may be initiated by any party to a dispute by giving notice to each party, by filing two copies of such notice with the American Arbitration Association and by complying with other applicable provisions of the Association's rule.

6.09 PARTICIPATING PROVIDER. Delta Dental will make reasonable efforts to provide Applicant a list of Participating Providers. The list may be provided in different formats. The Providers may change from time to time, and Delta Dental reserves the right to change the list without prior notice to the Applicant.

Neither Delta Dental nor Applicant is liable for any act or omission by Providers or their agents or employees who provide or contract to provide dental Services under this Contract. Providers who participate with Delta Dental are independent contractors. They are neither agents nor employees of Delta Dental. Nor is Delta Dental an agent or employee of any Participating Provider. Delta Dental will not be responsible for any claim or demand for damages arising out of any injuries suffered by a Member while receiving care from any Participating provider or in any Participating provider's facilities.

6.10 SUBSCRIBER BENEFIT BOOKLET. Delta Dental will give a Subscriber Benefit Booklet to the Group. The Group will make the booklet available to each Subscriber. If an amendment to this Contract will materially affect the Benefits in the booklet, we will give a revised Subscriber Benefit Booklet or inserts showing the change to the Group.

6.11 PHYSICAL EXAMINATION. Delta Dental, at its own expense, may examine an individual for whom a claim or request for pre-estimation of Benefits is pending under this Contract.

6.12 GENDER. The use of the singular will include the plural and the plural the singular. Use of any gender will include all genders.

6.13 NON-DISCRIMINATION. Delta Dental does not use individual health factors to determine benefits or premium rates. Health factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability.

6.14 HIPAA PRIVACY & SECURITY. Delta Dental complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security regulations.

6.15 AGREEMENT WITH STATE LAW. Any requirement in this Contract which on its effective date is in conflict with the laws of the state in which any Member lives is hereby changed to the minimum requirement of such laws.

ARTICLE VII. RENEWAL AND TERMINATION

7.01 RENEWAL. The Contract will renew for one-year periods unless either party elects not to renew by giving the other party written notice. Notice must be received at least 60 days before the end of the current Contract year. If there are changes to the rates or other terms of this Contract effective on an Anniversary Date, Delta Dental will provide notice of the proposed changes with the notice of renewal.

7.02 TERMINATION. This Contract will be terminated as follows:

a) By either the Group or Delta Dental at the end of the original Contract or at the end of any renewal year, provided the required notice of non-renewal is given.

b) In the event any Service Fee due as stated in Article II of this Contract is not paid within 20 days of the due date, Delta Dental may give notice that payment is due, and if such payment is not received by the last day of the Grace Period, as referenced in Article II, Section 2.06, Delta Dental may terminate all further obligations.

c) In the event any Claims Reimbursement due as stated in Article II of this Contract is not paid within 10 calendar days of the due date, Delta Dental may give notice that payment is due, and if such payment is not received by the last day of the Grace Period, as referenced in Article II, Section 2.06, Delta Dental may terminate all further obligations.

d) By election of the Group if Delta Dental defaults in providing the Benefits under the Contract and such default is not corrected within 60 days of notice of such default.

e) By election of Delta Dental in the event enrollment of Subscribers changes by 10% or more from the minimum enrollment requirements included on Delta Dental's proposal.. Delta Dental may, at its option, terminate or propose to the Group alternative adjustment in rates, Benefits, or copayments. Within 30 days, the Group will select an alternative by written notice to Delta Dental. If an alternative is not selected, Delta Dental may terminate this Contract.

f) Upon written notification by the Group of its intention to terminate this Contract as of any date other than the end of the Contract Term. The termination date will be the last day of the month during which Delta Dental received the Group's written notification of intent to terminate.

g) By election of Delta Dental in the event of fraud or misrepresentation by the Applicant, or with respect to coverage of a Subscriber, fraud or misrepresentation by the Subscriber or such person's representative.

In the event this Agreement terminates as stated, the Group will remain liable to Delta Dental for the full amount of the Providers' statements paid or otherwise discharged by Delta Dental for services rendered and incurred under this Contract prior to the termination date. In addition, the Group will be and remain liable to Delta Dental for a period of 12 months following the termination date for the full amount of Provider's statements paid or otherwise discharged by Delta Dental for services rendered according to ARTICLE V, CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED, 5.03 and 5.04.

7.03 PROCEDURES ON TERMINATION

a) In the event of termination of this Agreement in accordance with the provisions of Article VII, Section 7.02, no Subscriber will, on or after the date on which the termination takes effect, be entitled to any further benefit payments hereunder.

However, Delta Dental will have the right to process Providers' statements for payment where each of the following terms are met, provided that any Claims Reimbursement and Service Fees owed Delta Dental have been paid:

1. the Provider's statement is first received by Delta Dental within 12 months of the termination date of this Agreement according to ARTICLE V, CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED, 5.03 and 5.04;

2. the date of service reported on the Provider's statement was within 12 months of the date the claim was first received by Delta;

3. the date of service reported on the Provider's statement was no later than the termination date of this Agreement.

b) In the event of termination by Delta Dental, all Benefits will terminate and Delta Dental will be released from all further obligations of this Agreement, effective on the last day of the month in which written notice of termination is given; provided, however, that Delta Dental will make payments for dental services for Extended Benefits. Applicant will remain liable to Delta Dental for:

1. the unpaid payments applicable for the period this Agreement was in effect prior to termination; and
2. the full amount of all Provider's statements paid or otherwise discharged by Delta Dental after the termination date but incurred during the full Term of this Contract.

3. In the event of termination of this Agreement for any cause, Delta Dental will not be required to pay for services provided beyond such termination date, except for the completion of single procedures started while this Agreement was in effect, which are otherwise Benefits under the terms of this Agreement, provided that any Claims Reimbursement and Service Fees owed Delta Dental have been paid.

7.04 If on termination of this Contract for any cause Group has not paid Service Fee and/or Claims Reimbursement to Delta Dental applicable to a period of time up to and including the termination date Group will, within 30 days after termination, remit such to Delta.

ARTICLE VIII. CONTINUATION COVERAGE

8.01 **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)** generally applies to Groups with 20 or more Subscriber s.

Under COBRA, Members who have a qualifying event may be able to continue coverage for a period of time. The benefits will be the same as those of active Subscriber s. The Member must pay the Premium, which cannot exceed 102% of the cost for an active Subscriber with the same plan.
Qualifying events govern if a person may elect COBRA and the length of coverage. The employer or Group must administer COBRA according to federal requirements.

COBRA Continuation coverage will end on the earliest of the following:

a) the last day of the month in which COBRA Continuation ends;
b) the day the Contract terminates;
c) the last day of the month for which premium has been paid;
d) the last day of the month the person becomes entitled to Medicare;
e) the last day of the month the person is eligible for coverage under another group plan.

8.02 Continued Health Coverage required by the State of Colorado (State Continuation) applies to Groups not subject to COBRA.

Members covered under this Contract, or a similar contract it replaces, for at least 6 months may be able to continue coverage for up to 18 months under State Continuation. Their premium and benefits will be the same as those for active Subscribers, except that the Member will be responsible for the Premium. The Employer or Group must administer State Continuation according to state law.

State Continuation coverage is effective upon loss of coverage. Within 60 days of the loss, the Group must send enrollment information and premium to Delta Dental for the Member's benefits to continue.

State Continuation coverage will terminate on the earliest of the following:

a) the last day of the month after 18 months of continued coverage;
b) the day the Contract terminates;
c) the last day of the month that premium is paid;
d) the day the person becomes entitled to Medicare;
e) the day the person is eligible for coverage under another group plan; or
f) in the case of a Dependent child, the day he no longer meets the definition of Dependent.

RIDERS and APPENDICES

COVERED DENTAL SERVICES

Subject to the limitations and exclusions included in this Contract, the Completed dental Services are Benefits when provided by a Provider (or other person legally permitted to perform such Services by authority of license) and are determined under the standards of generally accepted dental practice to be Necessary and appropriate. Benefits will be determined based on the terms of this Contract and Delta Dental's Processing Policies.

DIAGNOSTIC & PREVENTIVE SERVICES

Diagnostic: Certain Services performed to assist the Provider in evaluating the existing conditions and determining the dental care required.

Preventive: Certain Services performed to prevent the occurrence of dental abnormalities or disease.

Adjunctive: Certain additional Services, including emergency palliative treatment, performed as a temporary measure that does not affect a definitive cure.

PROCEDURE	BENEFIT DESCRIPTION
Oral Exam (All exam types)	Two exams in a 12 month period are covered. There is no separate benefit for diagnosis, treatment planning or consultation by the treating provider
Dental Cleaning	Two cleanings in a 12 month period are covered unless documentation of special need is provided. For those with documentation, 2 additional cleanings (or any procedure that includes cleaning) will be provided during a 12 month period. An adult cleaning is not covered for persons under age 14.
Bitewing X-rays	Covered twice in a 12 month period.
Full Mouth Survey or Panoramic X-ray	Covered one time in a 36 month period.
Individual Periapical X-rays Intraoral Occlusal X-rays Extraoral X-rays	Limited to the allowance for a full mouth survey or panoramic x-ray. If the fee meets or exceeds the allowance for a full mouth survey, it will be processed as a full mouth survey.
Sealants	Covered one time per tooth in a 36 month period. Allowed for the occlusal (chewing) surface of decay-free unrestored permanent molars. Covered for children through age 15. There is no separate benefit for preparation of the tooth or any other procedure associated with the sealant application.
Preventive Resin Restoration	Covered as a sealant above.

Fluoride Treatment	Covered once in a 12 month period for children through age 15.
Space Maintainer	Covered once per lifetime for children through age 13 to maintain space left by prematurely lost baby back teeth.
Adjunctive Services	Services related to another category of covered services will be covered at the same percentage as the related category of covered services.
Palliative Treatment	Covered as a separate benefit only if no other service is provided during the visit except an exam and/or x-rays.
Oral Pathology Lab Procedures	Covered with a pathology report.

BASIC SERVICES

Basic Restorative: Fillings and preformed shell crowns, for treatment of tooth decay which results in visible destruction of hard tooth structure or loss of tooth structure due to fracture.

Oral Surgery: Extractions and certain other surgical Services and associated covered anesthesia and/or related Covered Services.

Endodontic: Certain Services for treatment of non-vital tooth pulp resulting from disease or trauma.

Periodontic: Certain Services for treatment of gum tissue and bone supporting teeth.

PROCEDURE	BENEFIT DESCRIPTION
Amalgam Fillings (silver fillings)	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam filling is allowed if at least 12 months have passed since the existing amalgam was placed.
Composite Resin (white plastic) Fillings	Multiple fillings on one surface will be paid as a single filling. Replacement of an existing composite resin filling is allowed if at least 12 months have passed since the filling was placed. Composite resin fillings on back teeth will be covered up to the cost of an amalgam filling.
Stainless Steel Crowns Resin Crowns	Covered when the tooth cannot be restored by a filling and then 1 time in a 12 month period.
Protective Filling	Covered if no other restorative service is performed on the same tooth on the same date. Not covered during a course of endodontic therapy.
Pin Retention	Covered with a basic (amalgam or composite) filling. A benefit one time per filling.
Extraction - Coronal Remnants Deciduous Tooth	Includes local anesthesia and routine post-operative care, which are not covered separately.

Extraction - Erupted Tooth or Exposed Root	Includes local anesthesia and routine post-operative care, which are not covered separately.
Therapeutic Pulpotomy	Covered for baby teeth.
Root Canal Therapy	Covered once per tooth. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Repeat Root Canal therapy	Covered if the first root canal procedure on the same tooth was performed at least 24 months earlier.
Apexification/Recalcification (apical closure/calcific repair of perforations, root resorption, etc.)	Covered once per tooth. A course of treatment includes initial, interim and final visits. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Apicoectomy	Covered once per root each 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Retrograde Filling (per root)	Covered once per root each 24 months. X-rays, cultures, tests, local anesthesia and routine follow-up care are not covered separately.
Root Amputation (per root)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Hemisection (includes any root removal)	X-rays, cultures, tests, local anesthesia and routine follow-up care are not separately covered.
Periodontal Scaling and Root Planing - Per Quadrant	Covered one time per quadrant of the mouth in any 24 month period.
Periodontal Maintenance Procedures Following Active Therapy	Periodontal maintenance procedures or any combination of periodontal maintenance procedures and prophylaxis (adult and child cleanings), are limited to 4 per any 12 month period.
Gingivectomy	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Gingival Flap Procedure	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Root planing, local anesthesia and routine post-operative care are not separately covered.

Crown Lengthening - Hard Tissue, by Report	Not covered if performed on the same date as surgery to bone structures, crown preparation or other restoration.
Osseous Surgery, Guided Tissue Regeneration (includes surgery and re-entry), Pedicle Soft Tissue Graft, Free Soft Tissue Graft (including donor site)	One periodontal surgical procedure is covered per quadrant in any 36 month period. If less than a full quadrant is treated, benefits will be based on the fee for a partial quadrant. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Surgical Extractions of Teeth or Tooth Roots	Local anesthesia and routine post-operative care are not separately allowed as benefits.
Oral Surgery Services	Includes fistula closure, sinus perforation closure, tooth reimplantation, surgical access to expose teeth, biopsies, soft-tissue lesion removal, excision of bone tissue, excision of hyperplastic gum tissue, surgical incisions, and cyst removal. Local anesthesia and routine post-operative care are not separately allowed as benefits.
Alveoloplasty	Not allowed as a separate benefit when performed on the same date as extractions. Includes local anesthesia and routine post-operative care.
General Anesthesia **Analgesia (Nitrous Oxide)** **I.V. Sedation**	Only one type of anesthesia procedure per date of service is allowed as a separate benefit when provided for covered oral surgical procedures.
Localized Delivery of Antimicrobial Agents	Covered once in a 24 month period. Benefit is limited to a maximum of two teeth per quadrant.

MAJOR SERVICES

Special Restorative: Buildups (which may or may not include a post) and laboratory processed restorations (crowns, onlays) for treatment of tooth decay which results in visible destruction of hard tooth structure, or loss of tooth structure due to fracture, which cannot be restored with amalgam or composite restorations.

Prosthodontics: Services for construction or repair of fixed partial dentures (bridges), cast or acrylic removable partial dentures, acrylic complete dentures, and removable temporary partial dentures to replace completely extracted or avulsed natural permanent teeth.

Implants: Prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prostheses.

PROCEDURE	**BENEFIT DESCRIPTION**
Re-Cement Crowns and Onlays	Covered after 6 months from initial insertion.
Repairs to Crowns	Subject to Delta Dental's consultant review.

Re-Cement Fixed Bridges	Covered after 6 months from initial insertion of fixed bridge.
Repairs to Fixed Bridges	Subject to Delta Dental's consultant review.
Denture Adjustments	Covered after 6 months from the insertion of the full or partial denture.
Repairs to Full and Partial Dentures	Covered after 6 months from the insertion of the full or partial denture.
Tissue Conditioning per Denture Unit	Covered two times in a 36 month period.
Relining Dentures **Rebasing Dentures**	Relining or rebasing is covered at least 6 months after the initial insertion of a full or partial denture and then not more than one time in a 36 month period.
Inlays	An alternate benefit allowance for an amalgam filling will be made for the same number of surfaces. Any difference in fee is chargeable to the patient. It will be covered if 60 months have passed since the last placement. Not covered for children under age 12.
Crowns and Onlays	Covered when the tooth cannot be restored by an amalgam or composite filling and if more than 60 months since the last placement. Not covered for children under age 12.
Core (Crown) Buildup including any Pins	Covered when needed to retain a crown or onlay and only when need is due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 12.
Post and Core (in conjunction with a Crown or Onlay)	Covered for endodontically treated teeth. Must be needed to retain a crown or onlay, and only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 12.
Implants - Surgical Placement & Restoration	The placement of the surgical implant, and the placement of a crown, full or partial denture, or bridge over the implant, are covered once in 60 months for restorations involving the same tooth. This limitation includes any prior Special Restorative or Prosthodontic benefits for the same tooth. Not covered for children under age 16.
Fixed Bridges	Initial fixed bridge is covered. Replacement of an existing fixed bridge is covered if the existing fixed bridge is more than 60 months old, is not serviceable, and cannot be repaired, and there is no prior payment of covered Special Restorative or Prosthodontic benefits for the same tooth. Not covered for children under age 16.

Core (Bridge) Buildup including any Pins (in conjunction with a Bridge Abutment or a Fixed Bridge)	Covered when needed to retain a fixed bridge or endodontically treated teeth. Only when necessary due to extensive loss of tooth structure caused by decay or fracture. Covered only if 60 months have passed since the last buildup or post and core procedure for the same tooth. Not covered for children under age 16.
Full Dentures	Initial full dentures are covered. Replacement is covered after 60 months from the last placement. Dentures must not be able to be repaired. Personalized dentures, overdentures or associated procedures are not covered.
Partial Dentures	Initial partial dentures are covered. Replacement is covered after 60 months have elapsed since the last placement. Dentures must not be able to be repaired. Precision or semi-precision attachments are not covered. The benefit for a partial denture includes any clasps and rests and all teeth. Metal based partial dentures are not covered for children under age 16.
Temporary Removable Partial Dentures	Initial temporary removable partial dentures are covered to replace missing permanent front teeth. Replacement is covered only after 60 months have elapsed since the last placement.

ORTHODONTIC SERVICES

PROCEDURE	BENEFIT DESCRIPTION
Orthodontic Treatment	Orthodontics are defined as the services provided by a licensed Provider involving orthognathic surgery or appliance therapy for movement of teeth and post-treatment retention for treatment of malalignment of teeth and/or jaws including any related interceptive services.
Limitations on Orthodontic Benefits	a) No benefits will be provided for: • Replacement or repair of appliances. • Orthodontic care provided in the treatment of periodontal cases or cases involving treatment or repositioning of the temporomandibular joint or related conditions. b) Periodic Orthodontic payments will end upon termination of treatment for any reason prior to completion of the case, or upon termination of the Covered Person's eligibility. c) We will make periodic payments based on the provider's treatment plan. Total case fees include active treatment and post treatment retention or stabilization. We will not make separate benefit for post treatment stabilization. d) For comprehensive orthodontic treatment in progress that began prior to eligibility in the plan, Delta Dental will reduce periodic payments using its applicable processing policies.

LIMITATIONS/EXCLUSIONS (What Is Not Covered)
GENERAL LIMITATIONS – ALL SERVICES

a. Alternate Benefits - Often more than one service or supply can be used for treatment. In deciding the amount allowed on a claim, Plan will consider other materials and methods of treatment. Payment will be limited to the Covered Amount for the least costly Covered Service that meets accepted standards of dental care as determined by Delta Dental. The covered person and his Provider may decide on a more costly treatment. Delta Dental will pay toward the cost of the selected procedure at the Coinsurance level shown on the Declaration Page. Payment will be limited to the Covered Amount for the least costly treatment. **Only covered services will receive alternate benefits.**
b. The benefit allowed for a temporary service and the final service is limited to the benefit allowed for the final dental service, unless the temporary service is specifically included as a Covered Service in this Contract.
c. Dental procedures performed at the same time and as part of a primary procedure will be paid at the amount allowed for the primary procedure.
d. Services are covered when provided by a person legally permitted to perform such Services and are determined to be Necessary and appropriate. Benefits will be based on the terms of this plan and Delta Dental's Processing Policies, even if no monies are paid.
e. Pre- and post-operative procedures are considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.
f. Local anesthesia is considered part of any associated Covered Service. Benefit will be limited to the Covered Amount for the Covered Service.
g. The Covered Amount for a Covered Service Started but not Completed will be limited to the amount determined by Delta Dental.
h. Allowance for an assistant surgeon, when determined by Delta Dental to be a Covered Service, will not exceed 20% of the surgeon's fee for the same Covered Service.
i. Services related to another category of Covered Services will be covered at the same percentage as the related category of Covered Services.

EXCLUSIONS

a) Services for injuries or conditions which are covered under Worker's Compensation or employer's liability laws. Services provided by any federal or state agency. Services provided without cost by any city, county or other political subdivision. Any Services for which the person would not have to pay if not insured, except if such exclusion may be prohibited by law.
b) Any Service Started when the person was not covered under this Contract. This includes any Service Started during an applicable Waiting Period.
c) Services for treatment of birth or developmental defects, ***except*** **dental Services within the mouth for treatment of a condition related to cleft lip and/or cleft palate**.
d) Any treatment provided primarily for cosmetic purposes. Veneers on teeth and facings or veneers placed on crowns or bridge units for teeth after the first molar will always be considered cosmetic. Delta Dental will limit their allowance to a Covered Service without facings or veneers and the patient is responsible for the remainder of the Provider's approved fee.
e) Services to treat tooth structure lost from wear, erosion, attrition, abrasion or abfraction.

f) Services resulting from improper alignment, occlusion or contour.
g) Services related to periodontal stabilization of teeth (splinting).
h) Habit appliances, night guards, occlusal guards, athletic mouth guards and gnathological (jaw function) services, bite registration or analysis, or any related services.
i) Patient management services (***except*** covered anesthetic services).
j) Charges for prescribed drugs.
k) Any Experimental or Investigational treatment.
l) Services that may otherwise be covered, but due to the patient's condition would not prove successful to improve the patient's oral health.
m) Any treatment done in anticipation of future need (***except*** covered preventive services).
n) Hospital costs or any charges for use of any facility.
o) Any anesthesia service not included in Covered Services.
p) Grafts done in the mouth where teeth are not present.
q) Grafts of tissues from outside the mouth into the mouth.
r) Therapy for speech or the function of the tongue or face.
s) Orthodontic Services unless shown as covered on the Declaration Page.
t) Implant Services unless shown as covered on the Declaration Page.
u) Treatment of any temporomandibular joint (TMJ) problems, including facial pain, or any related conditions. Any related diagnostic, preventive or treatment Services.
v) Services not performed in accordance with Colorado state laws. Services by any person other than a person licensed to perform them. Services to treat any condition, other than an oral or dental disease, abnormality or condition.
w) Teaching services.
x) Completion of forms. Providing diagnostic information. Copying of other records.
y) Replacement of lost, stolen or damaged items.
z) Repair of items altered by someone other than a Provider.
aa) Any Services not included in Covered Services.
bb) Services for which charges would not have been made but for this coverage, except for Services as provided under Medicaid.
cc) Missed appointment charges.
dd) Preventive control programs, including home care items.
ee) Plaque control programs.
ff) Self-injury.
gg) Provisional splinting.
hh) Bone grafting when done in the same site as a tooth extraction, implant, apicoectomy or hemisection.
ii) Services provided for treatment of teeth retained in relation to an Overdenture.
jj) Any Prosthodontic service provided within 60 months of Special Restorative services involving the same teeth.
kk) Any Special Restorative service provided within 60 months of fixed Prosthodontic Services involving the same teeth.
ll) Fixed and removable Prosthodontic appliances (bridges and partials) are not a benefit in the same arch except when the fixed denture (bridge) replaces front teeth. Allowance is limited to the allowance for the removable partial denture.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: July 17, 2018
SUBJECT: 2018 United Healthcare Contracts
FROM: Terri Lautt, Director
AGENCY/DEPARTMENT: Human Resources
HEARD AT STUDY SESSION ON: August 22, 2017
AUTHORIZATION TO MOVE FORWARD: ☒ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners approves the 2018 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 2018.

The attached Amendment to the Specific Excess Loss Insurance Policy provides for changes as outlined in the Schedule of Benefits.

The attached Summary Plan Descriptions provide for changes based on Federal and State law with no other changes to the plan design, as approved through Study Session.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Human Resources
County Manager's Office
Budget Office

ATTACHED DOCUMENTS:

Financial Renewal and Terms Amendment (Exhibit A and Exhibit B)
Stop Loss Amendment No. 5
UHC Choice EPO Plan Summary Plan Description
UHC Choice Plus POA Plan 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 APPROVING AMENDMENTS TO ADAMS COUNTY'S CONTRACTS WITH UNITED HEALTHCARE SERVICES, INC.

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, 2018; 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. 5") provides for changes as outlined in the United HealthCare Schedule of Benefits; and

WHEREAS, the attached United HealthCare Choice EPO and Choice Plus POA Summary Plan Descriptions outline the Benefits provided under the contract, and are in effect through December 31, 2018; and

WHEREAS, the following attached documents constitute the Amendments to Adams County's contracts with United HealthCare Services for the 2018 plan year:

1. Financial Renewal and Terms Amendment (Exhibit A and Exhibit B)
2. Stop Loss Amendment No. 5
3. United HealthCare Choice EPO Summary Plan Description
4. United HealthCare Choice Plus POS Summary Plan Description

NOW, THEREFORE, BE IT RESOLVED, that the Board of County Commissioners, County of Adams, State of Colorado, hereby approves the attached Amendments to Adams County's contracts with United Healthcare Services, Inc., and the chair is hereby authorized to execute same.

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, 2018 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	**United HealthCare Services, Inc.**
By _____	By _____
Authorized Signature	Authorized Signature
Print Name _____	Print Name _____
Print Title _____	Print Title _____
Date _____	Date _____

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, 2018 through December 31, 2018.

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 820 enrolled Employees.

- $51.44 per Employee per month.

Average Contract Size: 2.12

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	Customer will pay a fee equal to thirty-five percent (35%) of the "Savings Obtained" as a result of the 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

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, 2018 through December 31, 2018 (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.

Claim Operations			
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%		
Member Phone Service			
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%		
Satisfaction			
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		

UnitedHealthcare Insurance Company

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-860-702-5000

AMENDMENT NO. 5

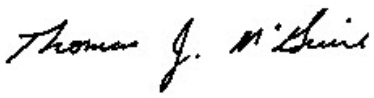
Amendment to be attached to and made a part of Group Policy No. GA-701043AL, issued by UnitedHealthcare Insurance Company (herein called "Company") to Adams County Government (herein called "Policyholder").

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, 2018.

UnitedHealthcare Insurance Company

Jeffrey Alter, President



Thomas J. McGuire, Secretary

ACCEPTED BY: _____

Title: _____

Date: _____

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, 2018

Administrator: United HealthCare Services, Inc.

Coverage specified herein is applicable only during the Policy Period from January 1, 2018 through December 31, 2018, 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, 2018 and Paid from January 1, 2018 through December 31, 2018.

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: $59.66 per subscriber per month

EXPERIENCE REFUND ENDORSEMENT

Policyholder: Adams County Government

Effective Date: January 1, 2018

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.

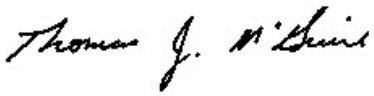
CALCULATION OF REFUND

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.

Jeffrey Alter, President



Thomas J. McGuire, Secretary

Summary Plan Description

Adams County Government
Choice Plan

Effective: January 1, 2018
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 Company 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 who is scheduled to work at least 40 hours per week, a regular part-time employee who is scheduled to work at least 30 hours per week or a person who retires while covered under the Plan.

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).
- You and/or your Spouse's, or civil union partner's biological children under the age of 26.
  - Children born through gestational surrogacy 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.

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.
- 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℠

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 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 Designated Network
■ Physician's Office Services - Primary Physician.	$30 Network
■ Physician's Office Services – Specialist Physician.	$30 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.
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.	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
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.	
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
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*.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
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.
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-

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
	based lab No copayment applies when no Physician charge is assessed.
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. ■ 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
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

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*
	Designated Network and Network
	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.	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

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
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.
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

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
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
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

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
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

[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[SM].
- 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).

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.
- 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. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. 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.

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 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. Benefits

under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

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 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, 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 and if, as a result, the services are not performed at a Designated Provider, Benefits will not be paid.

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 offer 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).

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 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.
2. Aromatherapy.
3. Hypnotism.
4. 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 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. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.

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 impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.

4. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

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. 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.

3. 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, unless medically necessary.

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. Routine vision examinations (including refractive examinations) to determine the need for vision correction.

2. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

3. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

4. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

5. Eye exercise or vision therapy.

6. 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.

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. 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.

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 do not pass these rebates on to you, nor are they applied to your Annual Deductible or 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.

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.

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.

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).

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.

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 Mental Illnesses listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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 - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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.

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 pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

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.

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 who retires while covered under the Plan.

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 Additive Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current ***Diagnostic and Statistical Manual of the American Psychiatric Association***, unless those services are specifically excluded. The fact that a disorder is listed in the ***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.

Step Therapy

Certain Prescription Drug Products for which Benefits are described in this section 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 determine whether a particular Prescription Drug Product is subject to step therapy requirements by visiting www.myuhc.com or by calling the number on the back of your ID card.

Rebates and Other Discounts

UnitedHealthcare and the Company may, at times, receive rebates for certain drugs on the PDL, including those drugs that you purchase prior to meeting your Annual Drug Deductible. UnitedHealthcare does not pass these rebates on to you, nor are they applied to the Annual Drug Deductible or taken into account in determining your Copays.

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 until they are reviewed and assigned to a tier by the 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.

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
http:///1-877-267-2323, Ext. 61565

ATTACHMENT V – 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 VI– 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.

ATTACHMENTVII– GETTING HELP IN OTHER LANGUAGES OR FORMATS

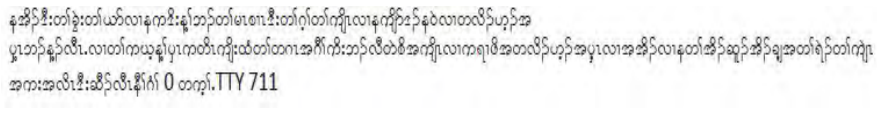
You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

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 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 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 ?।?? পরিক?নার আই ডি কাড?এ তালিকাভূ? ও কর দিতে হবে না এমন ?টলিফোন ন?রে ?ফান ক? ন। (০) শূণ? 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	អ្នក? នសិទិទ្ធទទួលជំនួយ និងព័ត៌? ន ? ? ? របស់អ្នក ? យមិនអស់ថៃ្ង? ដើមី?សុំអ្នកបកៃ្ប សូមទូរស័ព?? លេខឥតចេញថៃ្លសំ? ប់ស? ផិក ដែល? នកត់? ក្នុងប័ណ្ណ?ID គំ? ងសុខ? ពរបស់អ្នក រួចហើយចុច ០។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏫ ᏰᎱ ᏧᏟᏃᏢᏧ ᏧᏎᏍᏧ ᏥᎪᏪᎳ iƫ ᏣᏉᎱ ᏙᎯ ᏰᏒ ᏧᏣᎪᏙᏧ ᎠᏟᏍᏙᏧ ᏆᎾᏂᏍᏧᎢ, ᏬᏐᏅᏍᏓ 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	□□□□ □□□□ □□□□□□ □□□ □□□ □□□□□ □□□□□□□ □□□□□□ □□□□□□□□ □□□□□□ □□. □□□□□□□□ □□□□ □□□□□□ □□□□, □□□□□ □□□□□ □□□□□ ID □□□□□ □□□□ □□□□□□□ □□□□ □□□-□□□□ □□□□□□ □□□ □□□□ □□□ □□□ □□□, □ □□□□□. 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 म? सहायता एवं जानकारी नि:शु? ?ा? करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने है? ? ान ID काड? पर सूचीब? टोल-?ी नंबर पर फ़ोन कर?, 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,ໂທຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आप? ाला आप? ा भाषेत विनामू? मदत आणि माहिती मिळ? ाचा अधिकार आहे. दूभाषकास विनंती कर? ासाठी आप? ा आरो? योजना ओळखप?ावरील सूचीब?द केले? ा सद? ास विनामू? फोन नंबरवर संपक? कर? ासाठी 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.

Language	Translated Taglines
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 hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आ?नो भाषामा निःशु? सहयोग र जानकारी ?ा? गन? अधिकार तपाईंसँग छ। अनुवादक ?ा? गरीपाऊँ भनी अनुरोध गन?तपाईंको ? ा? योजना प?चय काड?मा सूचीकृत टोल-? ी सद? फोन न?बरमा स? क? गनुह्होस्, 0 थि?नुहोस्। 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 ਪ?ਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟੋਲ ਫ਼ੀ?ਮਬ?ਰ 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,

Language	Translated Taglines
	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-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	ܠܗܦ ܐܝܬ ܠܟ ܙܟܘܬܐ ܕܬܩܒܠ ܥܕܪܐ ܘܝܕܥܬܐ ܒܠܫܢܟ ܒܚܢܡ. ܠܡܬܚܢܢܐ ܕܬܬܟܠܡ ܥܡ ܡܬܪܓܡܢܐ، ܩܪܝ ܠܡܣܦܪ ܕܛܠܦܘܢ ܕܐܝܬ ܒܟܪܛܝܣ ܕܐܢܫܘܬܐ ܕܒܝܛܘܚܐ ܕܐܝܬ ܥܠ ܟܪܛܝܣ ܕܗܘܝܬܟ ܘܠܚܘܨ 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	ఎ? ం? ఖ? ? ? ? ం? ? ? ష? ? యం? మ? ? స? ? ర ? ంద? ? ? ? ? హ? ? ఉం? . ఒక? ళ ? ? ? ? లం? , ? ? ? ? ? ఐ? ? ? ?? ద ? ? ? యబడ? ? ? ?? ? ంబ? ? ? ? ? ? , 0 ?? ? ? ? ?. TTY 711

Language	Translated Taglines
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 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
Choice Plus Plan

Effective: January 1, 2018
Group Number: 701043

UnitedHealthcare®

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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 CompanyChoice 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 who is scheduled to work at least 40 hours per week, a regular part-time employee who is scheduled to work at least 30 hours per week or a person who retires while covered under the Plan.

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).
- You and/or your Spouse's, or civil union partner's biological children under the age of 26.
  - Children born through gestational surrogacy 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.

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.
- 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 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 Designated Network Benefits, Network Benefits or Non-Network Benefits.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified 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.

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 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 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 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..

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.

- For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

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.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. 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 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?
Copays, including those for Covered Health Services available in Section 15, ***Outpatient Prescription Drugs***	Yes	Yes
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[SM]	No	No
Charges that exceed Eligible Expenses	No	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	Non-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	$200
■ Physician's Office Services - Primary Physician.	Designated Network $35 Network $35	N/A
■ Physician's Office Services – Specialist Physician.	Designated Network $50 Network $100	N/A
■ Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.	$35	N/A

Plan Features	Designated Network (includes United UnitedHealth Premium®) and Network Amounts	Non-Network Amounts
■ Urgent Care Center Services. ■ Virtual Visits. Copays do not apply toward the Annual Deductible. Copays do apply toward the Out-of-Pocket Maximum.	$55 $35	N/A N/A
Annual Deductible ■ Individual. ■ Family (not to exceed the Individual amount for all Covered Persons in a family).	$900 $1,800	$2,100 $4,200
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.	$6,350 $12,700	$8,000 $16,000
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	Unlimited	

Plan Features	Designated Network (includes United UnitedHealth Premium®) and Network Amounts	Non-Network Amounts
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).		

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	Non-Network
Ambulance Services ■ Emergency Ambulance.	*Ground and/or Air Ambulance* 80% after you meet the Annual Deductible	*Ground and/or Air Ambulance* 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.	
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	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	Non-Network
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.)		
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	60% 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.	
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as	

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Designated Network and Network	Non-Network
	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	60% after you meet the Annual Deductible
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	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	60% after you meet the Annual Deductible
Hospice Care See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% 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,*	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	Non-Network
Additional Coverage Details.		

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Designated Network and Network	Non-Network
Lab, X-Ray and Diagnostics - Outpatient		
■ Lab testing - Outpatient.	100% at a freestanding lab 80% 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.	60% after you meet the Annual Deductible
■ X-ray and Other Diagnostic Testing - Outpatient.	100% after you pay a Copayment of $150 per date of service at a free-standing center 80% 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	60% 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	Non-Network
	Physician charge is assessed.	
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 80% at a Hospital-based lab after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services		
■ Inpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient.	100% after you pay a Copayment of $35 per visit 80% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% 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.	

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Designated Network and Network	Non-Network
Neurobiological Disorders - Autism Spectrum Disorder Services		
■ Inpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient.	100% after you pay a Copayment of $35 per visit	60% after you meet the Annual Deductible
	80% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible	60% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Nutritional Counseling	100% after you pay a Copayment of $35 per visit	60% after you meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient		
■ Primary Physician.	Designated Network	
	100% after you pay a Copayment of $35 per visit	60% after you meet the Annual Deductible
	Network	
	100% after you pay a Copayment of $35 per visit	
■ Specialist Physician.	Designated Network	60% after you meet the Annual

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Designated Network and Network	Non-Network
	100% after you pay a Copayment of $50 per visit Network 100% after you pay a Copayment of $100 per visit	Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury ■ Primary Physician.	Designated Network 100% after you pay a Copayment of $35 per visit Network 100% after you pay a Copayment of $35 per visit	60% after you meet the Annual Deductible
■ Specialist Physician.	Designated Network 100% after you pay a Copayment of $50 per visit Network 100% after you pay a Copayment of $100 per visit	60% 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	Non-Network
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. ■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps.	100% 100% 100%	Non-Network Benefits are not available
Prosthetic Devices See Section 6, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	60% 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 $35 per visit	60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	100% after you pay a Copayment of $150 per date of service at a free-standing center 80% at a Hospital-based lab after you	60% 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	Non-Network
	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.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services		
■ Inpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient.	100% after you pay a Copayment of $35 per visit 80% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% 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	Non-Network
Therapeutic Treatments - Outpatient	100% after you pay a Copayment of $35 per visit	60% 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	100% after you pay a Copayment of $55 per visit	60% 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.	100% after you pay a Copayment of $35 per visit	Non-Network Benefits are not available

[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.

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).

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.
- 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. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. 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 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.

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 [5]must][6]should] 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 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[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.

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. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

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 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.

No copay applies to office visits after the first visit, unless non routine maternity health services are provided.

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 lepharoplasty 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 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, 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 offer 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).

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.
2. Aromatherapy.
3. Hypnotism.
4. 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 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. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.

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 impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.

4. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

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. 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.

3. 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, unless medically necessary.

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. Routine vision examinations (including refractive examinations) to determine the need for vision correction.

2. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

3. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

4. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

5. Eye exercise or vision therapy.

6. 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 Copay, 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 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, 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

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a non-Network provider without UnitedHealthcare's consent. 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.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Participant) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network 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 non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network 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 non-Network provider, you remain the sole beneficiary of the payment, and the non-Network 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 non-Network provider as well. If payment to a non-Network 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
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

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
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

*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 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.

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. 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.

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 do not pass these rebates on to you, nor are they applied to your Annual Deductible or 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.

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.

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.

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).

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.

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 Mental Illnesses listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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 - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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.

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 pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

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.

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 who retires while covered under the Plan.

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 Additive Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current ***Diagnostic and Statistical Manual of the American Psychiatric Association***, unless those services are specifically excluded. The fact that a disorder is listed in the ***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 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.

Step Therapy

Certain Prescription Drug Products for which Benefits are described in this section 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 determine whether a particular Prescription Drug Product is subject to step therapy requirements by visiting www.myuhc.com or by calling the number on the back of your ID card.

Rebates and Other Discounts

UnitedHealthcare and the Company may, at times, receive rebates for certain drugs on the PDL, including those drugs that you purchase prior to meeting your Annual Drug Deductible. UnitedHealthcare does not pass these rebates on to you, nor are they applied to the Annual Drug Deductible or taken into account in determining your Copays.

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 until they are reviewed and assigned to a tier by the 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.

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
http:///1-877-267-2323, Ext. 61565

ATTACHMENT V – 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 VI– 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 VII – 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 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 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 ?।?? পরিক?নার আই ডি কাড?এ তালিকাভূ? ও কর দিতে হবে না এমন ?টলিফোন ন?রে ?ফান ক? ন। (০) শূণ? 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	អ្នក? នសិទ្ធិទទួលជំនួយ និងព័ត៌? ន ? ? ? របស់អ្នក ឲ? យមិនអស់ថ្លៃ? ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទ? លេខឥតចេញថ្លៃសំ? ប់ស? ជិក ដែល? នកត់ឲ? ក្នុងប័ណ្ណ?ID គំរ? ងសុខ? ពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏫ ᎨᏥ ᏧᏟᏃᏢᏗ ᏧᏎᏍᏗ ᏥᎪᏪᎳ Ꭵᏼ ᏣᏉᏥ ᏙᎯ ᎨᏒ ᏗᏓᎪᏙᏗ ᎠᏟᏍᏙᏗ ᏆᎾᏂᏍᏗᎢ, ᏅᏐᏛᏍᏓ 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	□□□□ □□□□ □□□□□□ □□□ □□□ □□□□□ □□□□□□□ □□□□□□ □□□□□□□□ □□□□□□ □□. □□□□□□□□ □□□□ □□□□□□ □□□□, □□□□□ □□□□□ □□□□□ ID □□□□□ □□□□ □□□□□□□ □□□□ □□□-□□□□ □□□□□□ □□□ □□□□ □□□ □□□ □□□, □ □□□□□. 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 म? सहायता एवं जानकारी नि:शु? ?ा? करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने है? ? ान ID काड? पर सूचीब? टोल-?ी नंबर पर फ़ोन कर?, 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

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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	နအိဉ်ဒီးတါ်ခွဲးတါ်ယာ်လၢနကဒီးန့ါဘဉ်တါ်မၤစၢးဒီးတါ်ဂ့ၢ်တါ်ကျိုၤလၢနကိုဉ်ဒဉ်နဝဲလၢတလိဉ်ဟုဉ်အ ပူၤဘဉ်နှဉ်လီၤ.လၢတါ်ကဃ့နှါ်ပှၤကတိၤကျိုးထံတါ်တကၤအဂီၢ်ကီးဘဉ်လီတဲစီအကျိုၤလၢကရၢဖိအတလိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနတါ်အိဉ်ဆူဉ်အိဉ်ချုအတါ်ရဲဉ်တါ်ကျဲၤ အကားအလိၤဒီးဆီဉ်လိၤနီၢ်ဂ်ၢ် 0 တက့ၢ်.TTY 711
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,ໂທຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आप? ाला आप? ा भाषेत विनामू? मदत आणि माहिती मिळ? ाचा अधिकार आहे. दूभाषकास विनंती कर? ासाठी आप? ा आरो? योजना ओळखप?ावरील सूचीब?द केले? ा सद? ास विनामू? फोन नंबरवर संपक? कर? ासाठी 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.

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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 hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आ?नो भाषामा निःशु? सहयोग र जानकारी ?ा? गन? अधिकार तपाईंसँग छ। अनुवादक ?ा? गरीपाऊँ भनी अनुरोध गन?तपाईंको ? ा? योजना प?चय काड?मा सूचीकृत टोल-? ी सद? फोन न?बरमा स? क? गनुहोस्, 0 थि?नुहोस्। 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 ਪ?ਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟੋਲ ਫ਼ੀ?ਮਬ?ਰ 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,

Language	Translated Taglines
	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-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	ܐܼܝܬܠܘܼܟ ܐܝܼܬܠܗܘܿܢ ܢܩܘܼܒܬܵܐ ܕܩܲܒܠܝܼܬܘܿܢ ܗܲܝܪ̈ܬܵܐ ܘܡܲܕܥܵܢܘܼܬܵܐ ܒܠܸܫܵܢܘܼܟ݂ܘܿܢ ܬܲܪ̈ܓܡܵܢܵܐܝܬ ܠܒܘܼܩܵܫܵܐ ܚܕ ܢܒܝ ܡܚܘܿܪ ܠܡܸܢܝܵܢܵܐ، ܡܢܘܿܢ ܥܠ ܡܢܝܵܢܵܐ ܕܦܠܛܘܿܢ ܕܐܝܠܗ ܠܡܢܝܵܢܵܐ ܒܝܬ ܦܠܛܵܐ ܕܡܫܠܡܵܢܵܐ ܘܡܚܘܿܪ 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	ఎ? ం? ఖ? ? ? ? ం? ? ? ష? ? యం? మ? ? స? ? ర ? ందు? ? ? ? ? హ? ? ఉం? . ఒక? ళ ? ? ? ? ? లం? , ? ? ? ? ఐ? ? ? ⁇ ద ? ? ? ? యబడ? ? ? ⁇ ? ంబ? ? ? ? ? ? , 0 ⁇ ? ? ? ?. TTY 711

Language	Translated Taglines
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 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).

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: July 17, 2018
SUBJECT: 2018 Group Agreement with Kaiser Permanente
FROM: Terri Lautt, Director
AGENCY/DEPARTMENT: Human Resources
HEARD AT STUDY SESSION ON: August 22, 2017
AUTHORIZATION TO MOVE FORWARD: ☒ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners Approve the 2018 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 2018, 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:

Human Resources
County Manager's Office
Budget Office

ATTACHED DOCUMENTS:

2018 Evidence of Coverage
2018 Medicare Evidence of Coverage
2018 Large Group Agreement
Amendment to Group Agreement – Contribution and Participation Requirements
Amendment to Group Agreement – Dues
January 1, 2018 Letter of Understanding
January 1, 2018 Letter re: Late Enrollment Penalty
Amendment One 2018 Group Agreement Non-Medicare
Amendment Two 2018 Group Agreement Medicare Employees
Amendment Three 2018 Group Agreement Senior Advantage Medicare
Amendment Four 2018 Group Agreement Medicare Employees (LIS)
ADCO Rate Sheet
Medicare Rates and Combos 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 APPROVING 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, 2018:

1. 2018 Evidence of Coverage
2. 2018 Medicare Evidence of Coverage
3. 2018 Large Group Agreement
4. Amendment to Group Agreement – Contribution and Participation Requirements
5. Amendment to Group Agreement – Dues
6. January 1, 2018 Letter of Understanding
7. January 1, 2018 Letter re: Late Enrollment Penalty
8. Amendment One 2018 Group Agreement Non-Medicare
9. Amendment Two 2018 Group Agreement Medicare Employees
10. Amendment Three 2018 Group Agreement Senior Advantage Medicare
11. Amendment Four 2018 Group Agreement Medicare Employees (LIS)
12. ADCO Rate Sheet
13. Medicare Rates and Combos Rate Sheet

NOW, THEREFORE, BE IT RESOLVED, that the Board of County Commissioners, County of Adams, State of Colorado, hereby approves the attached Amendments to Adams County's Group Agreements with Kaiser Permanente, and the Chair is authorized to execute same.

AMENDMENT ONE
2018 GROUP AGREEMENT
NON-MEDICARE

This document amends the January 1, 2018, 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, 2018
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE: _____, 2018

GROUP: County of Adams

BY: _____
GROUP REPRESENTATIVE

DATE: _____, 2018

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.

AMENDMENT TWO
2018 GROUP AGREEMENT
MEDICARE EMPLOYEES

This document amends the January 1, 2018, 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, 2018
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE: _____, 2018

GROUP: County of Adams

BY: _____
GROUP REPRESENTATIVE

DATE: _____, 2018

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.

AMENDMENT THREE
2018 GROUP AGREEMENT
SENIOR ADVANTAGE MEDICARE

This document amends the January 1, 2018, 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, 2018
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE: _____, 2018

GROUP: County of Adams

BY: _____
GROUP REPRESENTATIVE

DATE: _____, 2018

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.

AMENDMENT FOUR
2018 GROUP AGREEMENT
MEDICARE EMPLOYEES (LIS)

This document amends the January 1, 2018, 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, 2018
KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NON PROFIT CORPORATION

DATE: _____, 2018

GROUP: County of Adams

BY: _____
GROUP REPRESENTATIVE

DATE: _____, 2018

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.

Group Name: COUNTY OF ADAMS Group Number: 385

Contract Period: 2018-01-01 - 2018-12-31

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	$536.74
Spouse Only	$536.74
Child Only	$536.74
Employee & Spouse	$1,127.15
Employee & Child	$1,127.15
Spouse & Child	$1,127.15
Children Only (CK)	$1,127.15
Employee, Spouse & Child/Children	$1,621.01
Employee & Children (ECK+)	$1,621.01
Spouse & Children (SCK+)	$1,621.01
Children Only (CKK+)	$1,621.01

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: 2018-01-01 - 2018-12-31

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	$253.29
Medicare Risk B	$620.74
Medicare Risk BD	$620.74
Medicare Risk CD	$253.29

Group Name: COUNTY OF ADAMS Group Number: 385

Contract Period: 2018-01-01 - 2018-12-31

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	$577.99
Spouse Only	$577.99
Child Only	$577.99
Employee & Spouse	$1,213.78
Employee & Child	$1,213.78
Spouse & Child	$1,213.78
Children Only (CK)	$1,213.78
Employee, Spouse & Child/Children	$1,745.47
Employee & Children (ECK+)	$1,745.47
Spouse & Children (SCK+)	$1,745.47
Children Only (CKK+)	$1,745.47

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: 2018-01-01 - 2018-12-31

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	$253.29
Medicare Risk B	$620.74
Medicare Risk BD	$620.74
Medicare Risk CD	$253.29

KAISER PERMANENTE®

KAISER FOUNDATION HEALTH PLAN, INC.

CY2018 Current Benefit Renewal Rates

Group Name:	COUNTY OF ADAMS
Group	00000385
Subgroup	002

Category	Benefit	Description
AFTR	Urgent Care	M$40 COPAY OPM
AMB	Ambulance	M$195 PER TRIP OPM
CHIR	Chiropractic	SR-$15 CPAY/20 VST+MEDCAR
CMPL	Accupuncture	NOT COVERED
DIAL	Renal Dialysis	M NO CHARGE
DMEB	Durable Medical Equipment	M20% UNLTD OPM
DPP	Dental	NOT COVERED
EMER	Emergency Room	M$65 IN/OUT PLN INCLSV
HEAR	Hearing	MEXAM @ $15 COPAY/NO AID
HOSP	Inpatient Hospital	M$250 PER ADMIT OPM TG
MHIP	Inpatient Mental Health	MLG $250/ADMIT FMH
OPT	Optical	MDC$100/24MOLENS/FRM/CNTS
OVC	Office Visit	M$15 OPM TG
RX	Prescription Drugs	MDE $15G$30BSP/39 D0 ISDN
SGOP	Outpatient Surgery	M$200 OPM TG
SNF	Skilled Nursing Facility	100 SNF DAYS/MDC BFT PD
SPVC	Specialist Visit	M $25 OPM TG
XPRO	Radiology Specialty	M $100 CP SPC PRCDR
OOPM	OOPM	$2500/IND MEDICARE
XRAY	Radiology	$25CP THERA $0CP DIAG MED

Senior Advantage Rate	$253.29
Part B Only Rate	$620.74

KAISER PERMANENTE

KAISER FOUNDATION HEALTH PLAN, INC.

Medicare Combos 2018

Effective Year 2018
Effective Date 1/1/2018

Tier Structure (2,3,4): 2-Tier 3-Tier 4-Tier

Group Name: COUNTY OF ADAMS
Grp#/Subgroup#: 385 / 2

3 Tier

Subscriber	*EE+1*	*Family*
$ 577.99	$ 1,213.78	$ 1,745.47

Medicare Combo Rates (non-custom):

ONE SENIOR ADVANTAGE	$253.29
SUB AND ONE DEP TWO SENIOR ADVANTAGE	$ 506.57
SUB AND ONE DEP ONE SENIOR ADVANTAGE	$ 831.05
SUB AND TWO+ DEPS ONE SENIOR ADVANTAGE	$ 1,394.72
SUB AND TWO+ DEPS TWO SENIOR ADVANTAGE	$ 1,084.33

Note: Actively at-work Medicare enrollees classified as "RO WC" and "RO WB" are not eligible for the Senior Advantage Rate. They should be billed at the single, non-Medicare rate.

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 2018 contract year.

kp.org

KAISER PERMANENTE®

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 the number provided below.

Colorado	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 with the Kaiser Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, telephone number: 1-800-632-9700. You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser 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, 1-800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Help in your Language

English: You have the right to get help in your language at no cost. If you have questions about your application or coverage through Kaiser Permanente, or this notice requires you to take action by a specific date, call the number provided for your state or region to talk to an interpreter.
Colorado 1-800-632-9700 (TTY 711)

አማርኛ (Amharic): ያለምንም ክፍያ በራስዎ ቋንቋ እገዛ የማግኘት መብት አለዎት። ስለ ማመልከቻዎ ወይም ከኬሰር ፐርማነንቴ Kaiser Permanente ስለሚያገኙት ሽፋን ማንኛውም ጥያቄዎች ካሉዎት፣ ወይም ይህ ማሳወቂያ በግልፅ በተጠቀሰ ቀን ማድረግ ያለብዎ ነገር እንዳለ የሚያስገድድዎ ከሆነ፣ በተጠቀሰው የስልክ ቁጥር ለስቴትዎ ወይም ለክልልዎ ደውለው ከአስተርጓሚ ጋር ይነጋገሩ።
Colorado 1-800-632-9700 (TTY 711)

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن طلبك أو تغطيتك التي تقدمها Kaiser Permanente، أو يتطلب هذا الإشعار منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.
Colorado 1-800-632-9700 (TTY 711)

Bàsɔ̀ɔ̀ Wùɖù (Bassa): Ǹ ɓéɖé dyí-ɓèɖèìn-ɖèɔ̀ ɓé m̀ ké gbo-kpá-kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Ɔ jǔ ké m̀ dyi dyi-dieǹ-ɖè ɓě ɓéɖé ɓá nì ɖɛ-mó-ɖìfèɖèɔ̀ dyí, mɔɔ ɓá nì kũùn kpɔ̃ jè dyí dyììn ɖé Kaiser Permanente mú, mɔɔ ɔ jǔ ké bɔ̃̌i-po-po nià kɛ dyi níiń m̀ mɛ nyùìn ɖɛ dɔ̀ wé jɛ́ɛ́ ɖɔ̀ kɔ̃ɛ nì, nìí, ɖá nɔɓà ɓé wa tòà ɓó nì gbɛ̌ɛ̀ vènè mɔɔ nì gbɛ̌ɛ̀ dyùɔ̀ jèɛ ɓé m̀ ké wuɖu-zǐìn-nyɔ̀ ɖɔ̀ gbo wùɖù.
Colorado 1-800-632-9700 (TTY 711)

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的Kaiser Permanente申請或承保有任何疑問，或者本通知要求您在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。
Colorado 1-800-632-9700 (TTY 711)

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de votre demande d'inscription ou de la couverture par Kaiser Permanente, ou si cet avis vous demande de prendre des mesures à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.
Colorado 1-800-632-9700 (TTY 711)

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutzes durch Kaiser Permanente haben oder falls Sie aufgrund dieser Benachrichtigung bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.
Colorado 1-800-632-9700 (TTY 711)

Igbo (Igbo): Ị nwere ikike ịnweta enyemaka n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ọ bụrụ na ị nwere ajụjụ gbasara akwụkwọ anamachọihe gị ma ọ bụ mkpuchi si na Kaiser Permanente, ma ọ bụ na ọkwa a chọrọ ka ị mee ihe tupu otu ụbọchị, kpọọ nọmba enyere maka steeti ma ọ bụ mpaghara gị iji kwukọrịta okwu n'etiti onye ọkọwa okwu.
Colorado 1-800-632-9700 (TTY 711)

日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。お申し込みまたはKaiser Permanenteの担保範囲に関してご質問があるか、または本通知により、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳と, お話ください。
Colorado 1-800-632-9700 (TTY 711)

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. Kaiser Permanente를 통한 귀하의 보험 신청서나 보험 보장 범위에 관해 질문이 있을 경우 또는 이 통지서의 요구대로 일정 날짜까지 조취를 취해야 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락해 통역사와 통화하십시오.
Colorado 1-800-632-9700 (TTY 711)

Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

Naabeehó (Navajo): T'áá ni nizaad bee níká i'doolwoł doo bik'é asíníłáágóó éí bee náhaz'ą́. Kaiser Permanente áká aná'álwo' ná bik'é azláadoo yíníkeedgo naaltsoos hadinilaa, éí bína'ídíłkid doogo, éí doodago díí naaltsoos haa'ída yoołkáałgo hait'áoda í'díílíił niłníigo éí nitsaa hahoodzojí éí doodago t'áá aadi nahós'a'di ata' dahalne'ígíí bich'į' hólne'go bee bił ahił hodíílnih.
Colorado 1-800-632-9700 (TTY 711)

नेपाली (Nepali): तपाईंसगं कुनै शुल्क नदिइ आफ्नो भाषामा सहायता पाउने अधिकार छ । तपाईंसंग आफ्नो आवेदन बारे वा Kaiser Permanente मार्फत कवरेज बारेमा कुनै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईंले कुनै निर्धारित मितिमा कुनै कार्यवाही गर्नुपरेमा, दोभाषेसंग कुराकानी गर्न तपाईंको राज्य वा क्षेत्रका लागि दिइएको नम्वरमा कल गर्नुहोस् ।
Colorado 1-800-632-9700 (TTY 711)

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee iyyata keetii yookaan tajaajila Kaiser Permanente hammatu ilaalchisee gaaffii yoo qabaatte, yookaan beeksisi Kun guyyaa murtaa'e irratti tarkaanfii akka ati fudhattu kan gaafatu yoo ta'e, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bibiluudhaan turjumaana haasofisiisi.
Colorado 1-800-632-9700 (TTY 711)

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره درخواست یا پوشش خود در Kaiser Permanente سؤالی داشته یا بر اساس این اعلامیه باید تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.
Colorado 1-800-632-9700 (TTY 711)

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно вашего заявления или медицинского страхования в Kaiser Permanente, либо данное уведомление требует от вас каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.
Colorado 1-800-632-9700 (TTY 711)

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de su solicitud o cobertura a través de Kaiser Permanente, o este aviso requiere que usted tome alguna medida antes de una fecha determinada, llame al número de teléfono que se le proporcionó para su estado o región para hablar con un intérprete.
Colorado 1-800-632-9700 (TTY 711)

Tagalog (Tagalog): Mayroon kang karapatan na kumuha ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong aplikasyon o coverage sa pamamagitan ng Kaiser Permanente, o ang abisong ito ay nangangailangan ng iyong aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap usap sa tagapagsalin.
Colorado 1-800-632-9700 (TTY 711)

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về mẫu đơn hoặc mức bảo hiểm của mình thông qua Kaiser Permanente, hoặc thông báo này yêu cầu quý vị thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.
Colorado 1-800-632-9700 (TTY 711)

Yorùbá (Yoruba): O ní ẹ̀tọ́ láti rí ìrànlọ́wọ́ gbà nípa èdè rẹ láìsan owó. Bí o bá ní ìbéèrè nípa ìṣàfilọ́lẹ̀ tàbí ìṣedéédé nípaṣẹ̀ Kaiser Permanente, tàbí ìfitọnilétí yìí fẹ́ kí gbé ìgbésẹ̀ kan ní ọjọ́ kan patọ́, pé nọ́mbà tí a pèsè fún ìpínlẹ̀ tàbí agbègbè rẹ láti bá òǹgbifọ̀ kan sọ̀rọ̀.
Colorado 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. 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. A Plan Physician ***must*** determine that the Service is ***Medically Necessary*** to prevent, diagnose, or treat your medical condition. A Service is Medically Necessary ***only*** if a Plan Physician determines that it is medically appropriate for you and its omission would have an adverse effect on your health; ***and***
   b. The Service ***must be*** provided, prescribed, authorized, or directed by a Plan Physician; ***and***
   c. The Service ***must be*** a ***covered*** Service described in this EOC.
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.
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.

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
Telemedicine	
• 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
• Online	
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	
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 *(Does not apply to Out-of-Pocket Maximum)*	$15 Copayment each visit
o Specialty care visits *(Does not apply 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 *(Not subject to medical Deductible)*	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 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 *(Does not apply to Out-of-Pocket Maximum)*	$15 Copayment each visit
• Fitting and Recheck Visits *(Does not apply 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

Infertility 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

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 living outside the Service Area	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and chemical dependency, gynecology care, preventive care, and a visit with the administration of allergy injections. Office vists do not include: allergy evaluation, routine prenatal and postpartum visits, chiropractic care, acupuncture services, hearing exams, home health visits, hospice services, immunizations, and applied behavioral analysis (ABA))* *Visit: (Does not apply to Out-of-Pocket Maximum)* *Other Services: (Do not apply to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit Other Services received during an office visit: Not Covered Limited to 5 visits per Accumulation Period
Diagnostic X-ray Services *(Does not apply to Out-of-Pocket Maximum)*	20% Coinsurance Limited to 5 diagnostic X-rays per Accumulation Period
Outpatient physical, occupational, and speech therapy visits *(Does not apply to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit Limited to 5 therapy visits (any combination) per Accumulation Period
Outpatient prescription drugs *(Not subject to pharmacy Deductible);* *(See "Prescription Drugs, Supplies, and Supplements" for Out –of-Pocket Maximum information)*	See "Prescription Drugs, Supplies, and Supplements" for applicable Copayment or Coinsurance Limited to 5 prescription drug fills per Accumulation Period

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 *(Do apply to Out-of-Pocket Maximum)*	
• Pharmacy Deductible	Not Applicable
• Copayment/Coinsurance (except as listed below):	$15 Generic/$30 Brand name
• Preventive drugs on the Kaiser Permanente preventive drug list	See applicable Outpatient prescription drug Copayment/Coinsurance
• Specialty drugs	See applicable Outpatient prescription drug Copayment/Coinsurance
• Infertility drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Prescribed supplies *(When obtainted from sources designated by Kaiser Permanente)*	20% Coinsurance
• Over the counter items (OTC): *(Includes federally mandated over the counter items (OTC). OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)*	No Charge
• Tobacco cessation drugs	No Charge
• Sexual dysfunction drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
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	No Charge
• Flexible sigmoidoscopies	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

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
Routine eye exam and eye refraction test when performed by an Optometrist *(Does not apply to Out-of-Pocket Maximum)*	
• Members up to the end of the calendar year he/she turns age 19 *(Does not apply to Out-of-Pocket Maximum)*	$15 Copayment each visit
• Members age 19 and over *(Does not apply to Out-of-Pocket Maximum)*	$15 Copayment each visit
Routine eye exam and eye refraction test when performed by an Ophthalmologist	
• Members up to the end of the calendar year he/she turns age 19 *(Does not apply to Out-of-Pocket Maximum)*	$25 Copayment each visit
• Members age 19 and over *(Does not apply to Out-of-Pocket Maximum)*	$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.

HMO Plus	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, outpatient mental health and chemical dependency individual therapy and short-term outpatient physical, occupational and speech therapy visits with a non-Plan Provider *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty and gynecology care visits and allergy testing and evaluations with a non-Plan Provider *(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 X-ray special procedures *(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 Foundation Health Plan or allied 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 60 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, sign on to kp.org/specialenrollment, or 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.
- "Access to Other Providers" in this section.
- "Cross Market Access" in this section.

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. Female members do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Medical Group physician 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. Female members do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Medical Group physician 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.

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 Foundation Health Plan or Allied Plan Service Areas

If you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily, you can get visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered Services, Copayments, and Coinsurance described in this EOC.

Please call **Member Services** to get more information about visiting member care, including facility locations in other service areas. Service areas and facilities where you may get visiting member care may change at any time.

You receive the same prescription drug benefit as your home Service Area benefit. This includes your Copayments or Coinsurance, exclusions and limitations.

F. Moving Outside of Any Kaiser Foundation Health Plan or Allied Plan Service Area

If you move to an area not within any Kaiser Foundation Health Plan or allied 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 Foundation Health Plan or allied 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 Foundation Health Plan or allied plan service area for care, covered Services, Copayments or Coinsurance will be as described under "Visiting Other Kaiser Foundation Health Plan or Allied 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 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 (b) "Urgent Care Outside the Service Area" in "Emergency Services and Urgent Care"; 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").
- 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. Telehealth and telemedicine visits.
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 Outpatient 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 when administered in an outpatient setting:

1. Outpatient surgery at designated Plan Facilities, including an ambulatory surgical center, surgical suite, or outpatient hospital facility.
2. Outpatient hospital Services at designated outpatient hospital facilities, including but not limited to: sleep study, stress test, pulmonary function test, treatment room, or 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 Exclusion
   Transportation by other than a licensed ambulance. This includes transportation by car, taxi, bus, gurney van, minivan and any other type of transportation, 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 (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:

1. We would have covered the Services if they were not related to a clinical trial.

2. 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:
   a. A Plan Provider makes this determination.
   b. You provide us with medical and scientific information establishing this determination.
3. 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.
4. 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:
   a. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
   b. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
   c. The study or investigation is approved or funded by at least one of the following:
      i. The National Institutes of Health.
      ii. The Centers for Disease Control and Prevention.
      iii. The Agency for Health Care Research and Quality.
      iv. The Centers for Medicare & Medicaid Services.
      v. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
      vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
      vii. 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:
         1. It is comparable to the National Institutes of Health system of peer review of studies and investigations.
         2. 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.

Clinical Trials Exclusions
1. The investigational Service.
2. 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 that are necessary as a result of an acute medical condition; or
   b. Services provided to a child that is not participating in the Early Intervention program for infants and toddlers under Part C of the federal "Individuals with Disabilities Act"; or

c. Services that are not provided pursuant to an Individualized Family Service Plan developed pursuant to 20 U.S.C. Sec. 1436 and 34 C.F.R. 303.340, as amended.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination, as defined by state or federal law; and
   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."

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, Health Plan 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, Health Plan 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".

K. Family Planning 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 Services Exclusions
   a. Donor semen or eggs.
   b. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
   c. 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 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. Infertility Services

Infertility Services are **not** covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the infertility benefit, see the "Schedule of Benefits (Who Pays What)."

Q. 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. Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance, including but not limited to attention deficit disorder.
   c. Mental health Services ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless Medically Necessary.
   d. Court-ordered testing and testing for ability, aptitude, intelligence, or interest.
   e. Services which are custodial or residential in nature.

R. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser Foundation 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. Mental health visit.
      vi. Chemical dependency visit.
      vii. Visits with the administration of allergy injections.
   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: lab, procedures, and office administered drugs and devices except for allergy injections.
   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 exams, home health visits, hospice services, and 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.

S. 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.

T. 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, or in the ***Southern, Northern,*** and ***Mountain Colorado*** Service Areas, at pharmacies designated by Health Plan. 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.

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.

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. (***Denver/Boulder, Northern,*** and ***Mountain Colorado*** Members only).
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".

U. 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.

V. 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.

W. Skilled Nursing Facility Care

1. Coverage
We cover skilled inpatient Services in a licensed Skilled Nursing Facility. 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 and laboratory tests, Services and materials, which includes, but is not limited to isotopes, electrocardiograms, electroencephalograms, mammograms, and ultrasounds.
      ii. Therapeutic X-ray Services and materials.
      iii. 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. **Certain Exams and Services.** Physical examinations and other Services, and related reports and paperwork, in connection with third-party requests or requirements, such as those for:
   a. Employment;
   b. Participation in employee programs;
   c. Insurance;
   d. Disability;
   e. Licensing; or on court order or for parole or probation.

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 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 and, unless otherwise specified herein, (a) and (b) are received at a Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; lab 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. **Intermediate Care.** Care in an intermediate care facility.
12. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.
13. **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.
14. **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.
15. **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.
16. **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.
17. **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.
18. **Weight Management Facilities.** Services received in a weight management facility.
19. **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 compared to another plan covering the person.

   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.
   ii. If a person is covered by 2 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 2 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 two or more plans pay benefits, the rules for determining the order of 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. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.
   i. There is an exception: 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. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
   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 primary and the plan that covers the person as a dependent is secondary. 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 secondary and the other plan is primary.

   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 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) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive
- 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 Foundation Health Plan or Allied Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser Foundation Health Plan or allied 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 180 days 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 180 days 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).

Telehealth: A mode of delivery of health care services through telecommunications systems, including information, electronic, and communication technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a covered person's health care while the covered person is located at an originating site and the provider is located at a distant site. The term includes synchronous interactions and store-and-forward transfers. Telehealth does not include the delivery of health care services via telephone, facsimile machine, or electronic mail systems.

Telemedicine: The delivery of medical services and any diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication.

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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.

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)

INFERTILITY 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 the 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. Donor semen or eggs.
   c. Any and all Services, supplies, office administered drugs, and prescription drugs received from the pharmacy related to the procurement and/or storage of semen and/or eggs, except as listed in the "Coverage" section of this benefit.
   d. Prescription drugs received from the pharmacy for infertility services unless prescription drug coverage for infertility is purchased.
   e. Any and all Services, supplies, office administered drugs, and prescription drugs received from the 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 Infertility 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 (01-18)

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.

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. Compounded medications.

d. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.

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.

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. (***Denver/Boulder, Northern Colorado,*** and ***Mountain Colorado*** Members only)
   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 (01-18)

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

2500 S. Havana St.

Aurora, CO 80014-1622

FORWARDING SERVICE REQUESTED

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U.S. POSTAGE PAID
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PERMIT #300

USPS 1000 Approved Poly

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CHERYL DENISE ADAMS
946 E EGBERT ST APT A
BRIGHTON, CO 80601-2274

CHERYL DENISE ADAMS

Important plan information

000000385 002 A215 K NQ AB GP 50_18 [Jun 7 2018] OVC7XHOSPB4BLDQBMHOP71SPVC57OPT--CDOP22HEARHPEMER07PV0AAFTR16 ACUMCLALGA3ALGT2CAMB02AUTBD8CDIPJPCDRR20CHIR 3TCMPL--COIN--CRCS62DEDNADENNADIALA5DMEB85DMES2JDPP--DUMY01EMPH0YEPO--EXAB--FAM23GRP1AGYN29HC0AHCSS0QHH0AHOOP1VHOS21EHRA--INFT0JLAB1NMHBI02MHBO01MHIP35 OPM24OVC208OXYG1YPNMT2KPP01REHB11REOPA4SGOP63SNF1SSNKR--STU5FTABS4XTRAN04TRGNCCTRVL--VADD--WLCH65XPRO1AXRAY2NOVC7XRX02QB APO45GLISGMGREX01GRFD07OAD6 MOAS6MSRDC11SV03WORA

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 2018 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, 2019, 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.

EG18001DB (MC/11/2017)

KPSA-GROUP-PART D DEN(01-18)

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 well.	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 cancer or have had an abnormal Pap test and are of childbearing age: 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	$15 Copayment each visit Up to 20 visits per year See Additional Provisions See X-ray
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 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

†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
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 can special order it for you. The most recent list of suppliers is available on our website at **kp.org/directory**.	20% Coinsurance See Additional Provisions
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 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 Healthways 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. • SilverSneakers® Steps, a self-directed fitness program for members without convenient access to SilverSneakers® fitness locations, which includes tools and resources 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.	**No charge**
Hearing 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

†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
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 a year in the fall or winter. • 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, 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 we provide transplant services at a distant location (outside of the service area) 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

†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
Inpatient mental health care†	
Covered services include mental health care services that require a hospital stay. 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.	$250 Copayment per admission
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 referred 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 referral. A physician must prescribe these services and renew his or her referral 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) Beginning April 1, 2018, 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.

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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 listed 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
• †Therapeutic X-rays	$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

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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 $3,750
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 $5,000
• 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

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Services that are covered for you	What you must pay when you get these covered services
Physician/practitioner services, including doctor's office visits	
"Providers" include, but are not limited to, physicians, physician assistants and nurse practitioners. 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.	$15 Copayment each visit or $25 Copayment each visit 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.

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Services that are covered for you	What you must pay when you get these covered services
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.
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

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Services that are covered for you	What you must pay when you get these covered services
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.
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.

†Your provider must obtain prior authorization from our plan.
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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 "Medicare Part B prescription drugs".	No Charge

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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 when prescribed by a network physician. No prior hospital stay is required. Covered services include: • 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 skilled nursing facility (SNF) for 60 calendar days in a row. **Note:** If a benefit period begins in 2017 for you and does not end until sometime in 2018, the 2017 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.
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 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.	$40 Copayment each visit
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.	

†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
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.
• 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 ***

†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
"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.**

2018 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 is 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 of 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 2018 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, 2018, and December 31, 2018,

unless amended. If your group's agreement renews at a later date in 2018, 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, 2018. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2018. 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 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: **Boulder, Broomfield, Denver, and Gilpin.** Also, our service area includes these parts of counties in Colorado, **in the following ZIP codes only:**

- **Adams County:** 80002, 80003, 80010, 80011, 80019, 80020, 80022, 80023, 80024, 80030, 80031, 80035, 80036, 80037, 80040, 80042, 80045, 80102, 80137, 80212, 80216, 80221, 80229, 80233, 80234, 80241, 80247, 80249, 80260, 80601, 80602, 80603, 80614, 80640,80642, and 80643.
- **Arapahoe County:** 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80041, 80044, 80046, 80047, 80102, 80110, 80111, 80112, 80113, 80120, 80121, 80122, 80123, 80128, 80129, 80137, 80150, 80151, 80154, 80155, 80160, 80161, 80165, 80166, 80222, 80231, 80236, 80246, and 80247.
- **Clear Creek County:** 80439 and 80452.
- **Douglas County:** 80104, 80108, 80109, 80112, 80116, 80124, 80125, 80126, 80129, 80130, 80131, 80134, 80135, 80138, and 80163.
- **Elbert County:** 80102, 80107, 80117, 80134, and 80138.
- **Jefferson County:** 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80020, 80021, 80031, 80033, 80034, 80123, 80127, 80128, 80162, 80212, 80214, 80215, 80225, 80226, 80227, 80228, 80232, 80235, 80401, 80402, 80403, 80419, 80425, 80433, 80437, 80439, 80453, 80454, 80457, 80465, and 80470.
- **Park County:** 80421 and 80470.

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, **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your 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 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 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 in some 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 2018 **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 2018 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.

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*"): Report 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 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 amount of the penalty depends upon how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months 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 2018, this average premium amount is $35.02.
- 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 $35.02, which equals $4.90. This rounds to $4.90. 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.
- 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** 2018 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 with 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 letter you receive stating you have to pay a 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. The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2017 was:	If you were married but filed a separate tax return and your income in 2017 was:	If you filed a joint tax return and your income in 2017 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	$0
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$13.00
Greater than $107,000 and less than or equal to $133,500		Greater than $214,000 and less than or equal to $267,000	$33.60
Greater than $133,500 and less than or equal to $160,000		Greater than $267,000 and less than or equal to $320,000	$54.20
Greater than $160,000	Greater than $85,000	Greater than $320,000	$74.80

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 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** 2018 gives you information about Medicare premiums in the section called "2018 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** 2018 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 the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

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
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 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	**1-866-466-4042**
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.comwww.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 50% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 35% 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 (15%) 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 56% of the price for generic drugs and you pay the remaining 44% of the price. For generic drugs, the amount paid by our plan (56%) 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 50% discount on covered brand-name drugs. Also, the plan pays 15% of the costs of brand-name drugs in the coverage gap. The 50% discount and the 15% 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.
- 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.

- 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, except for certain specialty care.
- Mental health care or substance abuse services, as long as you get them from a network provider.
- Preventive care except abdominal aortic aneurysm and bone density screenings, as long as you get them from a network provider.
- Podiatry 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.

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 or make an appointment, please refer to your **Provider Directory** for appointment and advice telephone numbers.

What if you are outside 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 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.

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.

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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 2018 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, our plan covers 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 2018** 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 2018, 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		√ The 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 eyeware. 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, vision therapy, 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

SECTION 1. Introduction

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 1.1 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 2018 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. However, currently this is not applicable to our plan because there are no such pharmacies inside 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. 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 2018 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.
2. Visit our website (**kp.org/seniormedrx).** Our Drug List (**Kaiser Permanente 2018 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 2018 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 2018 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 and aren't in a long-term care (LTC) facility:** 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.
- **For those members who are new or who were in our plan last year and reside in a long-term care (LTC) facility:** 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. The total supply will be for a maximum of a 98-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day supply of medication. (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 long-term care transition supply.
- 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

For drugs in Tiers 2-4, 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.

In almost all cases, we must get approval from Medicare for changes we make to our Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage for a drug you are taking, we will send you a notice to tell you. Normally, we will let you know at least 60 days ahead of time.

Once in a while, a drug is suddenly recalled because it's been found to be unsafe or for other reasons. If this happens, we will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change 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, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happen to a drug you are taking, 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. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a brand-name drug you are taking is replaced by a new generic drug, we must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
  - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
  - Or 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)."
- Again, if a drug is suddenly recalled because it's been found to be unsafe or for other reasons, we will immediately remove the drug from the Drug List. We will let you know of this change right away.
  - Your provider will also know about this change, and can work with you to find another drug for your condition.

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, such as Viagra®, Cialis®, Levitra®, and Caverject®.
- 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 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 2018 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 has a deductible).** **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 **$3,750**. 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 **$5,000**. (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 44% of the price**, whichever is lower. For **brand-name drugs, you pay 35% 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 **$5,000**. 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, 2018). (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 **$5,000**. When you reach an out-of-pocket limit of **$5,000**, 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 **$3,750 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 2018, 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 **$3,750** limit in a year.

We will let you know if you reach this **$3,750** 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 $5,000

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 44% 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 2018, that amount is **$5,000.**

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 2018, that amount is **$5,000**.

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 **$5,000**, 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 **$5,000** 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 **$5,000** 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 **$5,000** 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 **$3.05** for covered generic drugs (includes drugs treated like generics). You will pay **$8.10** 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 2018 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 2018 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.

When you pay copayments under a drug manufacturer patient assistance program

If you get help from, and pay copayments under, a drug manufacturer patient assistance program outside our plan's benefit, you may submit a paper claim to have your out-of-pocket expense count toward qualifying you for catastrophic coverage.

- Save your receipt and send a copy to us.

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.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). For that reason, some plan members must pay a premium for Medicare Part A and 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 161

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," 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** 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 send you a written denial notice informing you that we have automatically sent 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 send you a written denial notice informing you that we have automatically sent 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. 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 2018 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 2018 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 2018 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 2018 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 2018 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 3 (preferred 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 2018 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**."

- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (specialty-tier drugs).

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**. 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.

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 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. 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 a judge.

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 a judge.
- 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 a judge.

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 **h**ttps://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.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 <u>not</u> 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 a judge.

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 a judge.
- 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 a judge.
- 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 who works for the federal government will review your appeal and give you an answer. This judge is called an "administrative law judge."

- **If the administrative law judge 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 judge'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 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 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 **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the federal government.

- **If the answer is *yes*, or if the Appeals 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 Appeals 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 Appeals 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 Appeals 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 administrative 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 who works for the federal government will review your appeal and give you an answer. This judge is called an "administrative law judge."

- **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 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 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 **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for 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 Appeals 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 Appeals 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 2018** 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. 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 7. 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 8. 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 9. 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 10. 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 11. 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 12. 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 13. 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 **$5,000** 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 **$3,750**, 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 2018 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 does 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**.

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 ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ 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**).

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 **1-800-476-2167** (رقم هاتف الصم والبكم: **711**-).

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 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	**303-338-3220**
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	https://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.

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)

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.
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.

OPT0AB

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.

OPT0AB (01-15)

SNKR0AA

SILVER SNEAKERS FITNESS BENEFIT

A health and fitness benefit is covered and provided at participating fitness or wellness facilities within our Service Area. Health and fitness benefits include:

1. Fitness classes (to improve posture, flexibility and strength).
2. Toning with weights.
3. Aerobic classes.
4. Circuit training.

Additional benefits provided at some facilities include:

1. Swimming.
2. Court sports.
3. Running tracks.
4. Saunas.

You may access Services by taking your current Plan Identification Card to one of the participating fitness facilities within our Service Area and enrolling in the program. To get a list of the participating facilities, please call **Member Services.**

You will be given a one-time activity readiness assessment. Participation in the Fitness Benefit program is dependent upon the result of this assessment and may require a subsequent evaluation at a Plan Medical Office. There is no initiation fee and no monthly dues for participation.

Programs, Services and facilities which carry additional charges such as:

1. Racquetball;
2. Tennis and other court sports;
3. Massage therapy;
4. Lessons related to recreational sports;
5. Tournaments; and
6. Similar fee-based activities;

are excluded.

SNKR0AA (01-12)

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)

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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

FORWARDING SERVICE REQUESTED

9 ***********************************SNGLP
S1 P1 019004628036
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COUNTY OF ADAMS
490 1ST ST
BENNETT, CO 80102-8633

Important plan information

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MECMPL--COIN--CRCS07DEDNADENNADIAL0MDMEB41DMES78DPP--DUMY01EMPH0REPO--EXAB--FAM11GRPM1GYN8CHC02HCSS45HH0MHOOP--HOS208HRA--INFT6MLAB56MHBI02MHBO01MHIP48
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KAISER PERMANENTE®

Kaiser Foundation Health Plan of Colorado

A Colorado Nonprofit Corporation

2018

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, 2018 (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

Health Plan may terminate this *Agreement* by giving advance written notice to Group, if Group fails to make any past-due payment during Health Plan's grace period. The advance written notice will indicate the termination date. A grace period of 31 days is observed by Health Plan, during which time the amounts specified in the Rate Sheet may be paid by the Group without loss of benefits. The grace period shall apply to all payments except the first payment and coverage shall remain in effect if payment is made during the grace period. Group is liable for all unpaid Dues through 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 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

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.

If Group does not prepay Full Dues by the first of the coverage month or by the date otherwise agreed to by Health Plan and Group, 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 : 1/1/2018

GROUP **COUNTY OF ADAMS 385**	**KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NONPROFIT CORPORATION**
BY: _____ **Authorized Group Officer Signature**	**BY:**  **Authorized Representative Signature**
_____ **Please Print Your Name and Title**	**R. Roland Lyon, President – Colorado Region** **Please Print Your Name and Title**
_____ **Date Signed**	**_____** **Date Signed 12/7/2017**

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.

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.

KAISER PERMANENTE®

January 1, 2018

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 2018 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: _____

KAISER PERMANENTE®

January 1, 2018

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, 2018 and for the duration of your 2018 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, 2018, 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: _____

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: July 17, 2018
SUBJECT: Traffic Signal Maintenance and Emergency Repairs
FROM: Raymond H. Gonzales, County Manager Alisha Reis, Deputy County Manager Benjamin Dahlman, Finance Director Kim Roland, Procurement and Contracts Manager
AGENCY/DEPARTMENT: Adams County Public Works
HEARD AT STUDY SESSION ON: N/A
AUTHORIZATION TO MOVE FORWARD: ☐ **YES** ☐ **NO**
RECOMMENDED ACTION: That the Board of County Commissioners approves Amendment One to the agreement with W. L. Contractors Inc., to provide Traffic Signal Maintenance and Emergency Repairs.

BACKGROUND:

The Public Works Department (Public Works) is responsible for operating thirty-nine (39) intersection traffic signals, eleven (11) mid-block traffic signals, and two (2) emergency/fire signals. Operating traffic signals require frequent inspection, on-going maintenance, repair, after hours emergency repair, specialized equipment, and qualified skilled labor trades. Because of these requirements, it has proven to be cost effective to best manage risk/liability by contracting these services.

A formal Request for Proposal was solicited through Rocky Mountain E-Purchasing and approved for award to W. L. Contractors Inc., by the Board of County Commissioners on August 15, 2017.

Public Works is pleased with the services provided by the contractor and is requesting the approval of the first renewal year option.

W. L. Contractors Inc., has agreed to hold their unit price for the 2018-2019 renewal year, in the not to exceed amount of one hundred twenty-five thousand dollars and no cents (125,000.00). The unit fees are considered fair and reasonable for the contracted scope of work.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Public Works

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: 13

Cost Center: 3055

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

	Object Account	Subledger	Amount
Current Budgeted Operating Expenditure:	7821		$150,000.00
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			$150,000.00

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

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

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING AMENDMENT ONE TO THE AGREEMENT BETWEEN ADAMS COUNTY AND W.L. CONTRACTORS INC., TO PROVIDE TRAFFIC SIGNAL MAINTENANCE AND EMERGENCY REPAIR SERVICES

WHEREAS, W.L. Contractors Inc., is currently providing traffic signal maintenance and emergency repair services; and,

WHEREAS, W.L. Contractors Inc., has agreed to provide traffic signal maintenance and emergency repair services in the amount of $125,000.00; and,

WHEREAS, the Public Works Department is pleased with the services provided by W.L. Contractors Inc., and wishes to renew the agreement for one year.

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 W.L. Contractors Inc., for traffic signal maintenance and emergency repair services be approved.

BE IT FURTHER RESOLVED, that the Chair is hereby authorized to sign said Amendment One with W.L. Contractors Inc., after negotiation and approval as to form is completed by the County Attorney's Office.

COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

STAFF REPORT

CASE NO.: PLT2017-00019

CASE NAME: COMANCHE VISTA ESTATES, FILING 5

TABLE OF CONTENTS

COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

STAFF REPORT

Board of County Commissioners July 17, 2018

Case No.: **PLT2017-00019**	CASE NAME: **Comanche Vista Estates, Filing # 5**

Owner's Name:	Kenneth Newby
Applicant's Name:	Kenneth Newby
Applicant's Address:	P.O. Box 830, Bennett, CO 80102
Location of Requests:	Approximately 1,300 feet northeast of the intersection of Headlight Mile Road & E. 38th Avenue.
Parcel #:	0181323200006
Nature of Requests:	Minor Subdivision Final Plat for 1 lot
Zone District:	Comanche Vista Estates Planned Unit Development (PUD)
Site Size:	5 acres
Proposed Uses:	Single-Family Residential
Existing Use:	Vacant
Hearing Date(s):	**PC: June 28, 2018 / 6:00 p.m.** **BoCC: July 17, 2018 / 9:30 a.m.**
Report Date:	June 29, 2018
Case Manager:	Greg Barnes
PC Recommendation:	APPROVAL of the final plat with 11 Findings-of-Fact and 1 Condition
Staff Recommendation:	APPROVAL of the final plat with 11 Findings-of-Fact and 1 Condition

SUMMARY OF PREVIOUS APPLICATIONS

On August 20, 2003, the Board of County Commissioners approved a Planned Unit Development (PUD-Comanche Vista Estates), a final development plan (FDP) on 307 acres, and a final plat(Filing # 1) on 10 acres of the 307 acre PUD. As part of the PUD, 217 acres of property was reserved as a conservation easement.

On November 28, 2005, the Board of County Commissioners approved a final plat (Filing # 4) to create 6 lots on 31 acres of the previously approved 307 acre FDP.

On June 25, 2007, the Board of County Commissioners approved a final plat (Filing #2) to create 4 lots on 20.8 acres of the 307 acre FDP.

On November 14, 2017, the Board of County Commissioners approved a preliminary plat (Filing #3 of the PUD) to create 5 lots on 25.8 acres of the 307 acre FDP.

Filing #	No. of Approved Lots (Final Development Plan	No of Approved Lots (Final Plat)
1	2	2
2	4	4
3	5	0
4	6	6
5	1	0*

The subject request will create this lot.

SUMMARY OF APPLICATION

Background:

The applicant, Kenneth Newby, is requesting a minor subdivision final plat (filing # 5) to create one single-family lot within the approved 307-acre FDP. The proposed filing is consistent with the approved FDP and the purpose and intent of the PUD. There are 18 lots approved with an FDP; however, only 12 lots have obtained approval of a final plat. Approval of this request will result in 13 approved lots with final plats. The remaining five lots approved with the FPD have received preliminary plat approval, but yet to submit for a final plat approval.

Site Characteristics:

The subject site is located approximately 1,300 feet northeast of the intersection of East 38th Avenue and Headlight Road. The property is vacant. The subject site has access on East 38th Avenue to the south. The proposed five acre lot is part of a 247 acre parcel of land with 217 acres reserved in a conservation easement. Three sections of the property will be surrounded by the conservation easement.

Development Standards and Regulations Requirements:

Per Section 5-03-03 of the County's Development Standards and Regulations, subdivision plats and lot dimensions are required to conform to requirements of the zone district in which the property is located. In addition, all lots created by a subdivision shall have access to a County maintained right-of-way. The minimum lot size required in the Comanche Vista Estates PUD is five acres. The proposed lot conforms to the minimum lot size allowed in the PUD. In addition, the proposed lot will have access on a County maintained right-of-way.

Provisions of adequate water and sewer service are required for approval of a final plat. The applicant has demonstrated the ability to provide water and sewer services to serve the lots through individual well and septic systems. Per Section 5-04 of the County's Development Standards and Regulations, public improvements may be required to be constructed with the development of a subdivision. There are no public improvements required with the proposed plat. Sections 5-05-04 and 05-05-05 of the County's Development Standards require land dedication to support new or expanded parks and schools. Cash-in-lieu, if deemed by the Board of County Commissioner to be appropriate, may be accepted for the land dedication. The applicant has provided $632.11 as cash-in-lieu of the school district land dedication and $177.61 for the parks land dedication.

Future Land Use Designation:

The future land use designation on the property is Parks & Open Space. The 217 acres of conservation easement seems to be the likely reason for the future land use designation. Other lots in the subdivision are designated as estate residential. Per Chapter 5 of the County's Comprehensive Plan, Parks & Open Space areas are intended to provide conservation areas for wildlife. The Estate Residential future land use areas are intended for rural residential development at a density of less than one dwelling unit per acre. As shown on the plat (see Exhibit 3.2), 217 acres of land surrounding the lot is reserved as conservation easement. The proposed final plat complies with the approved FDP and the County's Comprehensive Plan.

Surrounding Zoning Designations and Existing Use Activity:

Northwest PUD Conservation Easement	**North** PUD Conservation Easement	**Northeast** PUD Conservation Easement
West PUD Conservation Easement	**Subject Property** PUD Single-Family Residential	**East** PUD Conservation Easement
Southwest A-3 Vacant	**South** A-3 Vacant	**Southeast** A-3 Vacant

Compatibility with the Surrounding Land Uses:

The property to the north, west, and east of the subject property are located within the Comanche Vista Estates PUD and reserved as a conservation easement. The property to the south, across East 38th Avenue, is undeveloped, and zoned Agricultural-3 (A-3). Per Section 3-10-01 of the County's Development Standards, the A-3 district is intended for expansive land holdings for dry land and irrigated farming and food production. The proposed request is consistent with the approved FDP and will be compatible with the surrounding properties.

PLANNING COMMISSION UPDATE:

The Planning Commission (PC) considered this case on June 28, 2018. Ms. Lisa Gard, the applicant's representative, and Mr. Kenneth Newby, the property owner and applicant, both spoke at the meeting and had no concerns with the staff report or presentation. The PC asked staff if a comprehensive plan amendment was required with the application. Staff informed the PC that the request is for a final plat for a residential use approved in a PUD and does not require a comprehensive plan amendment. There was no one from the public to speak in favor or in opposition to the request.

The Planning Commission voted (7-0) to recommend approval of the request.

Staff Recommendations:

Based upon the application, the criteria for approval of a final plat, and a recent site visit, staff recommends approval of this request with 11 findings-of-fact and 1 condition.

RECOMMENDED FINDINGS-OF-FACT

1. The final plat is consistent and conforms to the approved sketch plan.
2. The final plat is in conformance with the subdivision design standards.
3. The applicant has provided evidence that a sufficient water supply has been acquired in terms of quantity, quality, and dependability for the type of subdivision proposed, as determined in accordance with the standards set forth in the water supply standards.
4. The applicant has provided evidence that provision has been made for a public sewage disposal system and, if other methods of sewage disposal are proposed, adequate evidence indicating that the system complies with state and local laws and regulations.
5. The applicant has provided evidence to show all areas of the proposed subdivision, which may involve soil or topographical conditions presenting hazards or requiring special precautions have been identified by the applicant and the proposed uses of these areas are compatible with such conditions.
6. The proposed or constructed drainage improvements are adequate and comply with these standards and regulations.
7. Adequate public facilities or infrastructure, or cash-in-lieu, for impacts reasonably related to the proposed subdivision have been constructed or financially guaranteed through cash-in-lieu or a subdivision improvements agreement so the proposed subdivision will not negatively impact the levels of service of the County.

8. The final plat is consistent with the Adams County Comprehensive Plan and any available area plan.
9. The final plat is consistent with the purposes of these standards and regulations.
10. The overall density of development within the proposed subdivision conforms to the zone district density allowances.
11. The proposed subdivision 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. The proposed subdivision has established an adequate level of compatibility by:
    a. Incorporating natural physical features into the development design and providing sufficient open spaces considering the type and intensity of use;
    b. Incorporating site planning techniques to foster the implementation of the County's plans and encourage a land use pattern to support a balanced transportation system, including auto, bike and pedestrian traffic, public or mass transit, and the cost effective delivery of other services consistent with adopted plans, policies and regulations of the County;
    c. Incorporating physical design features in the subdivision to provide a transition between the project and adjacent land uses through the provision of an attractive entryway, edges along public streets, architectural design, and appropriate height and bulk restrictions on structures; and
    d. Incorporating identified environmentally sensitive areas, including but not limited to, wetlands and wildlife corridors, into the project design.

RECOMMENDED CONDITION OF APPROVAL

1. All utilities shall be located underground pursuant to the Adams County Development Standards and Regulations.

PUBLIC COMMENTS

Number of Notifications Sent (2,000 Feet)	Number of Public Comments Received by Staff
471	0

All property owners and current residents within 2,000 feet of the subject property were notified of the application. As of writing this report, staff has not received any public comments.

COUNTY AGENCY COMMENTS

Adams County staff reviewed the subject and determined the proposed final plat conforms to the County's Development Standards and Regulations.

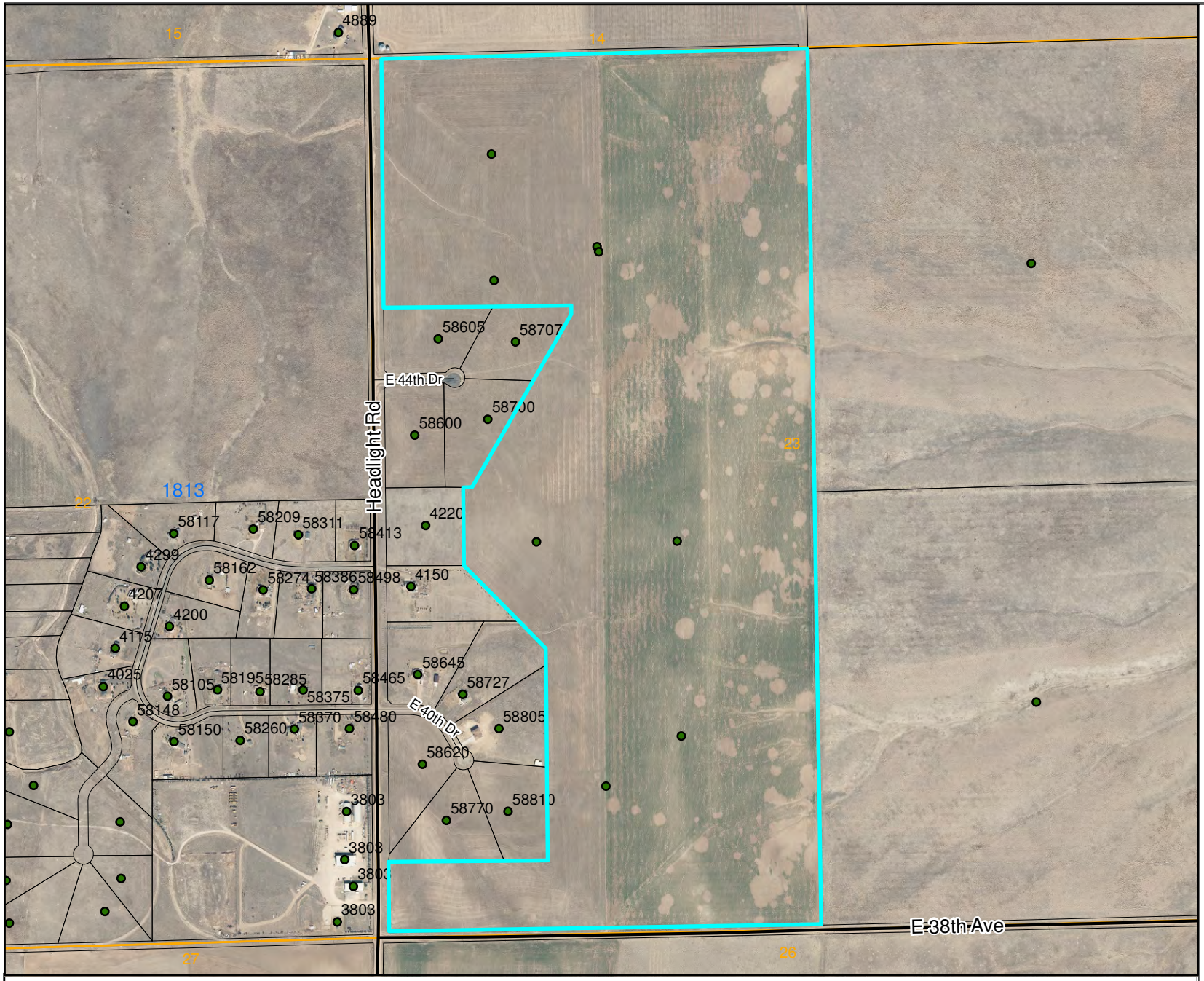
REFERRAL AGENCY COMMENTS

During the referral period, the Colorado Geologic Survey stated there is collapsible soil in the area, and requested special precautionary measures to be considered during development of the site. The Tri-County Health Department reviewed the request and had no objection so long as the on-site wastewater treatment system is permitted, installed, operated, and maintained according to required standards.

Responding with Concerns:
Colorado Geologic Survey
Tri-County Health Department

Responding without Concerns:
Intermountain Rural Electric Association (IREA)
Strasburg Fire Protection District #8
Xcel Energy

Notified but not Responding / Considered a Favorable Response:
Century Link
Colorado Division of Water Resources
Colorado Division of Wildlife
Comcast
East Adams Soil Conservation
Strasburg Parks & Recreation District
Strasburg School District 31J
U.S. Postal Service



LEGEND

- Special Zoning Conditions
- 3 Section Numbers
- 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)
- Airport Noise Overlay

ADAMS COUNTY COLORADO

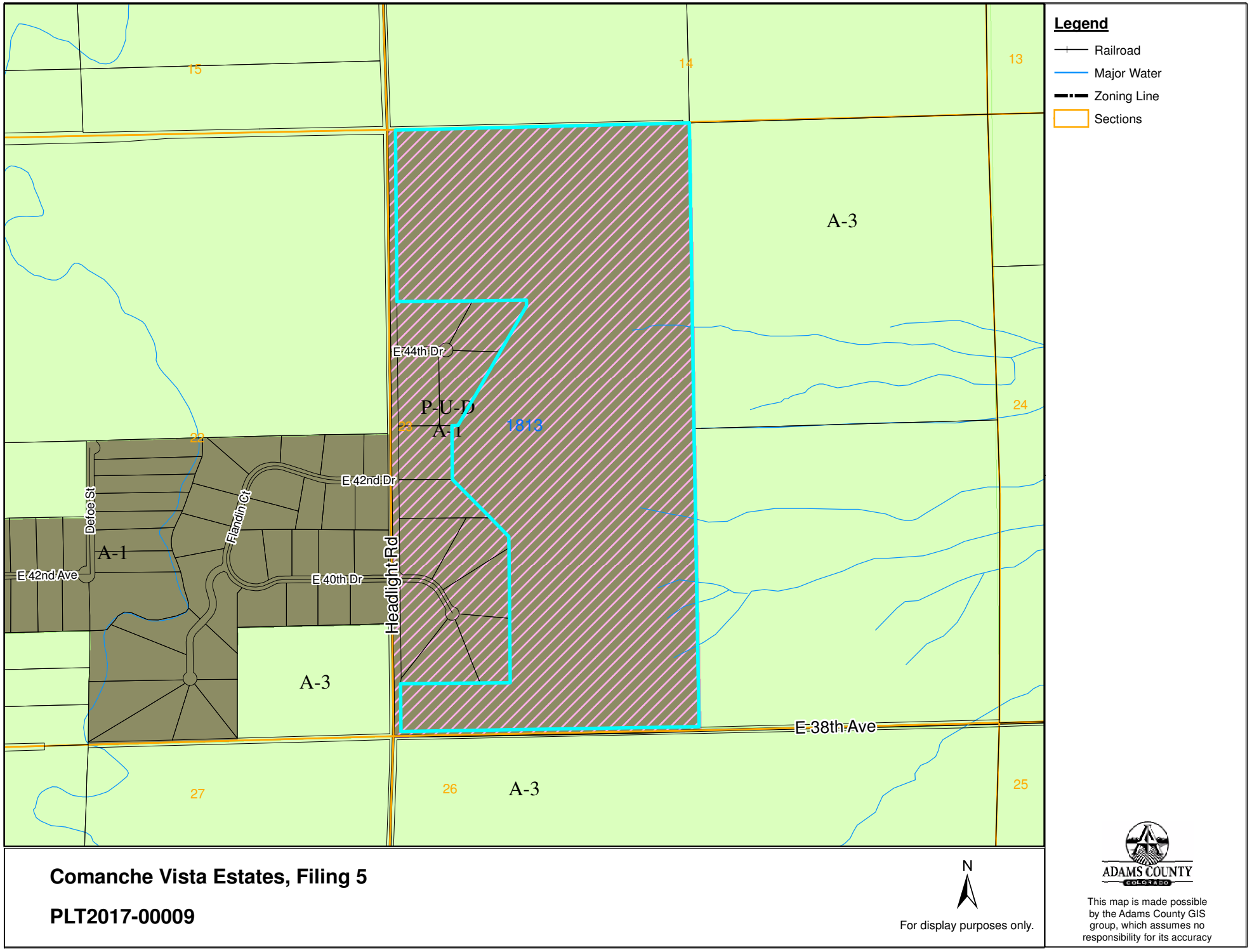
This map is made possible by the Adams County GIS group, which assumes no responsibility for its accuracy

Comanche Vista Estates, Filing #5

PLT2017-00019

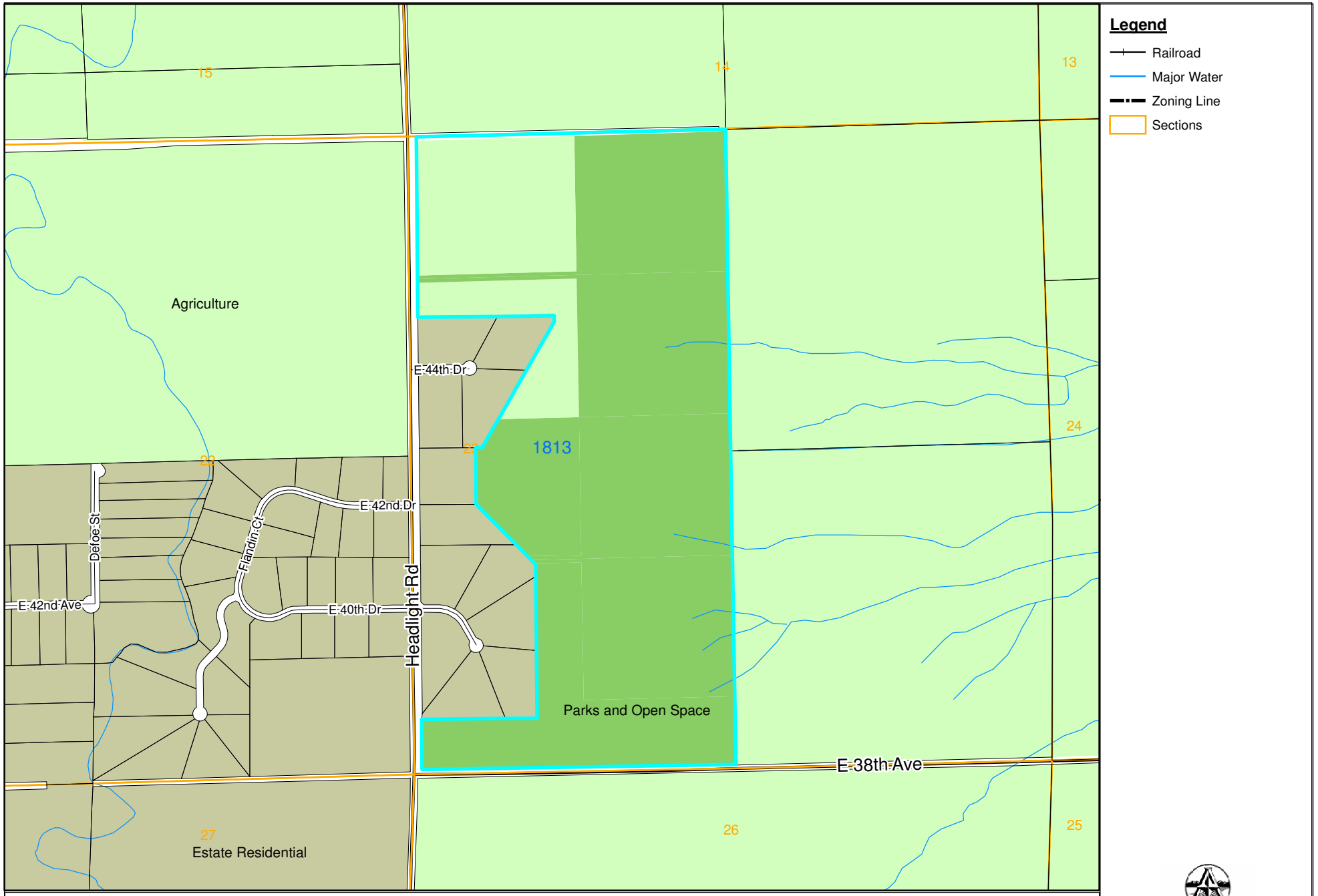
N

For display purposes only.



Comanche Vista Estates, Filing 5

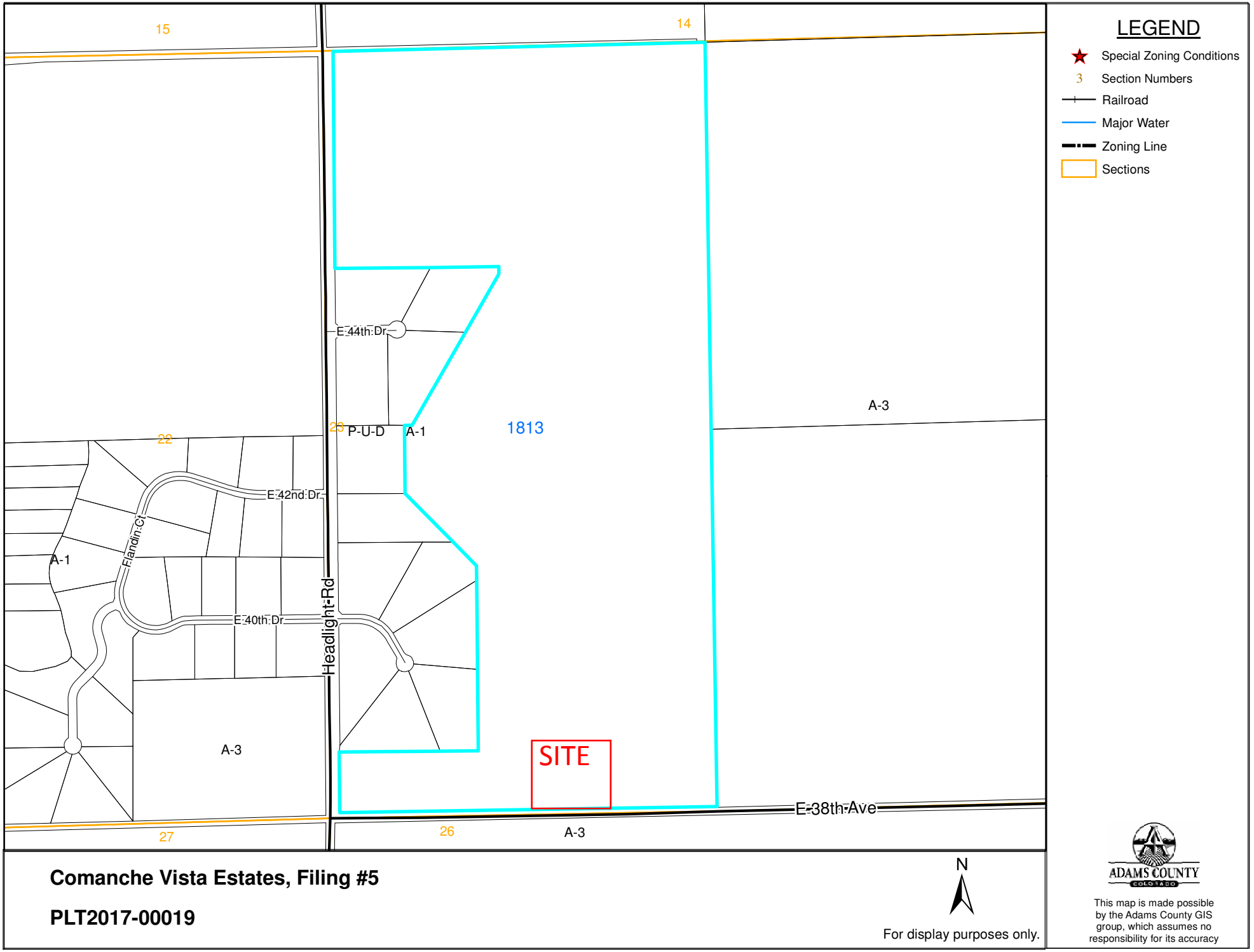
PLT2017-00009



Comanche Vista Estates, Filing 5

PLT2017-00009

EXHIBIT 2.4 SIMPLE MAP



Comanche Vista Estates, Filing #5

PLT2017-00019

For display purposes only.

This map is made possible by the Adams County GIS group, which assumes no responsibility for its accuracy

3. WRITTEN EXPLANATION OF THE PROJECT – Comanche Vista Estates Homesite Filing

The purpose of this project is to complete the application and filing for the minor subdivision of the 5 acre Homesite for the Comanche Vista Estates Planned Unit Development (PUD), originally certified by the Adams County Clerk and Recorder on August 27, 2003. The PUD was approved for development to allow 17-5+ acre lots and 1-future 5+ acre unsubdivided homesite "Homesite" that could be platted later. Filing No. 1, 2 and 4 final plats were approved between 2003 and 2007, along with an Agricultural Reserve of approximately 216.625 acres. Filing 3 is currently in the final review process. The last parcel to be created is the Homesite parcel for this PUD.

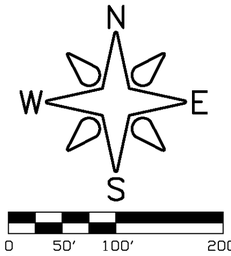
The proposed water supply plan is for all lots to be served by individual wells into the Laramie-Fox Hill aquifer. Sewer service will be individual on-site sewage disposal systems. Land use plat notes that were included on Filing No. 1, 2, 3 and 4, and are also included on the Homesite parcel, are as follows:

1. Soil Conditions – outlines the notice that soils may have high shrink swell potential and shall be designed to minimize foundation damage and movement, engineered sewage disposal systems may be required, and perched groundwater may be created if areas around foundations are excessively irrigated.
2. Sewer Service – outlines provisions for sewer service, including the Onsite Wastewater Systems (OWS) required maintenance responsibilities per recommendations of Tri-County Health.
3. County Drainage Policy – the County's standard drainage policy notes are also included on the plat per requirements of the Community & Economic Development Department including maintenance responsibilities.

COMANCHE VISTA ESTATES - PUD

A PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO.
SHEET 1 OF 1

HOMESITE AREA - SITE PLAN



SCALE: 1"=100'

Prepared By:

R. W. BAYER & ASSOCIATES, INC.
2090 East 104th Avenue, S-200
Thornton, Colorado 80233
303-452-4433 rwbsurveying@hotmail.com
CAD FILE: G17167/G17167B.DWG

Date Prepared: SEPTEMBER 28, 2017

LEGEND

- ● DENOTES: FOUND #5 REBAR & CAP, BAYER - P.L.S. 6973, FLUSH W/GROUND
- ■ DENOTES: FOUND 2" ALUMINUM CAP, RUSSELL, P.L.S. 23519, WC 40', 1.0' BELOW GROUND

COMANCHE VISTA ESTATES - FILING NO. 4
(RECEPTION NO. 20051220001389320, ADAMS COUNTY RECORDS)

N00°16'00"E 1271.37'

HEADLIGHT ROAD

S89°44'00"E 953.74'

EAST LINE S.W. 1/4 SEC. 23

S.W. 1/4
SEC. 23

S.E. 1/4
SEC. 23

(PARCEL SHOWN IN BOOK 1, PAGE 4889, RECEPTION NO. 2017-124, LAND SURVEY PLATS, ADAMS COUNTY RECORDS)

ACCEPTANCE OF DECLARATION OF USE RESTRICTION, RECEPTION NO. 200511090012427 90, ADAMS COUNTY RECORDS

S00°07'52"E

(UNPLATTED)
ADAMS COUNTY PARCEL #0181300000063

N89°50'48"E 466.69'

10' DRY UTILITY & DRAINAGE EASEMENT BY THIS PLAT (TYPICAL)

PROPOSED ISDS AREA

PROPOSED ISDS AREA (ALTERNATE)

ALLOWED HOMESITE AREA-COMANCHE VISTA ESTATES-PUD
(RECEPTION NO. C1200349, ADAMS COUNTY RECORDS)

466.69'

N00°09'12"W

S00°09'12"E

PROPOSED LOT 1, COMANCHE VISTA ESTATE - FILING NO. 5
CONTAINS 217,800 SQUARE FEET OR 5.000 ACRES MORE OR LESS

PROPOSED BUILDING ENVELOP

10' DRY UTILITY & DRAINAGE EASEMENT BY THIS PLAT (TYPICAL)

50' 50'

80' 15' PROPOSED DRIVEWAY 120' 80'

FOUND 2" ALUMINUM CAP, RUSSELL, P.L.S. 23519, WC 40', 1.0' BELOW GROUND

40' DEEDED TO ADAMS COUNTY IN RECEPTION NO. 20060111000037710, FOR PUBLIC ROAD

NORTH RIGHT-OF-WAY LINE EAST 136TH AVENUE
S89°50'48"W 570.00'

40'

S89°50'48"W 466.69'

40' N00°07'52"W 40.00'

S89°50'48"W 2659.08'

EAST 38TH AVENUE

SOUTH LINE S.W. 1/4 SEC. 23

S.W. COR. S.W. 1/4 SEC. 23, T.3S., R.62W
(FOUND SPIKE NAIL W/FLAGGING, FIT MONUMENT RECORD TIES BY R.W. BAYER & ASSOCIATES, FILED ON 9/23/2004, 0.2' BELOW GRAVEL ROAD)

S.E. COR. S.W. 1/4 SEC. 23, T.3S., R.62W.
(FOUND 3/4" IRON PIPE W/PLUMBERS CAP, 1.3' BELOW GROUND)

COMANCHE VISTA ESTATES - FILING NO. 5

A PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO. CASE NO: PLT2017-00019

SHEET 1 OF 2

DEDICATION:

KNOW ALL MEN BY THESE PRESENTS THAT KENNETH W. NEWBY, BEING THE OWNER OF THAT PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, DESCRIBED AS FOLLOWS:

COMMENCING AT THE SOUTHEAST CORNER OF THE SOUTHWEST ONE-QUARTER OF SAID SECTION 23; THENCE NORTH 00°07'52" WEST ALONG THE EAST LINE OF SAID SOUTHWEST ONE-QUARTER, A DISTANCE OF 40.00 FEET TO THE NORTH RIGHT-OF-WAY LINE OF EAST 38TH AVENUE AS DESCRIBED IN RECEPTION NO. 20060111000037710, ADAMS COUNTY RECORDS; THENCE SOUTH 89°50'48" WEST ALONG SAID NORTH RIGHT-OF-WAY LINE, PARALLEL WITH AND 40 FEET NORTH OF THE SOUTH LINE OF SAID SOUTHWEST ONE-QUARTER, A DISTANCE OF 570.00 FEET TO THE POINT OF BEGINNING; THENCE CONTINUING SOUTH 89°50'48" WEST ALONG SAID NORTH RIGHT-OF-WAY LINE, PARALLEL WITH AND 40 FEET NORTH OF THE SOUTH LINE OF SAID SOUTHWEST ONE-QUARTER, A DISTANCE OF 466.69 FEET; THENCE NORTH 00°09'12" WEST A DISTANCE OF 466.69 FEET; THENCE NORTH 89°50'48" EAST A DISTANCE OF 466.69 FEET; THENCE SOUTH 00°09'12" EAST A DISTANCE OF 466.69 FEET TO THE POINT OF BEGINNING.
CONTAINS 217,800 SQUARE FEET OR 5.000 ACRES MORE OR LESS.

HAS BY THESE PRESENTS LAID OUT, PLATTED AND SUBDIVIDED THE SAME AS SHOWN ON THIS PLAT INTO A LOT, STREETS AND EASEMENT UNDER THE NAME AND STYLE OF COMANCHE VISTA ESTATES - FILING NO. 5 AND DO HEREBY GRANT TO THE COUNTY OF ADAMS, STATE OF COLORADO, FOR THE USE OF THE PUBLIC, ALL STREETS, AND OTHER PUBLIC WAYS AND LANDS AS SHOWN ON THIS PLAT, FOREVER, AND ALSO RESERVE THOSE PORTIONS OF REAL PROPERTY WHICH ARE LABELED AS UTILITY EASEMENTS ON THIS PLAT, FOR THE INSTALLATION AND MAINTENANCE OF UTILITIES AND DRAINAGE FACILITIES, INCLUDING BUT NOT LIMITED TO ELECTRIC LINES, GAS LINES, TELEPHONE LINES, SEWER LINES, WATER LINES: TOGETHER WITH A RIGHT TO TRIM INTERFERING TREES AND BRUSH, TOGETHER WITH A PERPETUAL RIGHT OF INGRESS AND EGRESS FOR INSTALLATION, MAINTENANCE AND REPLACEMENT OF SUCH LINES; SAID EASEMENTS AND RIGHTS TO BE UTILIZED IN A RESPONSIBLE AND PRUDENT MANNER.
EXECUTED THIS _____ DAY OF _____, 20_____.

_____
KENNETH W. NEWBY

ACKNOWLEDGEMENT:

STATE OF COLORADO)
COUNTY OF ADAMS)

THE FOREGOING WAS ACKNOWLEDGED BY ME THIS _____ DAY OF _____, 20_____, BY KENNETH W. NEWBY.

_____
NOTARY PUBLIC
MY COMMISSION EXPIRES: _____
MY ADDRESS IS: _____
_____
_____

BASIS FOR BEARINGS:

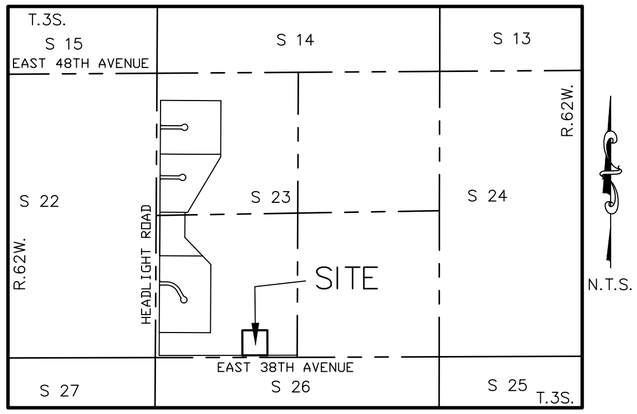
THE SOUTH LINE OF THE SOUTHWEST ONE-QUARTER (THE S.W. COR. IS A FOUND SPIKE NAIL W/FLAGGING, FIT MONUMENT RECORD TIES BY R.W. BAYER & ASSOCIATES, FILED ON 9/23/2004, 0.2' BELOW GRAVEL ROAD AND THE S.E. COR. IS A 3/4" IRON PIPE W/PLUMBERS CAP, 1.3' BELOW GROUND) OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, BEARS, SOUTH 89°50'48" WEST, PER THE RECORDED LAND SURVEY PLAT IN BOOK 1, PAGE 2052, RECEPTION NO. 104-068, ADAMS COUNTY RECORDS. ALL BEARINGS SHOWN HEREON ARE RELATIVE THERETO.

NOTICE:

ACCORDING TO COLORADO LAW YOU MUST COMMENCE ANY LEGAL ACTION BASED UPON ANY DEFECT IN THIS SURVEY WITHIN THREE YEARS AFTER YOU FIRST DISCOVER SUCH DEFECT. IN NO EVENT MAY ANY LEGAL ACTION BASED UPON ANY DEFECT IN THIS SURVEY BE COMMENCED MORE THAN TEN YEARS FROM THE DATE OF THE CERTIFICATION SHOWN HEREON.

THIS SURVEY DOES NOT CONSTITUTE A TITLE SEARCH BY R.W. BAYER & ASSOCIATES, INC. OF THE PROPERTY SHOWN AND DESCRIBED HEREIN TO DETERMINE OWNERSHIP OF THE TRACT OF LAND, COMPATIBILITY OF THIS DESCRIPTION WITH THOSE OF ADJACENT TRACTS OF LAND OR RIGHTS-OF-WAY, EASEMENTS OR ENCUMBRANCES OF RECORD AFFECTING THIS TRACT OF LAND. R.W. BAYER & ASSOCIATES, INC. HAS RELIED UPON TITLE REPORT PREPARED BY FIDELITY NATIONAL TITLE COMPANY, REPORT NO. F00603441-152-t56, EFFECTIVE DATE FEBRUARY 15, 2018 AT 8:00 A.M., THIS PARCEL SUBJECT TO THE EXCEPTIONS CONTAINED UNDER SCHEDULE B - SECTION 2.

VICINITY MAP



PLAT NOTES:

COMANCHE VISTA ESTATES PLANNED UNIT DEVELOPMENT RECORDED AS P.U.D. 3716, RECEPTION C1200349, ADAMS COUNTY RECORDS PROVIDED FOR THE DEVELOPMENT OF THIS 5 ACRE HOMESITE WHICH IS NOT PART OF THE AGRICULTURE RESERVE AREA. THIS 5 ACRE HOMESITE IS SUBJECT TO THE RESTRICTIONS, COVENANTS, AND REQUIREMENTS OF THE COMANCHE VISTA ESTATES PLANNED UNIT DEVELOPMENT.

A FIFTEEN-FOOT (15') WIDE DRY UTILITY AND DRAINAGE EASEMENT ADJOINING EAST 38TH AVENUE AND TEN-FOOT (10') WIDE DRY UTILITY AND DRAINAGE EASEMENTS ADJOINING THE REMAINING PERIMETER OF THIS SUBDIVISION ARE HEREBY GRANTED ON PRIVATE PROPERTY. SAID EASEMENT AND THEIR WIDTH ARE INDICATED ON SHEET 2 OF 2 OF THIS PLAT. THESE EASEMENTS ARE GRANTED FOR THE INSTALLATION, MAINTENANCE AND REPLACEMENT OF ELECTRIC, GAS, TELEVISION CABLE, AND TELECOMMUNICATIONS FACILITIES. UTILITIES SHALL ALSO BE PERMITTED WITHIN ANY ACCESS EASEMENTS AND PRIVATE STREETS IN THE SUBDIVISION. PERMANENT STRUCTURES AND WATER METERS SHALL NOT BE PERMITTED WITHIN SAID EASEMENTS. ADDITIONALLY, THESE UTILITY AND DRAINAGE EASEMENTS ARE GRANTED FOR DRAINAGE FACILITIES INCLUDING INLETS, PIPES, CULVERTS, CHANNELS, DITCHES, HYDRAULIC STRUCTURES, AND DETENTION BASINS.

THE POLICY OF THE COUNTY REQUIRES THAT MAINTENANCE ACCESS BE PROVIDED TO ALL STORM DRAINAGE FACILITIES TO ASSURE CONTINUOUS OPERATIONAL CAPABILITY OF THE SYSTEM. THE PROPERTY OWNERS SHALL BE RESPONSIBLE FOR THE MAINTENANCE OF ALL DRAINAGE FACILITIES INCLUDING INLETS, PIPES, CULVERTS, CHANNELS, DITCHES, HYDRAULIC STRUCTURES, AND DETENTION BASINS LOCATED ON THEIR LAND UNLESS MODIFIED BY SUBDIVISION DEVELOPMENT AGREEMENT. SHOULD THE OWNER FAIL TO ADEQUATELY MAINTAIN SAID FACILITIES, THE COUNTY SHALL HAVE THE RIGHT TO ENTER SAID LAND FOR THE SOLE PURPOSE OF OPERATIONS AND MAINTENANCE. ALL SUCH MAINTENANCE COSTS WILL BE ASSESSED TO THE PROPERTY OWNER.

Prepared By:

R.W. BAYER & ASSOCIATES, INC.
2090 East 104th Avenue, S-200
Thornton, Colorado 80233
303-452-4433 rwbsurveying@hotmail.com
CAD FILE: G17167/G17167.DWG

Date Prepared: SEPTEMBER 28, 2017
REVISED 01-26-2018 PER COUNTY COMMENTS

SOIL CONDITION NOTE:

SOILS ON LOTS CAN BE EXPECTED TO HAVE A HIGH SHRINK-SWELL POTENTIAL, AND FOUNDATIONS SHOULD BE DESIGNED TO MINIMIZE DAMAGE TO STRUCTURES FROM DIFFERENTIAL FOUNDATION MOVEMENT. ENGINEERED SEWAGE DISPOSAL SYSTEMS MAY BE REQUIRED. GROUNDWATER LEVELS ARE NOT EXPECTED TO BE HIGH ENOUGH TO AFFECT FOUNDATIONS, HOWEVER THERE IS A POSSIBILITY OF SEEPAGE FROM PERCHED GROUNDWATER, IF AREAS AROUND FOUNDATIONS ARE EXCESSIVE IRRIGATED.

ONSITE WATER SYSTEMS:

LOTS WITHIN COMANCHE VISTA ESTATES ARE SERVED BY ONSITE WASTEWATER SYSTEMS (OWS). TRI-COUNTY HEALTH DEPARTMENT REQUIRES THAT SEPTIC TANKS BE PUMPED AND INSPECTED EVERY FOUR YEARS. EACH PROPERTY OWNER SHALL HAVE HIS SEPTIC TANK PUMPED AND INSPECTED BY A SYSTEMS CLEANER, LICENSED BY TRI-COUNTY HEALTH DEPARTMENT AT LEAST EVERY FOUR YEARS, AND SHALL SUBMIT A RECEIPT INDICATING THAT THE SEPTIC SYSTEM HAS BEEN PUMPED AND INSPECTED TO THE TRI-COUNTY HEALTH DEPARTMENT, COMMERCE CITY OFFICE. IN ADDITION TO PUMPING THE, OWS HAVE OTHER MAINTENANCE AND USE REQUIREMENTS THAT CAN PREVENT FAILURE OF THE SYSTEM. THE TRI-COUNTY HEALTH DEPARTMENTS "SEPTIC SYSTEM GUIDELINES AND RECORDS" HAS BEEN PREPARED TO EDUCATE AND ADVISE OWNERS OF OWS ABOUT USE AND MAINTENANCE THEIR OWS. PROPERTY OWNERS CAN OBTAIN COPIES OF THE GUIDE, AS WELL AS ADDITIONAL INFORMATION ABOUT OWS FROM TRI-COUNTY HEALTH DEPARTMENT'S COMMERCE CITY OFFICE.

SURVEYOR'S CERTIFICATE:

I, RAYMOND W. BAYER, A REGISTERED LAND SURVEYOR, REGISTERED IN THE STATE OF COLORADO, DO HERBY CERTIFY THAT THERE ARE NO ROADS, PIPELINES, IRRIGATION DITCHES OR OTHER EASEMENTS IN EVIDENCE OR KNOW BY ME TO EXIST ON OR ACROSS THE HEREINBEFORE DESCRIBED PROPERTY, EXCEPT AS SHOWN ON THIS PLAT. I FURTHER CERTIFY THAT THIS SURVEY WAS PERFORMED BY ME OR UNDER MY DIRECT RESPONSIBILITY, SUPERVISION AND CHECKING, AND THAT THIS PLAT ACCURATELY REPRESENTS SAID SURVEY, AND THAT ALL MONUMENTS EXIST AS SHOWN HEREON.

RAYMOND W. BAYER,
REG P.L.S. NO. 6973

PLANNING COMMISSION APPROVAL:

APPROVED BY THE ADAMS COUNTY PLANNING COMMISSION THIS _____ DAY OF _____, 20____.

_____
CHAIR

BOARD OF COUNTY COMMISSIONERS APPROVAL:

APPROVED BY THE ADAMS COUNTY BOARD OF COUNTY COMMISSIONERS THIS DAY OF _____, 20_____.

_____
CHAIR

CERTIFICATE OF CLERK AND RECORDER

THIS PLAT WAS FILED FOR RECORD IN THE OFFICE OF THE ADAMS COUNTY CLERK AND RECORDER IN THE STATE OF COLORADO AT _____:_____ ___. M. ON THE _____ DAY OF _____, A.D., 20_____.

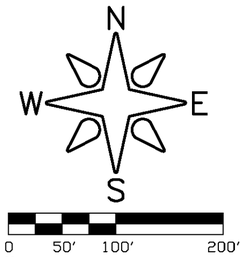
By:_____ _____
DEPUTY COUNTY CLERK AND RECORDER

RECEPTION NO: _____

COMANCHE VISTA ESTATES - FILING NO. 5

A PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO. CASE NO: .

SHEET 2 OF 2



SCALE: 1"=100'

Prepared By:

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CAD FILE: G17167/G17167A.DWG

Date Prepared: SEPTEMBER 28, 2017
REVISED 01-26-2018 PER COUNTY COMMENTS

LEGEND

- ● DENOTES: FOUND #5 REBAR & CAP, BAYER - P.L.S. 6973, FLUSH W/GROUND
- ■ DENOTES: FOUND 2" ALUMINUM CAP, RUSSELL, P.L.S. 23519, WC 40', 1.0' BELOW GROUND

COMANCHE VISTA ESTATES - FILING NO. 4
(RECEPTION NO. 2005122000138932O, ADAMS COUNTY RECORDS)

N00°16'00"E 1271.37'

ROAD

HEADLIGHT

S89°44'00"E 953.74'

S.W. 1/4
SEC. 23

EAST LINE S.W. 1/4 SEC. 23

S.E. 1/4 SEC. 23

(PARCEL SHOWN IN BOOK 1, PAGE 4889, RECEPTION NO. 2017-124, LAND SURVEY PLATS, ADAMS COUNTY RECORDS)

ACCEPTANCE OF DECLARATION OF USE RESTRICTION, RECEPTION NO. 2005110900124279O, ADAMS COUNTY RECORDS

S00°07'52"E

(UNPLATTED)
ADAMS COUNTY PARCEL #0181300000063

N89°50'48"E 466.69'

10' DRY UTILITY & DRAINAGE EASEMENT BY THIS PLAT

N00°09'12"W 466.69'

S00°09'12"E 466.69'

LOT 1
CONTAINS 217,800 SQUARE FEET
OR 5.000 ACRES MORE OR LESS

10' DRY UTILITY & DRAINAGE EASEMENT BY THIS PLAT

10' DRY UTILITY & DRAINAGE EASEMENT BY THIS PLAT

15' DRY UTILITY & DRAINAGE EASEMENT BY THIS PLAT

S89°50'48"W 466.69'

40' DEEDED TO ADAMS COUNTY IN RECEPTION NO. 20060111000037710, FOR PUBLIC ROAD

40'

S89°50'48"W

FOUND 2" ALUMINUM CAP, RUSSELL, P.L.S. 23519, WC 40', 1.0' BELOW GROUND

NORTH RIGHT-OF-WAY LINE EAST 38TH AVENUE

S89°50'48"W 570.00'

40'

N00°07'52"W 40.00'

2659.08'

EAST 38TH AVENUE

S. W. COR. S.W. 1/4 SEC. 23, T. 3S., R. 62W
(FOUND SPIKE NAIL W/FLAGGING, FIT MONUMENT RECORD TIES BY R. W. BAYER & ASSOCIATES, FILED ON 9/23/2004, 0.2' BELOW GRAVEL ROAD)

SOUTH LINE S.W. 1/4 SEC. 23
(BASIS FOR BEARINGS)

POINT OF BEGINNING

S.E. COR. S.W. 1/4 SEC. 23, T. 3S., R. 62W.
(FOUND 3/4" IRON PIPE W/PLUMBERS CAP, 1.3' BELOW GROUND)
POINT OF COMMENCEMENT

Community & Economic
Development Department
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000
Brighton, CO 80601-8204
PHONE 720.523.6800
FAX 720.523.6998

Development Review Team Comments

Date: 12/20/2017

Project Number: PLT2017-00019

Project Name: Comanche Vista Estates,

Note to Applicant:

The following review comments and information from the Development Review Team is based on the information you for a minor subdivision final plat. At this time, it is being requested that you resubmit to us based on the following comments. I'm happy to set up a meeting with necessary staff, if you need guidance. Please contact the case manager if you have any questions:

Commenting Division: Building Review

Name of Reviewer: Justin Blair

Date: 11/20/2017

Email: jblair@adcogov.org

No Comment

Commenting Division: Engineering Review

Name of Reviewer: Greg Labrie

Date: 12/04/2017

Email: glabrie@adcogov.org

Complete

ENG1: Flood Insurance Rate Map – FIRM Panel # (08001C0743H), Federal Emergency Management Agency, January 20, 2016. According to the above reference, the project site is NOT located within a delineated 100-year flood hazard zone; A floodplain use permit will not be required.
ENG2: The project site is not located in a NRCO district. An environmental assessment is not required.
ENG3; The project site is NOT within the County's MS4 Stormwater Permit area. The use of erosion and sediment control BMPs are expected. The applicant shall be responsible to ensure compliance with all Federal, State, and Local water quality construction requirements.
ENG4; Applicant is proposing to install over 3,000 square feet of impervious area on the project site. A drainage report and drainage plans in accordance to Chapter 9 of the Adams County Development Review Manual, are required to be completed by a registered professional engineer and submitted to Adams County for review and final approval.
ENG5; The applicant is required to complete a traffic impact study signed and stamped by a professional engineer.
ENG6; The developer is required to construct roadway improvements as required by the approved traffic impact study and must obtain any roadway construction permits from Adams County.
ENG7; No building permits will be issued until all public improvements have been constructed, inspected and preliminarily accepted by the County's Transportation Dept.
ENG8; East 38th Avenue is classified as a Section Line areterial. Any new access onto E. 38th Avenue must be approved through the Adams County One Stop Permit Center.
ENG9; Prior to scheduling the final plat/FDP BOCC hearing, the developer is required to submit for review and receive approval of all construction documents (construction plans and reports). Construction documents shall include, at a minimum, onsite and public improvements construction plans, drainage report, traffic impact study. All construction documents must meet the requirements of the Adams County Development Standards and Regulations. The developer shall submit to the Adams County Development Review Engineering division the following: Engineering Review Application, Engineering Review Fee, three (3) copies of all construction documents.

Commenting Division: Environmental Analyst Review

Name of Reviewer: Jen Rutter

Date: 11/28/2017

Email: jrutter@adcogov.org

No Comment

Commenting Division: Parks Review

Name of Reviewer: Aaron Clark

Date: 11/27/2017

Email: aclark@adcogov.org

Complete

PRK1. The Homesite Area is adjacent on three sides of lands protected by a conservation easement held by Adams County. Development of the Homesite Area shall not impair the conservation values of the easement.

Commenting Division: Planner Review

Name of Reviewer: Greg Barnes

Date: 12/19/2017

Email: gjbarnes@adcogov.org

Resubmittal Required

PLN01: A subdivision improvements agreement (SIA) must be submitted with separate application. This agreement must be reviewed by staff prior to scheduling the final plat for public hearings. Since the SIA was not submitted with the original application, a full 21-day review cycle may be needed when you resubmit.
PLN02: Construction documents shall be submitted and finalized prior to scheduling a final plat for public hearing.
PLN03: All PLD fees are to be submitted prior to public hearing. A fee calculation sheet has been included with these comments. Please note - It appears that your calculation was one cent short.
PLN04: Please review the criteria for approval of a minor subdivision final plat found in Section 2-02-18-03-05 of the Development Standards. Compliance with the subdivision design standards includes: public improvements and PLD fees. Traffic and drainage studies are also included in this criteria,
PLN05: The design of the lot appears to comply with the minimum standards of the Comanche Vista estates PUD. No further revision to the lot configuration appears to be necessary.

Commenting Division: ROW Review

Name of Reviewer: Marissa Hillje

Date: 12/14/2017

Email: mhillje@adcogov.org

Resubmittal Required

ROW1) SUBMIT TITLE COMMITMENT: Please submit a title commitment which should be used to depict the applicable recordings on the plat. Please send Adams County a copy of the title commitment with your application dated no later than 30 days to review in order to ensure that any other party's interests are not encroached upon.

ROW2) Revise Property Description/ Legal Description:

a. An accurate and clear property (legal) description of the overall boundary of the subdivision with the acreage of the subdivision. All courses in the property (legal) description shall be shown and labeled on the plat drawing, with all bearings having the same direction as called out in the legal description. The only exception being where more than one description is required, going a different direction over the same course. The direction shall then hold for the description having more weight (i.e., the overall boundary) for purposes of the plat. If both record and "as-measured" dimensions are being used, show both and clearly label on the plat drawing. Point of commencement and/or point of beginning shall be clearly labeled on the plat drawing.

ROW3) See additional comments that are in redlines on plat

Greg Barnes

From: Jennifer Lothrop
Sent: Monday, December 11, 2017 12:41 PM
To: Greg Barnes
Cc: Brigitte Grimm
Subject: For Review: Comanche Vista Estates, Filing 5 (PLT2017-00019)
Attachments: RFC.pdf

Parcel # 0181323200006

The above mentioned parcel IS current, therefore, the Treasurer's Office has no negative input regarding this case.

Jennifer Lothrop
Treasurer Technician

Adams County Treasurer's Office
4430 S. Adams County Pkwy., Suite C2436
Brighton, CO 80601
720.523.6761 | www.adcotax.com
Mon. – Fri. 7am-5pm

NEW Satellite Office
11860 Pecos St.
Westminster, CO 80234
720.523.6160
Tues. Wed. & Thurs. 7:30am-5pm

ADAMS COUNTY
COLORADO

Adams County Mission
To responsibly serve the Adams County Community with integrity and innovation.

From: Greg Barnes
Sent: Tuesday, November 28, 2017 10:53 AM
To: Greg Barnes
Subject: For Review: Comanche Vista Estates, Filing 5 (PLT2017-00019)

Request for Comments

Case Name: Comanche Vista Estates, Filing #5
Case Number: PLT2017-00019

November 28, 2017

COMANCHE VISTA ESTATES - 5th FILING

A PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO. CASE NO: PLT2017-00019

SHEET 1 OF 2

DEDICATION:

KNOW ALL MEN BY THESE PRESENTS THAT KENNETH W. NEWBY, BEING THE OWNER OF THAT PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, DESCRIBED AS FOLLOWS:

COMMENCING AT THE SOUTHEAST CORNER OF THE SOUTHWEST ONE-QUARTER OF SAID SECTION 23; THENCE NORTH 00°07'52" WEST ALONG THE EAST LINE OF SAID SOUTHWEST ONE-QUARTER, A DISTANCE OF 40.00 FEET; THENCE SOUTH 89°50'48" WEST PARALLEL WITH AND 40 FEET NORTH OF THE SOUTH LINE OF SAID SOUTHWEST ONE-QUARTER, A DISTANCE OF 570.00 FEET TO THE POINT OF BEGINNING; THENCE CONTINUING NORTH 89°50'48" EAST PARALLEL WITH AND 40 FEET NORTH OF THE SOUTH LINE OF SAID SOUTHWEST ONE-QUARTER, A DISTANCE OF 466.69 FEET; THENCE NORTH 00°09'12" WEST A DISTANCE OF 466.69 FEET; THENCE NORTH 89°50'48" EAST A DISTANCE OF 466.69 FEET; THENCE SOUTH 00°09'12" EAST A DISTANCE OF 466.69 FEET TO THE POINT OF BEGINNING.
CONTAINS 217,800 SQUARE FEET OR 5.000 ACRES MORE OR LESS.

a lot

HAS BY THESE PRESENTS LAID OUT, PLATTED AND SUBDIVIDED THE SAME AS SHOWN ON THIS PLAT INTO LOTS, ~~STREETS~~ AND EASEMENT UNDER THE NAME AND STYLE OF COMANCHE VISTA ESTATES - FILING NO. 5 AND DO HEREBY GRANT TO THE COUNTY OF ADAMS, STATE OF COLORADO, FOR THE USE OF THE PUBLIC, ALL STREETS, AND OTHER PUBLIC WAYS AND LANDS AS SHOWN ON THIS PLAT, FOREVER, AND ALSO RESERVE THOSE PORTIONS OF REAL PROPERTY WHICH ARE LABELED AS UTILITY EASEMENTS ON THIS PLAT, FOR THE INSTALLATION AND MAINTENANCE OF UTILITIES AND DRAINAGE FACILITIES, INCLUDING BUT NOT LIMITED TO ELECTRIC LINES, GAS LINES, TELEPHONE LINES, SEWER LINES, WATER LINES: TOGETHER WITH A RIGHT TO TRIM INTERFERING TREES AND BRUSH, TOGETHER WITH A PERPETUAL RIGHT OF INGRESS AND EGRESS FOR INSTALLATION, MAINTENANCE AND REPLACEMENT OF SUCH LINES; SAID EASEMENTS AND RIGHTS TO BE UTILIZED IN A RESPONSIBLE AND PRUDENT MANNER.
EXECUTED THIS _____ DAY OF _____, 20_____.

_____
KENNETH W. NEWBY

ACKNOWLEDGEMENT:

STATE OF COLORADO)
COUNTY OF ADAMS)

THE FOREGOING WAS ACKNOWLEDGED BY ME THIS _____ DAY OF _____, 20____, BY KENNETH W. NEWBY.

_____
NOTARY PUBLIC
MY COMMISSION EXPIRES: _____
MY ADDRESS IS: _____
_____
_____

BASIS FOR BEARINGS: label on sheet 2

THE SOUTH LINE OF THE SOUTHWEST ONE-QUARTER (THE S.W. COR. IS A FOUND SPIKE NAIL W/FLAGGING, FIT MONUMENT RECORD TIES BY R.W. BAYER & ASSOCIATES, FILED ON 9/23/2004, 0.2' BELOW GRAVEL ROAD AND THE S.E. COR. IS A 3/4" IRON PIPE W/PLUMBERS CAP, 1.3' BELOW GROUND) OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, BEARS, SOUTH 89°50'48" WEST, PER THE RECORDED LAND SURVEY PLAT IN BOOK 1, PAGE 2052, RECEPTION NO. 104-068, ADAMS COUNTY RECORDS. ALL BEARINGS SHOWN HEREON ARE RELATIVE THERETO.

NOTICE:

ACCORDING TO COLORADO LAW YOU MUST COMMENCE ANY LEGAL ACTION BASED UPON ANY DEFECT IN THIS SURVEY WITHIN THREE YEARS AFTER YOU FIRST DISCOVER SUCH DEFECT. IN NO EVENT MAY ANY LEGAL ACTION BASED UPON ANY DEFECT IN THIS SURVEY BE COMMENCED MORE THAN TEN YEARS FROM THE DATE OF THE CERTIFICATION SHOWN HEREON.

THIS SURVEY DOES NOT CONSTITUTE A TITLE SEARCH BY R.W. BAYER & ASSOCIATES, INC. OF THE PROPERTY SHOWN AND DESCRIBED HEREIN TO DETERMINE OWNERSHIP OF THE TRACT OF LAND, COMPATIBILITY OF THIS DESCRIPTION WITH THOSE OF ADJACENT TRACTS OF LAND OR RIGHTS-OF-WAY, EASEMENTS OR ENCUMBRANCES OF RECORD AFFECTING THIS TRACT OF LAND. R.W. BAYER & ASSOCIATES, INC. HAS RELIED UPON TITLE REPORT PREPARED BY FIDELITY NATIONAL TITLE COMPANY, REPORT NO. 592-F0575114-152-SKA, EFFECTIVE DATE FEBRUARY 22, 2017 5:00 P.M., THIS PARCEL SUBJECT TO THE EXCEPTIONS CONTAINED UNDER SCHEDULE B - SECTION 2.

submit updated title commitment

VICINITY MAP

PLAT NOTES:

TEN-FOOT (10') WIDE DRY UTILITY AND DRAINAGE EASEMENTS ADJOINING THE PERIMETER OF THIS SUBDIVISION ARE HEREBY GRANTED ON PRIVATE PROPERTY. SAID EASEMENT AND THEIR WIDTH ARE INDICATED ON SHEET 2 OF 2 OF THIS PLAT. THESE EASEMENTS ARE GRANTED FOR THE INSTALLATION, MAINTENANCE AND REPLACEMENT OF ELECTRIC, GAS, TELEVISION CABLE, AND TELECOMMUNICATIONS FACILITIES. UTILITIES SHALL ALSO BE PERMITTED WITHIN ANY ACCESS EASEMENTS AND PRIVATE STREETS IN THE SUBDIVISION. PERMANENT STRUCTURES AND WATER METERS SHALL NOT BE PERMITTED WITHIN SAID EASEMENTS. ADDITIONALLY, THESE UTILITY AND DRAINAGE EASEMENTS ARE GRANTED FOR DRAINAGE FACILITIES INCLUDING INLETS, PIPES, CULVERTS, CHANNELS, DITCHES, HYDRAULIC STRUCTURES, AND DETENTION BASINS.

THE POLICY OF THE COUNTY REQUIRES THAT MAINTENANCE ACCESS BE PROVIDED TO ALL STORM DRAINAGE FACILITIES TO ASSURE CONTINUOUS OPERATIONAL CAPABILITY OF THE SYSTEM. THE PROPERTY OWNERS SHALL BE RESPONSIBLE FOR THE MAINTENANCE OF ALL DRAINAGE FACILITIES INCLUDING INLETS, PIPES, CULVERTS, CHANNELS, DITCHES, HYDRAULIC STRUCTURES, AND DETENTION BASINS LOCATED ON THEIR LAND UNLESS MODIFIED BY SUBDIVISION DEVELOPMENT AGREEMENT. SHOULD THE OWNER FAIL TO ADEQUATELY MAINTAIN SAID FACILITIES, THE COUNTY SHALL HAVE THE RIGHT TO ENTER SAID LAND FOR THE SOLE PURPOSE OF OPERATIONS AND MAINTENANCE. ALL SUCH MAINTENANCE COSTS WILL BE ASSESSED TO THE PROPERTY OWNER.

Prepared By

R.W. BAYER & ASSOCIATES, INC.
2090 East 104th Avenue, S-200
Thornton, Colorado 80233
303-452-4433 rwbsurveying@hotmail.com
CAD FILE: G17167/G17167.DWG

Date Prepared: SEPTEMBER 28, 2017

SOIL CONDITION NOTE:

SOILS ON LOTS CAN BE EXPECTED TO HAVE A HIGH SHRINK-SWELL POTENTIAL, AND FOUNDATIONS SHOULD BE DESIGNED TO MINIMIZE DAMAGE TO STRUCTURES FROM DIFFERENTIAL FOUNDATION MOVEMENT. ENGINEERED SEWAGE DISPOSAL SYSTEMS MAY BE REQUIRED. GROUNDWATER LEVELS ARE NOT EXPECTED TO BE HIGH ENOUGH TO AFFECT FOUNDATIONS, HOWEVER THERE IS A POSSABLILITY OF SEEPAGE FROM PERCHED GROUNDWATER, IF AREAS AROUND FOUNDATIONS ARE EXCESSIVE IRRIGATED.

spell check

ONSITE WATER SYSTEMS:

LOTS WITHIN COMANCHE VISTA ESTATES ARE SERVED BY ONSITE WASTEWATER SYSTEMS (OWS). TRI-COUNTY HEALTH DEPARTMENT REQUIRES THAT SEPTIC TANKS BE PUMPED AND INSPECTED EVERY FOUR YEARS. EACH PROPERTY OWNER SHALL HAVE HIS SEPTIC TANK PUMPED AND INSPECTED BY A SYSTEMS CLEANER, LICENCED BY TRI-COUNTY HEALTH DEPARTMENT AT LEAST EVERY FOUR YEARS, AND SHALL SUBMIT A RECEPT INDICATING THAT THE SEPTIC SYSTEM HAS BEEN PUMPED AND INSPECTED TO THE TRI-COUNTY HEALTH DEPARTMENT, COMMERCE CITY OFFICE. IN ADDITION TO PUMPING THE, OWS HAVE OTHER MAINTENANCE AND USE REQUIREMENTS THAT CAN PREVENT FALURE OF THE SYSTEM. THE TRI-COUNTY HEALTH DEPARTMENTS "SEPTIC SYSTEM GUIDELINES AND RECORDS" HAS BEEN PREPARED TO EDUCATE AND ADVISE OWNERS OF OWS ABOUT USE AND MAINTENANCE THEIR OWS. PROPERTY OWNERS CAN OBTAIN COPIES OF THE GUIDE, AS WELL AS ADDITIONAL INFORMATION ABOUT OWS FROM TRI-COUNTY HEALTH DEPARTMENT'S COMMERCE CITY OFFICE.

SURVEYOR'S CERTIFICATE:

I, RAYMOND W. BAYER, A REGISTERED LAND SURVEYOR, REGISTERED IN THE STATE OF COLORADO, DO HERBY CERTIFY THAT THERE ARE NO ROADS, PIPELINES, IRRIGATION DITCHES OR OTHER EASEMENTS IN EVIDENCE OR KNOW BY ME TO EXIST ON OR ACROSS THE HEREINBEFORE DESCRIBED PROPERTY, EXCEPT AS SHOWN ON THIS PLAT. I FURTHER CERTIFY THAT THIS SURVEY WAS PERFORMED BY ME OR UNDER MY DIRECT RESPONSIBILITY, SUPERVISION AND CHECKING, AND THAT THIS PLAT ACCURATELY REPRESENTS SAID SURVEY, AND THAT ALL MONUMENTS EXIST AS SHOWN HEREON.

RAYMOND W. BAYER,
REG P.L.S. NO. 6973

PLANNING COMMISSION APPROVAL:

APPROVED BY THE ADAMS COUNTY PLANNING COMMISSION THIS _____ DAY OF _____, 20____.

_____
CHAIR

BOARD OF COUNTY COMMISSIONERS APPROVAL:

APPROVED BY THE ADAMS COUNTY BOARD OF COUNTY COMMISSIONERS THIS DAY OF _____, 20_____.

_____
CHAIR

CERTIFICATE OF CLERK AND RECORDER

THIS PLAT WAS FILED FOR RECORD IN THE OFFICE OF THE ADAMS COUNTY CLERK AND RECORDER IN THE STATE OF COLORADO AT _____:_____ ___. M. ON THE _____ DAY OF _____, A.D., 20_____.

By: _____ _____
DEPUTY COUNTY CLERK AND RECORDER

RECEPTION NO: _____

COMANCHE VISTA ESTATES - 5th FILING

A PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO. CASE NO: PLT2017-00019

SHEET 2 OF 2

N
W E
S

0 50' 100' 200'

SCALE: 1"=100

LEGEND

- DENOTES FOUND #5 REBAR & CAP, BAYER - P.L.S. 6973, FLUSH W/GROUND
- DENOTES FOUND 2" ALUMINUM CAP, RUSSELL, P.L.S. 23519, WC 40', 1.0' BELOW GROUND

Prepared By:
R.W. BAYER & ASSOCIATES, INC.
2090 East 104th Avenue, S-200
Thornton, Colorado 80233
303-452-4433 rwbsurveying@hotmail.com
CAD FILE: G17167/G17167A.DWG

Date Prepared: SEPTEMBER 28, 2017

COMANCHE VISTA ESTATES - FILING NO. 4
(RECEPTION NO. 20051220001389320, ADAMS COUNTY RECORDS)

HEADLIGHT ROAD

N00°16'00"E 1271.37'

S89°44'00"E 953.74'

EAST LINE S.W. 1/4 SEC. 23

S.W. 1/4
SEC. 23

S.E. 1/4 SEC. 23

(PARCEL SHOWN IN BOOK 1, PAGE 4889, RECEPTION NO. 2017-124, LAND SURVEY PLATS, ADAMS COUNTY RECORDS)

ACCEPTANCE OF DECLARATION OF USE RESTRICTION, RECEPTION NO. 200511090012427 90, ADAMS COUNTY RECORDS

S00°07'52"E

(UNPLATTED)
ADAMS COUNTY PARCEL #0181300000063

add note to sheet 1

N89°50'48"E 466.69'

10' DRY UTILITY & DRAINAGE EASEMENT BY THIS PLAT (TYPICAL)

~~ALLOWED HOMESITE AREA-COMANCHE VISTA ESTATES - PUD~~
(~~RECEPTION NO. C1200349, ADAMS COUNTY RECORDS~~)

LOT 1
CONTAINS 217,800 SQUARE FEET OR 5.000 ACRES MORE OR LESS

10' DRY UTILITY & DRAINAGE EASEMENT BY THIS PLAT (TYPICAL)

N00°09'12"W 466.69'

S00°09'12"E 466.69'

legal description is incorrect. Revise courses.

FOUND 2" ALUMINUM CAP, RUSSELL, P.L.S. 23519, WC 40', 1.0' BELOW GROUND

NORTH RIGHT-OF-WAY LINE EAST ~~SOUTH~~ AVENUE

S89°50'48"W 570.00'

40' DEEDED TO ADAMS COUNTY IN RECEPTION NO. 20060111000037710, FOR PUBLIC ROAD

40'

S89°50'48"W 466.69'

40'

N00°07'52"W 40.00'

S89°50'48"W

2659.08'

EAST 38TH AVENUE

SOUTH LINE S.W. 1/4 SEC. 23

POINT OF BEGINNING

S.W. COR. S.W. 1/4 SEC. 23, T.3S., R.62W (FOUND SPIKE NAIL W/FLAGGING, FIT MONUMENT RECORD TIES BY R.W. BAYER & ASSOCIATES, FILED ON 9/23/2004, 0.2' BELOW GRAVEL ROAD)

S.E. COR. S.W. 1/4 SEC. 23, T.3S., R.62W (FOUND 3/4" IRON PIPE W/PLUMBERS CAP, 1.3' BELOW GROUND)

POINT OF COMMENCEMENT

Community & Economic
Development Department
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000
Brighton, CO 80601-8204
PHONE 720.523.6800
FAX 720.523.6998

Development Review Team Comments

Date: 4/4/2018

Project Number: PLT2017-00019

Project Name: Comanche Vista Estates, Filing #5

Note to Applicant:

The following review comments and information from the Development Review Team is based on the information you resubmitted for a final plat application. A resubmittal is being required. Please contact the case manager if you have any questions:

Commenting Division: Engineering Review #2

Name of Reviewer: Greg Labrie

Date: 04/04/2018

Email: glabrie@adcogov.org

Complete

ENG1: East 38th Avenue is a rural arterial road. There are no public improvements required along E. 38th Avenue; therefore a Subdivision Improvement Agreement is not required to be submitted with the proposed plat.
ENG2: The proposed subdivision is generating less than 20 vehicles per day, a traffic impact study is not required.
ENG3; The proposed development has less than 3000 square feet of impervious surface, therefore a drainage study is not required.

Commenting Division: Planner Review #2

Name of Reviewer: Greg Barnes

Date: 04/04/2018

Email: gjbarnes@adcogov.org

Resubmittal Required

PLN03: Please provide more information in regard to the payment of PLD fees. Although some PLD fees appear to have been paid in June 2003, my records indicate that those fees were paid toward only two of the 18 lots of the PUD. I checked the last approved filing from 2007, and it appears that PLD fees were paid in 2007 as part of that filing.

Commenting Division: Parks Review #1

Name of Reviewer: Aaron Clark

Date: 11/27/2017

Email: aclark@adcogov.org

Complete

PRK1. The Homesite Area is adjacent on three sides of lands protected by a conservation easement held by Adams County. Development of the Homesite Area shall not impair the conservation values of the easement.

Commenting Division: ROW Review #1

Name of Reviewer: Marissa Hillje

Date: 12/14/2017

Email: mhillje@adcogov.org

Resubmittal Required

ROW1) SUBMIT TITLE COMMITMENT: Please submit a title commitment which should be used to depict the applicable recordings on the plat. Please send Adams County a copy of the title commitment with your application dated no later than 30 days to review in order to ensure that any other party's interests are not encroached upon.

ROW2) Revise Property Description/ Legal Description:

a. An accurate and clear property (legal) description of the overall boundary of the subdivision with the acreage of the subdivision. All courses in the property (legal) description shall be shown and labeled on the plat drawing, with all bearings having the same direction as called out in the legal description. The only exception being where more than one description is required, going a different direction over the same course. The direction shall then hold for the description having more weight (i.e., the overall boundary) for purposes of the plat. If both record and "as-measured" dimensions are being used, show both and clearly label on the plat drawing. Point of commencement and/or point of beginning shall be clearly labeled on the plat drawing.

ROW3) See additional comments that are in redlines on plat

Commenting Division: Engineering Review #1

Name of Reviewer: Greg Labrie

Date: 12/04/2017

Email: glabrie@adcogov.org

Complete

ENG1: Flood Insurance Rate Map – FIRM Panel # (08001C0743H), Federal Emergency Management Agency, January 20, 2016. According to the above reference, the project site is NOT located within a delineated 100-year flood hazard zone; A floodplain use permit will not be required.
ENG2: The project site is not located in a NRCO district. An environmental assessment is not required.
ENG3; The project site is NOT within the County's MS4 Stormwater Permit area. The use of erosion and sediment control BMPs are expected. The applicant shall be responsible to ensure compliance with all Federal, State, and Local water quality construction requirements.
ENG4; Applicant is proposing to install over 3,000 square feet of impervious area on the project site. A drainage report and drainage plans in accordance to Chapter 9 of the Adams County Development Review Manual, are required to be completed by a registered professional engineer and submitted to Adams County for review and final approval.
ENG5; The applicant is required to complete a traffic impact study signed and stamped by a professional engineer.
ENG6; The developer is required to construct roadway improvements as required by the approved traffic impact study and must obtain any roadway construction permits from Adams County.
ENG7; No building permits will be issued until all public improvements have been constructed, inspected and preliminarily accepted by the County's Transportation Dept.
ENG8; East 38th Avenue is classified as a Section Line areterial. Any new access onto E. 38th Avenue must be approved through the Adams County One Stop Permit Center.
ENG9; Prior to scheduling the final plat/FDP BOCC hearing, the developer is required to submit for review and receive approval of all construction documents (construction plans and reports). Construction documents shall include, at a minimum, onsite and public improvements construction plans, drainage report, traffic impact study. All construction documents must meet the requirements of the Adams County Development Standards and Regulations. The developer shall submit to the Adams County Development Review Engineering division the following: Engineering Review Application, Engineering Review Fee, three (3) copies of all construction documents.

Commenting Division: ROW Review #2

Name of Reviewer: Marissa Hillje

Date: 04/02/2018

Email: mhillje@adcogov.org

Resubmittal Required

ROW1: Add Case No to each sheet: PLT2017-00019

ROW2: Remove "streets and easements" in dedication paragraph: See redlines for clarification.

Commenting Division: Addressing Review #2

Name of Reviewer: Marissa Hillje

Date: 04/02/2018

Email: mhillje@adcogov.org

Complete

Address will be assigned with the access permit application

Commenting Division: Addressing Review #1

Name of Reviewer: Marissa Hillje

Date: 12/14/2017

Email: mhillje@adcogov.org

Complete

Will address on plat

Commenting Division: Planner Review #1

Name of Reviewer: Greg Barnes

Date: 12/19/2017

Email: gjbarnes@adcogov.org

Resubmittal Required

PLN01: A subdivision improvements agreement (SIA) must be submitted with separate application. This agreement must be reviewed by staff prior to scheduling the final plat for public hearings. Since the SIA was not submitted with the original application, a full 21-day review cycle may be needed when you resubmit.
PLN02: Construction documents shall be submitted and finalized prior to scheduling a final plat for public hearing.
PLN03: All PLD fees are to be submitted prior to public hearing. A fee calculation sheet has been included with these comments. Please note - It appears that your calculation was one cent short.
PLN04: Please review the criteria for approval of a minor subdivision final plat found in Section 2-02-18-03-05 of the Development Standards. Compliance with the subdivision design standards includes: public improvements and PLD fees. Traffic and drainage studies are also included in these criteria,
PLN05: The design of the lot appears to comply with the minimum standards of the Comanche Vista estates PUD. No further revision to the lot configuration appears to be necessary.

COMANCHE VISTA ESTATES - FILING NO. 5

A PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO. CASE NO: PLT2017-00019

SHEET 1 OF 2

DEDICATION:

KNOW ALL MEN BY THESE PRESENTS THAT KENNETH W. NEWBY, BEING THE OWNER OF THAT PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, DESCRIBED AS FOLLOWS:

COMMENCING AT THE SOUTHEAST CORNER OF THE SOUTHWEST ONE-QUARTER OF SAID SECTION 23; THENCE NORTH 00°07'52" WEST ALONG THE EAST LINE OF SAID SOUTHWEST ONE-QUARTER, A DISTANCE OF 40.00 FEET TO THE NORTH RIGHT-OF-WAY LINE OF EAST 38TH AVENUE AS DESCRIBED IN RECEPTION NO. 2006011100037710, ADAMS COUNTY RECORDS; THENCE SOUTH 89°50'48" WEST ALONG SAID NORTH RIGHT-OF-WAY LINE, PARALLEL WITH AND 40 FEET NORTH OF THE SOUTH LINE OF SAID SOUTHWEST ONE-QUARTER, A DISTANCE OF 570.00 FEET TO THE POINT OF BEGINNING; THENCE CONTINUING SOUTH 89°50'48" WEST ALONG SAID NORTH RIGHT-OF-WAY LINE, PARALLEL WITH AND 40 FEET NORTH OF THE SOUTH LINE OF SAID SOUTHWEST ONE-QUARTER, A DISTANCE OF 466.69 FEET; THENCE NORTH 00°09'12" WEST A DISTANCE OF 466.69 FEET; THENCE NORTH 89°50'48" EAST A DISTANCE OF 466.69 FEET; THENCE SOUTH 00°09'12" EAST A DISTANCE OF 466.69 FEET TO THE POINT OF BEGINNING.
CONTAINS 217,800 SQUARE FEET OR 5.000 ACRES MORE OR LESS.

HAS BY THESE PRESENTS LAID OUT, PLATTED AND SUBDIVIDED THE SAME AS SHOWN ON THIS PLAT INTO A LOT, ~~STREETS AND EASEMENT~~ UNDER THE NAME AND STYLE OF COMANCHE VISTA ESTATES - FILING NO. 5 AND DO HEREBY GRANT TO THE COUNTY OF ADAMS, STATE OF COLORADO, FOR THE USE OF THE PUBLIC, ALL STREETS, AND OTHER PUBLIC WAYS AND LANDS AS SHOWN ON THIS PLAT, FOREVER, AND ALSO RESERVE THOSE PORTIONS OF REAL PROPERTY WHICH ARE LABELED AS UTILITY EASEMENTS ON THIS PLAT, FOR THE INSTALLATION AND MAINTENANCE OF UTILITIES AND DRAINAGE FACILITIES, INCLUDING BUT NOT LIMITED TO ELECTRIC LINES, GAS LINES, TELEPHONE LINES, SEWER LINES, WATER LINES: TOGETHER WITH A RIGHT TO TRIM INTERFERING TREES AND BRUSH, TOGETHER WITH A PERPETUAL RIGHT OF INGRESS AND EGRESS FOR INSTALLATION, MAINTENANCE AND REPLACEMENT OF SUCH LINES; SAID EASEMENTS AND RIGHTS TO BE UTILIZED IN A RESPONSIBLE AND PRUDENT MANNER.
EXECUTED THIS _____ DAY OF _____, 20_____.

_____
KENNETH W. NEWBY

ACKNOWLEDGEMENT:

STATE OF COLORADO)
COUNTY OF ADAMS)

THE FOREGOING WAS ACKNOWLEDGED BY ME THIS _____ DAY OF _____, 20____, BY KENNETH W. NEWBY.

_____
NOTARY PUBLIC
MY COMMISSION EXPIRES: _____
MY ADDRESS IS: _____
_____
_____

BASIS FOR BEARINGS:

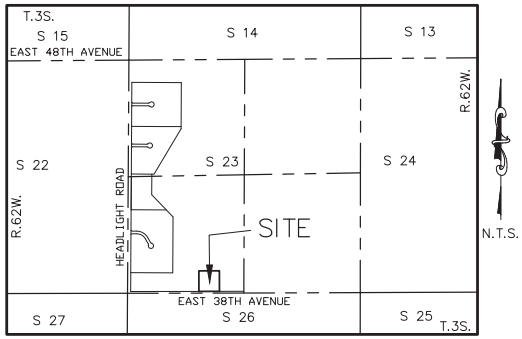
THE SOUTH LINE OF THE SOUTHWEST ONE-QUARTER (THE S.W. COR. IS A FOUND SPIKE NAIL W/FLAGGING, FIT MONUMENT RECORD TIES BY R.W. BAYER & ASSOCIATES, FILED ON 9/23/2004, 0.2' BELOW GRAVEL ROAD AND THE S.E. COR. IS A 3/4" IRON PIPE W/PLUMBERS CAP, 1.3' BELOW GROUND) OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, BEARS, SOUTH 89°50'48" WEST, PER THE RECORDED LAND SURVEY PLAT IN BOOK 1, PAGE 2052, RECEPTION NO. 104-068, ADAMS COUNTY RECORDS. ALL BEARINGS SHOWN HEREON ARE RELATIVE THERETO.

NOTICE:

ACCORDING TO COLORADO LAW YOU MUST COMMENCE ANY LEGAL ACTION BASED UPON ANY DEFECT IN THIS SURVEY WITHIN THREE YEARS AFTER YOU FIRST DISCOVER SUCH DEFECT. IN NO EVENT MAY ANY LEGAL ACTION BASED UPON ANY DEFECT IN THIS SURVEY BE COMMENCED MORE THAN TEN YEARS FROM THE DATE OF THE CERTIFICATION SHOWN HEREON.

THIS SURVEY DOES NOT CONSTITUTE A TITLE SEARCH BY R.W. BAYER & ASSOCIATES, INC. OF THE PROPERTY SHOWN AND DESCRIBED HEREIN TO DETERMINE OWNERSHIP OF THE TRACT OF LAND, COMPATIBILITY OF THIS DESCRIPTION WITH THOSE OF ADJACENT TRACTS OF LAND OR RIGHTS-OF-WAY, EASEMENTS OR ENCUMBRANCES OF RECORD AFFECTING THIS TRACT OF LAND. R.W. BAYER & ASSOCIATES, INC. HAS RELIED UPON TITLE REPORT PREPARED BY FIDELITY NATIONAL TITLE COMPANY, REPORT NO. FO0603441-152-t56, EFFECTIVE DATE FEBRUARY 15, 2018 AT 8:00 A.M., THIS PARCEL SUBJECT TO THE EXCEPTIONS CONTAINED UNDER SCHEDULE B - SECTION 2.

VICINITY MAP



PLAT NOTES:

COMANCHE VISTA ESTATES PLANNED UNIT DEVELOPMENT RECORDED AS P.U.D. 3716, RECEPTION C1200349, ADAMS COUNTY RECORDS PROVIDED FOR THE DEVELOPMENT OF THIS 5 ACRE HOMESITE WHICH IS NOT PART OF THE AGRICULTURE RESERVE AREA. THIS 5 ACRE HOMESITE IS SUBJECT TO THE RESTRICTIONS, COVENANTS, AND REQUIREMENTS OF THE COMANCHE VISTA ESTATES PLANNED UNIT DEVELOPMENT.

A FIFTEEN-FOOT (15') WIDE DRY UTILITY AND DRAINAGE EASEMENT ADJOINING EAST 38TH AVENUE AND TEN-FOOT (10') WIDE DRY UTILITY AND DRAINAGE EASEMENTS ADJOINING THE REMAINING PERIMETER OF THIS SUBDIVISION ARE HEREBY GRANTED ON PRIVATE PROPERTY. SAID EASEMENT AND THEIR WIDTH ARE INDICATED ON SHEET 2 OF 2 OF THIS PLAT. THESE EASEMENTS ARE GRANTED FOR THE INSTALLATION, MAINTENANCE AND REPLACEMENT OF ELECTRIC, GAS, TELEVISION CABLE, AND TELECOMMUNICATIONS FACILITIES. UTILITIES SHALL ALSO BE PERMITTED WITHIN ANY ACCESS EASEMENTS AND PRIVATE STREETS IN THE SUBDIVISION. PERMANENT STRUCTURES AND WATER METERS SHALL NOT BE PERMITTED WITHIN SAID EASEMENTS. ADDITIONALLY, THESE UTILITY AND DRAINAGE EASEMENTS ARE GRANTED FOR DRAINAGE FACILITIES INCLUDING INLETS, PIPES, CULVERTS, CHANNELS, DITCHES, HYDRAULIC STRUCTURES, AND DETENTION BASINS.

THE POLICY OF THE COUNTY REQUIRES THAT MAINTENANCE ACCESS BE PROVIDED TO ALL STORM DRAINAGE FACILITIES TO ASSURE CONTINUOUS OPERATIONAL CAPABILITY OF THE SYSTEM. THE PROPERTY OWNERS SHALL BE RESPONSIBLE FOR THE MAINTENANCE OF ALL DRAINAGE FACILITIES INCLUDING INLETS, PIPES, CULVERTS, CHANNELS, DITCHES, HYDRAULIC STRUCTURES, AND DETENTION BASINS LOCATED ON THEIR LAND UNLESS MODIFIED BY SUBDIVISION DEVELOPMENT AGREEMENT. SHOULD THE OWNER FAIL TO ADEQUATELY MAINTAIN SAID FACILITIES, THE COUNTY SHALL HAVE THE RIGHT TO ENTER SAID LAND FOR THE SOLE PURPOSE OF OPERATIONS AND MAINTENANCE. ALL SUCH MAINTENANCE COSTS WILL BE ASSESSED TO THE PROPERTY OWNER.

Prepared By:

R.W. BAYER & ASSOCIATES, INC.
2090 East 104th Avenue, S-200
Thornton, Colorado 80233
303-452-4433 rwbsurveying@hotmail.com
CAD FILE: G17167/G17167.DWG

Date Prepared: SEPTEMBER 28, 2017
REVISED 01-26-2018 PER COUNTY COMMENTS

SOIL CONDITION NOTE:

SOILS ON LOTS CAN BE EXPECTED TO HAVE A HIGH SHRINK-SWELL POTENTIAL, AND FOUNDATIONS SHOULD BE DESIGNED TO MINIMIZE DAMAGE TO STRUCTURES FROM DIFFERENTIAL FOUNDATION MOVEMENT. ENGINEERED SEWAGE DISPOSAL SYSTEMS MAY BE REQUIRED. GROUNDWATER LEVELS ARE NOT EXPECTED TO BE HIGH ENOUGH TO AFFECT FOUNDATIONS, HOWEVER THERE IS A POSSIBILITY OF SEEPAGE FROM PERCHED GROUNDWATER, IF AREAS AROUND FOUNDATIONS ARE EXCESSIVE IRRIGATED.

ONSITE WATER SYSTEMS:

LOTS WITHIN COMANCHE VISTA ESTATES ARE SERVED BY ONSITE WASTEWATER SYSTEMS (OWS). TRI-COUNTY HEALTH DEPARTMENT REQUIRES THAT SEPTIC TANKS BE PUMPED AND INSPECTED EVERY FOUR YEARS. EACH PROPERTY OWNER SHALL HAVE HIS SEPTIC TANK PUMPED AND INSPECTED BY A SYSTEMS CLEANER, LICENSED BY TRI-COUNTY HEALTH DEPARTMENT AT LEAST EVERY FOUR YEARS, AND SHALL SUBMIT A RECEIPT INDICATING THAT THE SEPTIC SYSTEM HAS BEEN PUMPED AND INSPECTED TO THE TRI-COUNTY HEALTH DEPARTMENT, COMMERCE CITY OFFICE. IN ADDITION TO PUMPING THE, OWS HAVE OTHER MAINTENANCE AND USE REQUIREMENTS THAT CAN PREVENT FAILURE OF THE SYSTEM. THE TRI-COUNTY HEALTH DEPARTMENTS "SEPTIC SYSTEM GUIDELINES AND RECORDS" HAS BEEN PREPARED TO EDUCATE AND ADVISE OWNERS OF OWS ABOUT USE AND MAINTENANCE THEIR OWS. PROPERTY OWNERS CAN OBTAIN COPIES OF THE GUIDE, AS WELL AS ADDITIONAL INFORMATION ABOUT OWS FROM TRI-COUNTY HEALTH DEPARTMENT'S COMMERCE CITY OFFICE.

SURVEYOR'S CERTIFICATE:

I, RAYMOND W. BAYER, A REGISTERED LAND SURVEYOR, REGISTERED IN THE STATE OF COLORADO, DO HERBY CERTIFY THAT THERE ARE NO ROADS, PIPELINES, IRRIGATION DITCHES OR OTHER EASEMENTS IN EVIDENCE OR KNOW BY ME TO EXIST ON OR ACROSS THE HEREINBEFORE DESCRIBED PROPERTY, EXCEPT AS SHOWN ON THIS PLAT. I FURTHER CERTIFY THAT THIS SURVEY WAS PERFORMED BY ME OR UNDER MY DIRECT RESPONSIBILITY, SUPERVISION AND CHECKING, AND THAT THIS PLAT ACCURATELY REPRESENTS SAID SURVEY, AND THAT ALL MONUMENTS EXIST AS SHOWN HEREON.

RAYMOND W. BAYER,
REG P.L.S. NO. 6973

PLANNING COMMISSION APPROVAL:

APPROVED BY THE ADAMS COUNTY PLANNING COMMISSION THIS _____ DAY OF _____, 20____.

_____
CHAIR

BOARD OF COUNTY COMMISSIONERS APPROVAL:

APPROVED BY THE ADAMS COUNTY BOARD OF COUNTY COMMISSIONERS THIS DAY OF _____, 20_____.

_____
CHAIR

CERTIFICATE OF CLERK AND RECORDER

THIS PLAT WAS FILED FOR RECORD IN THE OFFICE OF THE ADAMS COUNTY CLERK AND RECORDER IN THE STATE OF COLORADO AT _____:_____ ___. M. ON THE _____ DAY OF _____, A.D., 20_____.

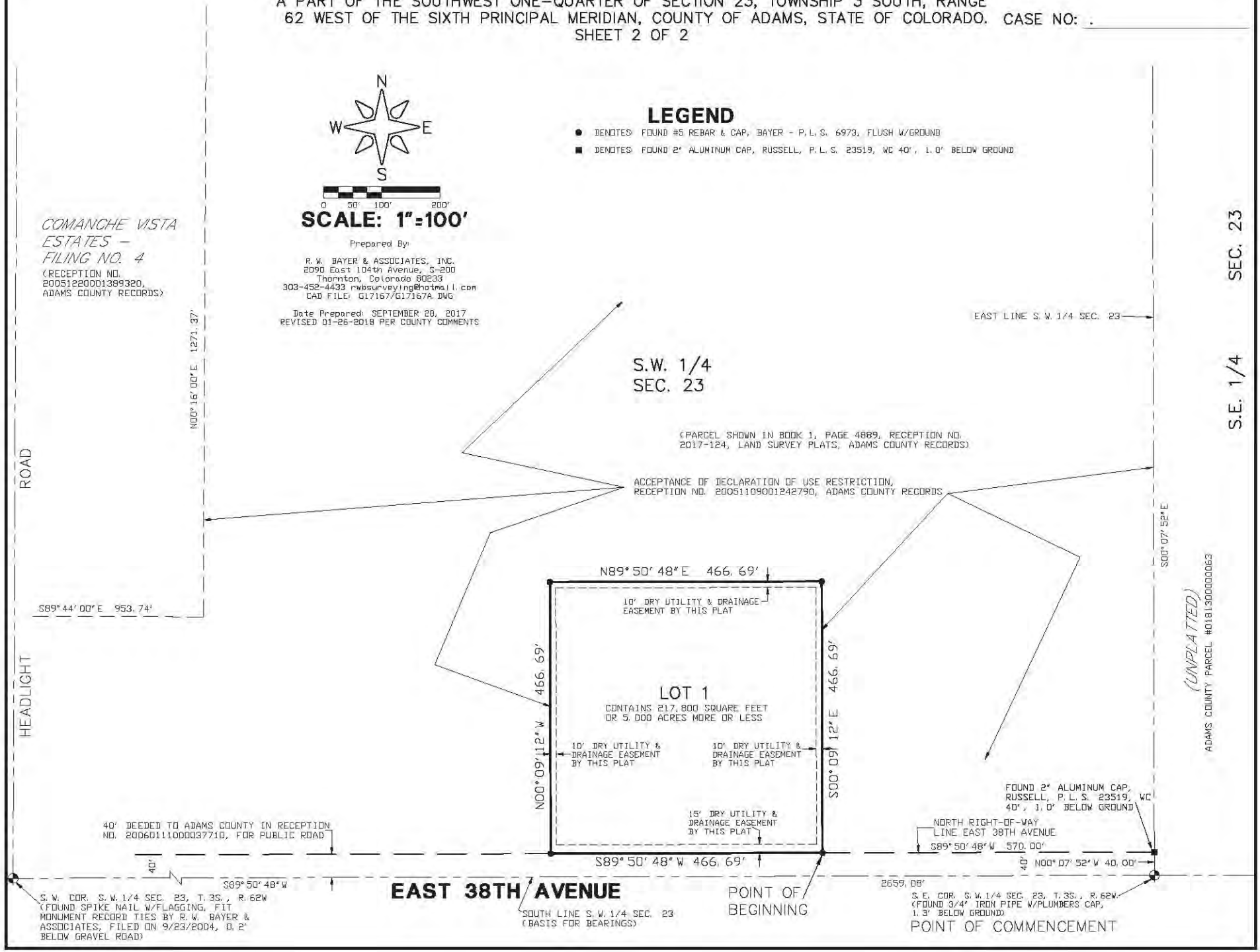
By:_____ _____
DEPUTY COUNTY CLERK AND RECORDER

RECEPTION NO: _____

COMANCHE VISTA ESTATES - FILING NO. 5

A PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO. CASE NO: .

SHEET 2 OF 2



Adams County Public Land Dedication Worksheet
Rural School District

Date Computed= 6/14/2018

Case Name: Comanche Vista Estates, Filing 5	
Case Number: PLT2017-00019	
Rural Residential (A-1, RE)	
Number of Units=	1
Population generated=	3
Student population generated=	0.775
School Acreage Needed=	0.0462675
Regional Park Acreage Needed=	0.013
Total Acres of PLD Needed=	**0.0592675**
Land Value per acre=	$13,662.00
PLD Fee in lieu=	**$809.71**
Deposits:	
School District { } Account=	**$632.11**
Regional Parks Account=	**$177.61**

COLORADO GEOLOGICAL SURVEY

1801 19th Street
Golden, Colorado 80401

Karen Berry
State Geologist

December 13, 2017

Greg Barnes
Adams County
Community & Economic Development Department
4430 S. Adams County Parkway, Suite W2000A
Brighton, CO 80601

Location:
SW SE SW Section 23,
T3S, R62W of the 6th P.M.
39.7684, -104.2957

Subject: Comanche Vista Estates Filing No. 5 – Final Plat
Project Number PLT2017-00019; Adams County, CO; CGS Unique No. AD-18-0007

Dear Greg:

Colorado Geological Survey has reviewed the Comanche Vista Estates Filing No. 5 preliminary plat referral, for one five-acre "Homesite" lot located on the north side of E. 38th Ave., about 1500 feet east of Headlight Road, north of Strasburg. With this referral, I received a Request for Comments (November 28, 2017), a Written Explanation (undated), and a set of two plat sheets (R.W. Bayer & Associates, September 28, 2017). CGS previously reviewed a Comanche Vista Estates sketch plan referral, which included a Groundwater and Soils Investigation (Judith Hamilton, June 14, 2002).

The site does not contain steep slopes, is located outside of the Comanche Creek flood hazard zone, is not undermined, and is not exposed to any geologic hazards that would preclude the proposed residential use and density. **CGS therefore has no objection to approval of the plat as proposed.** The Soil Condition plat note satisfactorily addresses potential soils-related concerns. These constraints will need to be addressed prior to building permit application, and include:

Collapsible and expansive soils. The site is underlain by relatively low density, low strength, eolian (wind-deposited) silts, clays and sands. Some of the soils are calcareous. Eolian soils, especially those containing soluble calcareous minerals, tend to be loose, fine-grained, and hydrocompactive, meaning they can lose strength, settle, compress, or collapse when water infiltrates the soils. Thick columns of compressible or collapsible soils can result in very significant settlement and structural damage. Alternatively, clay minerals and clayey pockets within the surficial soils may exhibit volume changes (shrink-swell) in response to changes in water content. Potentially highly expansive claystones and shales of the Dawson arkose are present at unknown depths beneath the surficial soils. If claystone layers capable of producing high swell pressures are present within a few feet of foundation bearing depths, they can cause significant structural damage if not properly characterized and mitigated. Lignite is a relatively soft, low-strength material present as layers and discontinuous lenses within the Dawson, and is unsuitable as a foundation bearing material.

Lot-specific geotechnical investigations consisting of drilling, sampling, lab testing and analysis will be needed, once a building location has been identified, to: determine the thickness and extent to which the soils beneath the proposed home are subject to collapse under loading and/or wetting; characterize soil and bedrock engineering properties such as density, strength, water content, swell/consolidation potential

and bearing capacity; determine depths to groundwater, bedrock, and any impermeable layers that might lead to development of a perched water condition; verify the feasibility of a full-depth basement, if planned; and provide earthwork, foundation, floor system, subsurface drainage, and pavement recommendations for design purposes. It is imperative that grading, surface drainage, and subsurface drainage are correctly designed, constructed and maintained to prevent wetting of potentially collapsible and expansive soils in the immediate vicinity of foundation elements.

Thank you for the opportunity to review and comment on this project. If you have questions or require additional review, please call me at (303) 384-2643, or e-mail carlson@mines.edu.

Sincerely,

Jill Carlson, C.E.G.
Engineering Geologist

Brooks Kaufman
Lands and Rights of Way Director

December 18, 2017

Greg Barnes
Adams County
Department of Planning and Development
4430 South Adams County Parkway
Suite W2000A
Brighton, Colorado 80601-8216

Re: COMMANCHE VISTA ESTATES F5
Case No.: PLT2017-00019

Dear Mr. Barnes:

The Association has reviewed the contents in the above-referenced referral response packet. We reviewed the project for maintaining our existing facilities, utility easements, electric loading, and service requirements. We are advising you of the following concerns and comments:

The Association will require a fifteen-foot (15') utility easement adjacent to East 38th Ave. for the installation of electric facilities. The smaller width easements depicted on the plat will create difficulties during installation of dry utilities due to the limited amount of space made available.

Sincerely,
Brooks Kaufman
Lands and Rights-of-Way Director

INTERMOUNTAIN RURAL ELECTRIC ASSOCIATION
5496 N. U.S. Highway 85, P.O. Drawer A / Sedalia, Colorado 80135
Telephone (720)733-5493
bkaufman@irea.coop

COMANCHE VISTA ESTATES - HOMESITE FILING

A PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO. CASE NO: .

SHEET 1 OF 2

DEDICATION:

KNOW ALL MEN BY THESE PRESENTS THAT KENNETH W. NEWBY, BEING THE OWNER OF THAT PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE 6TH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, DESCRIBED AS FOLLOWS:

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CONTAINS 217,800 SQUARE FEET OR 5.000 ACRES MORE OR LESS.

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EXECUTED THIS _____ DAY OF _____, 20_____.

_____
KENNETH W. NEWBY

ACKNOWLEDGEMENT:

STATE OF COLORADO)
COUNTY OF ADAMS)

THE FOREGOING WAS ACKNOWLEDGED BY ME THIS _____ DAY OF _____, 20_____, BY KENNETH W. NEWBY.

_____
NOTARY PUBLIC
MY COMMISSION EXPIRES: _____
MY ADDRESS IS: _____
_____
_____

BASIS FOR BEARINGS:

THE SOUTH LINE OF THE SOUTHWEST ONE-QUARTER (THE S.W. COR. IS A FOUND SPIKE NAIL W/FLAGGING, FIT MONUMENT RECORD TIES BY R.W. BAYER & ASSOCIATES, FILED ON 9/23/2004, 0.2' BELOW GRAVEL ROAD AND THE S.E. COR. IS A 3/4" IRON PIPE W/PLUMBERS CAP, 1.3' BELOW GROUND) OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO, BEARS, SOUTH 89°50'48" WEST, PER THE RECORDED LAND SURVEY PLAT IN BOOK 1, PAGE 2052, RECEPTION NO. 104-068, ADAMS COUNTY RECORDS. ALL BEARINGS SHOWN HEREON ARE RELATIVE THERETO.

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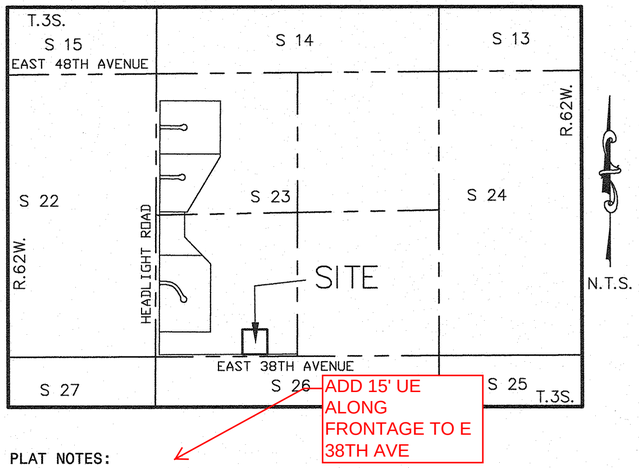
VICINITY MAP



N.T.S.

PLAT NOTES:

TEN-FOOT (10') WIDE DRY UTILITY AND DRAINAGE EASEMENTS ADJOINING THE PERIMETER OF THIS SUBDIVISION ARE HEREBY GRANTED ON PRIVATE PROPERTY. SAID EASEMENT AND THEIR WIDTH ARE INDICATED ON SHEET 2 OF 2 OF THIS PLAT. THESE EASEMENTS ARE GRANTED FOR THE INSTALLATION, MAINTENANCE AND REPLACEMENT OF ELECTRIC, GAS, TELEVISION CABLE, AND TELECOMMUNICATIONS FACILITIES. UTILITIES SHALL ALSO BE PERMITTED WITHIN ANY ACCESS EASEMENTS AND PRIVATE STREETS IN THE SUBDIVISION. PERMANENT STRUCTURES AND WATER METERS SHALL NOT BE PERMITTED WITHIN SAID EASEMENTS. ADDITIONALLY, THESE UTILITY AND DRAINAGE EASEMENTS ARE GRANTED FOR DRAINAGE FACILITIES INCLUDING INLETS, PIPES, CULVERTS, CHANNELS, DITCHES, HYDRAULIC STRUCTURES, AND DETENTION BASINS.

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Prepared By:

R. W. BAYER & ASSOCIATES, INC.
2090 East 104th Avenue, S-200
Thornton, Colorado 80233
303-452-4433 rwbsurveying@hotmail.com
CAD FILE: G17167/G17167.DWG

Date Prepared: SEPTEMBER 28, 2017

SOIL CONDITION NOTE:

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SURVEYOR'S CERTIFICATE:

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RAYMOND W. BAYER,
REG P.L.S. NO. 6973

PLANNING COMMISSION APPROVAL:

APPROVED BY THE ADAMS COUNTY PLANNING COMMISSION THIS _____ DAY OF _____, 20____.

_____
CHAIR

BOARD OF COUNTY COMMISSIONERS APPROVAL:

APPROVED BY THE ADAMS COUNTY BOARD OF COUNTY COMMISSIONERS THIS DAY OF _____, 20_____.

_____
CHAIR

CERTIFICATE OF CLERK AND RECORDER

THIS PLAT WAS FILED FOR RECORD IN THE OFFICE OF THE ADAMS COUNTY CLERK AND RECORDER IN THE STATE OF COLORADO AT _____:_____ ___. M. ON THE _____ DAY OF _____, A.D., 20_____.

By:_____ _____
DEPUTY COUNTY CLERK AND RECORDER

RECEPTION NO: _____

COMANCHE VISTA ESTATES - HOMESITE FILING

A PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO. CASE NO: .

SHEET 2 OF 2

N

W E

S

0 50' 100' 200'

SCALE: 1"=100'

Prepared By:

R. W. BAYER & ASSOCIATES, INC.
2090 East 104th Avenue, S-200
Thornton, Colorado 80233
303-452-4433 rwbsurveying@hotmail.com
CAD FILE: G17167/G17167A.DWG

Date Prepared: SEPTEMBER 28, 2017

LEGEND

- ● DENOTES: FOUND #5 REBAR & CAP, BAYER - P. L. S. 6973, FLUSH W/GROUND
- ■ DENOTES: FOUND 2" ALUMINUM CAP, RUSSELL, P. L. S. 23519, WC 40', 1.0' BELOW GROUND

COMANCHE VISTA ESTATES - FILING NO. 4
(RECEPTION NO. 20051220001389320, ADAMS COUNTY RECORDS)

N00° 16' 00" E 1271.37'

HEADLIGHT ROAD

S89° 44' 00" E 953.74'

EAST LINE S.W. 1/4 SEC. 23

SEC. 23

S.E. 1/4

S.W. 1/4
SEC. 23

(PARCEL SHOWN IN BOOK 1, PAGE 4889, RECEPTION NO. 2017-124, LAND SURVEY PLATS, ADAMS COUNTY RECORDS)

ACCEPTANCE OF DECLARATION OF USE RESTRICTION, RECEPTION NO. 20051109001242790, ADAMS COUNTY RECORDS

S00° 07' 52" E

(UNPLATTED)
ADAMS COUNTY PARCEL #0181300000063

N89° 50' 48" E 466.69'

10' DRY UTILITY & DRAINAGE EASEMENT BY THIS PLAT (TYPICAL)

ALLOWED HOMESITE AREA-COMANCHE VISTA ESTATES - PUD
(RECEPTION NO. C1200349, ADAMS COUNTY RECORDS)

LOT 1

CONTAINS 217,800 SQUARE FEET OR 5.000 ACRES MORE OR LESS

N00° 09' 12" W 466.69'

S00° 09' 12" E 466.69'

REQUIRE 15' UE ALONG E 38TH AVE

10' DRY UTILITY & DRAINAGE EASEMENT BY THIS PLAT (TYPICAL)

FOUND 2" ALUMINUM CAP, RUSSELL, P. L. S. 23519, WC 40', 1.0' BELOW GROUND

NORTH RIGHT-OF-WAY LINE EAST 136TH AVENUE
S89° 50' 48" W 570.00'

40' DEEDED TO ADAMS COUNTY IN RECEPTION NO. 20060111000037710, FOR PUBLIC ROAD

40'

S89° 50' 48" W 466.69'

40' N00° 07' 52" W 40.00'

S89° 50' 48" W

2659.08'

EAST 38TH AVENUE

S. W. COR. S. W. 1/4 SEC. 23, T. 3S., R. 62W
(FOUND SPIKE NAIL W/FLAGGING, FIT MONUMENT RECORD TIES BY R. W. BAYER & ASSOCIATES, FILED ON 9/23/2004, 0.2' BELOW GRAVEL ROAD)

SOUTH LINE S. W. 1/4 SEC. 23

POINT OF BEGINNING

S. E. COR. S. W. 1/4 SEC. 23, T. 3S., R. 62W.
(FOUND 3/4" IRON PIPE W/PLUMBERS CAP, 1.3' BELOW GROUND)

POINT OF COMMENCEMENT

Greg Barnes

From: Brooks Kaufman [BKaufman@Irea.Coop]
Sent: Tuesday, April 03, 2018 7:14 AM
To: Greg Barnes
Subject: RE: For Review: Comanche Vista Estates, Filing 5 (PLT2017-00019)

Mr. Barnes;

The Association has reviewed the contents in the above-referenced referral response packet. We reviewed the project for maintaining our existing facilities, utility easements, electric loading, service requirements and environmental impact.

The Association approves of the plat and has no comments at this time.

Brooks Kaufman
Lands and Rights of Way Director
5496 N. US Hwy 85
Sedalia, CO 80135
Direct : 720.733.5493
Cell : 303.912.0765
bkaufman@irea.coop

From: Greg Barnes [mailto:GJBarnes@adcogov.org]
Sent: Thursday, March 22, 2018 11:41 AM
To: George, Donna L; landuse@tchd.org; onroy@svfd8.org; Brooks Kaufman; Jill Carlson
Subject: For Review: Comanche Vista Estates, Filing 5 (PLT2017-00019)

We have received a resubmittal for a minor subdivision final plat application. Previously, you provided comments on this case. Please see the attached information, and provide any follow-up comments to me by April 4, 2018. I can provide you a copy of your previous comments (if needed). Thank you!

Greg Barnes
Planner II, *Community and Economic Development Dept.*
ADAMS COUNTY, COLORADO
4430 S. Adams County Parkway, 1st Floor, Suite W2000A
Brighton, CO 80601-8216
720.523.6853 *gjbarnes@adcogov.org*
adcogov.org

Greg Barnes

From: Patrick Conroy [pconroy@svfd8.org]
Sent: Saturday, December 02, 2017 10:34 PM
To: Greg Barnes
Cc: Frank Fields; Geri Ventura
Subject: Case PLT2017-00019 - Comanche Vista Estates, Filing #5

With regards to the above referenced case the Strasburg Fire Protection District has no comments to offer at this time.

Thanks you.

Patrick Conroy
EMT-P, CBO, CFM
Fire Marshal
Strasburg Fire Protection District

Tri-County Health Department

December 19, 2017

Greg Barnes
Adams County
Community and Economic Development
4430 S Adams County Parkway
Brighton, CO 80601

RE: Comanche Vista Estates Filing 5, PLT2017-00019
TCHD Case No. 4686

Dear Mr. Barnes,

Thank you for the opportunity to review and comment on the minor subdivision final plat to create one new lot in the Comanche Vista Estates PUD located at East 38th Ave and Headlight 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 – Plat Note
Proper wastewater management promotes effective and responsible water use, protects potable water from contaminants, and provides appropriate collection, treatment, and disposal of waste, which protects public health and the environment. TCHD requests that the plat note titled "Onsite Water Systems" be revised to reflect current terminology and regulatory requirements in TCHD's On-Site Wastewater Treatment System (OWTS) Regulation O-17. The term Onsite Water Systems should be revised to On-Site Wastewater Treatment Systems wherever present in the plat note. The plat note states:

> "Tri-County Health Department requires that septic tanks be pumped and inspected every four years. Each property owner shall have his septic tank pumped and inspected by a systems cleaner, licensed by Tri-County Health Department, at least every four years, and shall submit a receipt indicating that the septic system has been pumped and inspected to the Tri-County Health Department, Commerce City office. In addition to pumping, the OWS have other maintenance and use requirements that can prevent failure of the system. The Tri-County Health Departments "Septic System Guidelines and Records" has been prepared to educate and advise owners of OWS about use and maintenance of their OWS. Property owners can obtain copies of the guide, as well as information about OWS from Tri-County Health Department's Commerce City office".

Section 6.5 of TCHD's Regulation O-17 states "all septic tanks shall be inspected once every four years and pumped when the accumulation of sludge and scum is greater than 25% of the operating volume of the treatment tank. Dosing tanks shall be

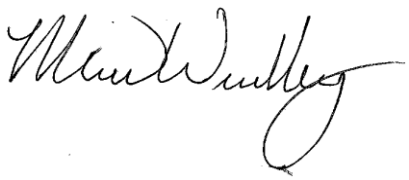
inspected and pumped if sludge accumulation is observed". TCHD recommends that the plat note be changed to the following:

> "Tri-County Health Department (TCHD) requires that septic tanks be inspected once every four years and pumped by a system cleaner, licensed by TCHD, when the accumulation of sludge and scum is greater than 25% of the operating volume of the treatment tank. The dosing tanks shall be inspected and pumped if sludge accumulation is observed. Each property owner shall submit a receipt indicating that the septic system has been inspected and pumped (if applicable) to the TCHD's Commerce City office. The TCHD's "Septic System Guidelines and Records" has been prepared to educate and advise owners of On-Site Wastewater Treatment System (OWTS) about use and maintenance of their OWTS. Property owners can obtain copies of the guide, as well as information about OWTS from TCHD Commerce City office".

On-Site Wastewater Treatment System (OWTS) – New OWTS Installation
The proposed residential lot will be served by OWTS. TCHD has no objection provided that the OWTS are permitted, installed, operated and maintained in accordance with our current regulation.

Please feel free to contact me at 720-200-1593 or mweakley@tchd.org if you have any questions.

Sincerely,



Michael Weakley
Water Program Supervisor

cc: Sheila Lynch, Monte Deatrich, Jeff McCarron, TCHD

April 3, 2018

Greg Barnes
Adams County Community and Economic Development
4430 South Adams County Parkway, Suite W2000A
Brighton, CO 80601

RE: Comanche Vista Estates Filing 5, PLT2017-00019
TCHD Case No. 4842

Dear Mr. Barnes,

Thank you for the opportunity to review and comment on the minor subdivision final plat resubmittal to create one new lot in the Comanche Vista Estates PUD located at East 38th Ave and Headlight Road. Tri-County Health Department (TCHD) staff previously reviewed the application for the minor subdivision and, in a letter dated December 19, 2017 responded with the comments included below. It does not appear that the Plat Note was updated in the resubmittal documents. TCHD has no further comments.

On-Site Wastewater Treatment Systems – Plat Note
Proper wastewater management promotes effective and responsible water use, protects potable water from contaminants, and provides appropriate collection, treatment, and disposal of waste, which protects public health and the environment. TCHD requests that the plat note titled "Onsite Water Systems" be revised to reflect current terminology and regulatory requirements in TCHD's On-Site Wastewater Treatment System (OWTS) Regulation O-17. The term Onsite Water Systems should be revised to On-Site Wastewater Treatment Systems wherever present in the plat note. The plat note states:

> "Tri-County Health Department requires that septic tanks be pumped and inspected every four years. Each property owner shall have his septic tank pumped and inspected by a systems cleaner, licensed by Tri-County Health Department, at least every four years, and shall submit a receipt indicating that the septic system has been pumped and inspected to the Tri-County Health Department, Commerce City office. In addition to pumping, the OWS have other maintenance and use requirements that can prevent failure of the system. The Tri-County Health Departments "Septic System Guidelines and Records" has been prepared to educate and advise owners of OWS about use and maintenance of their OWS. Property owners can obtain copies of the guide, as well as information about OWS from Tri-County Health Department's Commerce City office".

Section 6.5 of TCHD's Regulation O-17 states "all septic tanks shall be inspected once every four years and pumped when the accumulation of sludge and scum is greater

than 25% of the operating volume of the treatment tank. Dosing tanks shall be inspected and pumped if sludge accumulation is observed". TCHD recommends that the plat note be changed to the following:

> "Tri-County Health Department (TCHD) requires that septic tanks be inspected once every four years and pumped by a system cleaner, licensed by TCHD, when the accumulation of sludge and scum is greater than 25% of the operating volume of the treatment tank. The dosing tanks shall be inspected and pumped if sludge accumulation is observed. Each property owner shall submit a receipt indicating that the septic system has been inspected and pumped (if applicable) to the TCHD's Commerce City office. The TCHD's "Septic System Guidelines and Records" has been prepared to educate and advise owners of On-Site Wastewater Treatment System (OWTS) about use and maintenance of their OWTS. Property owners can obtain copies of the guide, as well as information about OWTS from TCHD Commerce City office".

On-Site Wastewater Treatment System (OWTS) – New OWTS Installation
The proposed residential lot will be served by OWTS. TCHD has no objection provided that the OWTS are permitted, installed, operated and maintained in accordance with our current regulation.

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, Monte Deatrich, Michael Weakley, TCHD

Right of Way & Permits
1123 West 3rd Avenue
Denver, Colorado 80223
Telephone: **303.571.3306**
Facsimile: 303. 571.3284
donna.l.george@xcelenergy.com

December 14, 2017

Adams County Community and Economic Development Department
4430 South Adams County Parkway, 3rd Floor, Suite W3000
Brighton, CO 80601

Attn: Greg Barnes

Re: Comanche Vista Estates Filing No. 5, Case # PLT2017-00019

Public Service Company of Colorado's Right of Way & Permits Referral Desk has reviewed the plat for **Comanche Vista Estates F5** and has **no conflict**.

If you have any questions about this referral response, please contact me at (303) 571-3306.

Donna George
Contract Right of Way Referral Processor
Public Service Company of Colorado

Right of Way & Permits
1123 West 3rd Avenue
Denver, Colorado 80223
Telephone: **303.571.3306**
Facsimile: 303. 571.3284
donna.l.george@xcelenergy.com

April 3, 2018

Adams County Community and Economic Development Department
4430 South Adams County Parkway, 3rd Floor, Suite W3000
Brighton, CO 80601

Attn: Greg Barnes

Re: Comanche Vista Estates Filing No. 5 – Re-submittal
Case # PLT2017-00019

Public Service Company of Colorado's Right of Way & Permits Referral Desk has reviewed the resubmitted plat for **Comanche Vista Estates F5** and has **no conflict**.

If you have any questions about this referral response, please contact me at (303) 571-3306.

Donna George
Right of Way and Permits
Public Service Company of Colorado

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

Request for Comments

Case Name: Comanche Vista Estates, Filing #5
Case Number: PLT2017-00019

November 28, 2017

The Adams County Planning Commission is requesting comments on the following application:
Minor Subdivision Final Plat to create one new lot in the Comanche Vista Estates PUD.

This request is located approximately 1,500 feet east of the intersection of East 38th Avenue and Headlight Mile Road. The Assessor's Parcel Number is 0181323200006. The legal description of the site is:

SECT,TWN,RNG:23-3-62 DESC: PARCEL 1 PT OF THE W2 OF SEC 23 DESC AS FOLS COMMENCING AT THE NW COR OF THE NW4 OF SD SEC 23 TH N 89D 22M 07S E 70/01 FT TO THE POB TH CONT N 89D 22M 07S E 2552/18 FT TH S 00D 07M 52S E 5251/13 FT TO THE N LN OF A PARC OF LAND DESC IN REC NO 2006000037710 BEING 40 FT N OF AS MEAS ALG SD E LN FROM THE SE COR OF THE SW4 OF SD SEC 23 TH S 89D 50M 48S W // WITH AND 40 FT N OF THE S LN OF SD SW4 AND ALG SD N LN A DIST OF 2588/80 FT TO THE E LN OF A PARC OF LAND DESC IN REC NO 2006000037710 BEUBG 70 FT E OF AS MEAS AT R/A FROM THE W LN OF SD SW4 TH N 00D 16M 00S E // WITH AND 70 FT E OF SD W LN AND ALG SD E LN A DIST OF 415/59 FT TO THE SW COR OF COMANCHE VISTA ESTATES FLG NO 4 TH ALG THE PERIMETER OF SD COMANCHE VISTA ESTATES FLG NO 4 COMANCHE VISTA ESTATES FLG NO 1 (C1200348) AND COMANCHE VISTA ESTATES FLG NO 2 THE FOL 9 COURSES AND DISTS TH 1)S 89D 44M 00S E 953/74 FT TH 2)N 00D 16M 00S E // WITH THE W LN OF SD SW4 A DIST OF 1271/37 FT TH 3)N 43D 50M 15S W 699/82 FT TH 4)N 00D 16M 00S E 466/69 FT TH 5)S 89D 43M 28S E 50 FT TH 6)N 30D 43M 19S E 1200/48 FT TH 7)N 00D 16M 32S E 51/30 FT TH 8)S 89D 55M 04S W 469/33 FT TH 9)N 89D 43M 28S W 655/68 FT TO THE E LN OF A PARC OF LAND IN REC NO 2006000037710 BEING 70 FT E OF AS MEAS AT RT ANGS FROM THE W LN OF SD NW4 TH N 00D 16M 32S E // WITH AND 70 FT E OF SD W LN AND ALG SD E LN A DIST OF 1490/44 FT TO THE POB 247/447A

Applicant Information: Kenneth W. Newby
PO Box 830
Bennett, CO 80102

Please forward any written comments on this application to the Community and Economic Development Department at 4430 South Adams County Parkway, Suite W2000A Brighton, CO 80601-8216, or call (720) 523-6800 by 12/20/2017 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 GJBarnes@adcogov.org.

Once comments have been received and the staff report written, the staff report and notice of public hearing dates may 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.

Greg Barnes
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

June 6, 2018

Case Name:	Comanche Vista Estates, Filing #5
Case Number:	PLT2017-00019
Planning Commission Hearing Date:	06/28/2018 at 6:00 p.m.
Board of County Commissioners Hearing Date:	07/17/2018 at 9:30 a.m.

A public hearing has been set by the Adams County Planning Commission and the Board of County Commissioners to consider the following request: **Minor Subdivision Final Plat to create one new lot in the Comanche Vista Estates PUD.**

The proposed use will be Residential. This request is located along East 38th Avenue, aproximately ¼ mile east of the intersection with Headlight Road. The proposal is on 5 acres. The Assessor's Parcel Number is 0181323200006.

Applicant Information: Newby, Kenneth W.
P.O. BOX 830
Bennett, CO 80102-0830

The hearing will be held in the Adams County Hearing Room located at 4430 S. 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 Community and Economic Development Department, 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.

Greg Barnes
Case Manager

Greg Barnes

From: Greg Barnes
Sent: Wednesday, June 06, 2018 4:16 PM
To: Shayla Christenson
Subject: For Newspaper Publication: Comanche Vista estates, Filing 5 (PLT2017-00019)

PUBLICATION REQUEST

Comanche Vista Estates, Filing #5

Case Number: **PLT2017-00019**
Planning Commission Hearing Date: **06/28/2018 at 6:00 p.m.**
Board of County Commissioners Hearing Date: **07/17/2018 at 9:30 a.m.**

Request: Minor Subdivision Final Plat to create one new lot in the Comanche Vista Estates PUD.

Location: **Along East 38th Avenue, approximately ¼ mile east of the intersection with Headlight Road**

Parcel Number: **0181323200006**

Case Manager: **Greg Barnes**

Case Technician: **Megan Ulibarri**

Owner & Applicant: **NEWBY, KENNETH W.**
720-281-2102
PO BOX 830
BENNETT, CO 801020830

Legal Description: SECT,TWN,RNG:23-3-62 DESC: PARCEL 1 PT OF THE W2 OF SEC 23 DESC AS FOLS COMMENCING AT THE NW COR OF THE NW4 OF SD SEC 23 TH N 89D 22M 07S E 70/01 FT TO THE POB TH CONT N 89D 22M 07S E 2552/18 FT TH S 00D 07M 52S E 5251/13 FT TO THE N LN OF A PARC OF LAND DESC IN REC NO 2006000037710 BEING 40 FT N OF AS MEAS ALG SD E LN FROM THE SE COR OF THE SW4 OF SD SEC 23 TH S 89D 50M 48S W // WITH AND 40 FT N OF THE S LN OF SD SW4 AND ALG SD N LN A DIST OF 2588/80 FT TO THE E LN OF A PARC OF LAND DESC IN REC NO 2006000037710 BEUBG 70 FT E OF AS MEAS AT R/A FROM THE W LN OF SD SW4 TH N 00D 16M 00S E // WITH AND 70 FT E OF SD W LN AND ALG SD E LN A DIST OF 415/59 FT TO THE SW COR OF COMANCHE VISTA ESTATES FLG NO 4 TH ALG THE PERIMETER OF SD COMANCHE VISTA ESTATES FLG NO 4 COMANCHE VISTA ESTATES FLG NO 1 (C1200348) AND COMANCHE VISTA ESTATES FLG NO 2 THE FOL 9 COURSES AND DISTS TH 1)S 89D 44M 00S E 953/74 FT TH 2)N 00D 16M 00S E // WITH THE W LN OF SD SW4 A DIST OF 1271/37 FT TH 3)N 43D 50M 15S W 699/82 FT TH 4)N 00D 16M 00S E 466/69 FT TH 5)S 89D 43M 28S E 50 FT TH 6)N 30D 43M 19S E 1200/48 FT TH 7)N 00D

16M 32S E 51/30 FT TH 8)S 89D 55M 04S W 469/33 FT TH 9)N 89D 43M 28S W 655/68 FT TO THE E LN OF A PARC OF LAND IN REC NO 2006000037710 BEING 70 FT E OF AS MEAS AT RT ANGS FROM THE W LN OF SD NW4 TH N 00D 16M 32S E // WITH AND 70 FT E OF SD W LN AND ALG SD E LN A DIST OF 1490/44 FT TO THE POB 247/447A

Greg Barnes
Planner II, *Community and Economic Development Dept.*
ADAMS COUNTY, COLORADO
4430 S. Adams County Parkway, 1st Floor, Suite W2000A
Brighton, CO 80601-8216
720.523.6853 *gjbarnes@adcogov.org*
adcogov.org

Referral Listing
Case Number PLT2017-00019
Comanche Vista Estates, Filing #5

Agency	Contact Information
Adams County	Planning Addressing PLN 720.523.6800
Adams County Construction Inspection	PWCI . PWCI 720-523-6878
Adams County Development Services - Building	Justin Blair 4430 S Adams County Pkwy Brighton CO 80601 720-523-6825 JBlair@adcogov.org
Adams County Treasurer: Send email	Adams County Treasurer bgrimm@adcogov.org 720.523.6376
Century Link, Inc	Brandyn Wiedreich 5325 Zuni St, Rm 728 Denver CO 80221 720-578-3724 720-245-0029 brandyn.wiedrich@centurylink.com
Code Compliance Supervisor	Eric Guenther eguenther@adcogov.org 720-523-6856 eguenther@adcogov.org
COLO DIV OF WATER RESOURCES	Joanna Williams OFFICE OF STATE ENGINEER 1313 SHERMAN ST., ROOM 818 DENVER CO 80203 303-866-3581 joanna.williams@state.co.us
COLORADO DIVISION OF WILDLIFE	Eliza Hunholz Northeast Regional Engineer 6060 BROADWAY DENVER CO 80216-1000 303-291-7454 eliza.hunholz@state.co.us
COLORADO DIVISION OF WILDLIFE	Serena Rocksund 6060 BROADWAY DENVER CO 80216 3039471798 serena.rocksund@state.co.us

Agency	Contact Information
COLORADO GEOLOGICAL SURVEY	Jill Carlson 1500 Illinois Street Golden CO 80401 303-384-2643 303-384-2655 CGS_LUR@mines.edu
Colorado Geological Survey: CGS_LUR@mines.edu	Jill Carlson Mail CHECK to Jill Carlson 303-384-2643 303-384-2655 CGS_LUR@mines.edu
COMCAST	JOE LOWE 8490 N UMITILLA ST FEDERAL HEIGHTS CO 80260 303-603-5039 thomas_lowe@cable.comcast.com
COUNTY ATTORNEY- Email	Christine Francescani CFrancescani@adcogov.org 6884
Engineering Department - ROW	Transportation Department PWE - ROW 303.453.8787
Engineering Division	Transportation Department PWE 6875
Intermountain Rural Electric Asso - IREA	Brooks Kaufman PO Box Drawer A 5496 North US Hwy 85 Sedalia CO 80135 303-688-3100 x105 bkaufman@intermountain-rea.com
NS - Code Compliance	Gail Moon gmoon@adcogov.org 720.523.6833 gmoon@adcogov.org
Parks and Open Space Department	Nathan Mosley mpedrucci@adcogov.org aclark@adcogov.org (303) 637-8000 nmosley@adcogov.org
SHERIFF'S OFFICE: SO-HQ	MICHAEL McINTOSH nblair@adcogov.org, aoverton@adcogov.org; mkaiser@adcogov.org snielson@adcogov.org (303) 654-1850 aoverton@adcogov.org; mkaiser@adcogov.org; snielson@adcogov.org
Sheriff's Office: SO-SUB	SCOTT MILLER TFuller@adcogov.org, smiller@adcogov.org aoverton@adcogov.org; mkaiser@adcogov.org 720-322-1115 smiller@adcogov.org

Agency	Contact Information
STRASBURG FIRE PROTECTION DIST #8	GERRI VENTURA PO BOX 911 STRASBURG CO 80136 303-622-4814 gventura@svfd8.org
STRASBURG PARKS AND REC DIST.	Angie Graf P.O. BOX 118 STRASBURG CO 80136 (303) 622-4260 angie@strasburgparks.org
STRASBURG SCHOOL DISTRICT 31J	Monica Johnson 56729 E Colorado Ave STRASBURG CO 80136 303-622-9211 mjohnson@strasburg31j.org
TRI-COUNTY HEALTH DEPARTMENT	MONTE DEATRICH 4201 E. 72ND AVENUE SUITE D COMMERCE CITY CO 80022 (303) 288-6816 mdeatrich@tchd.org
TRI-COUNTY HEALTH DEPARTMENT	Sheila Lynch 6162 S WILLOW DR, SUITE 100 GREENWOOD VILLAGE CO 80111 720-200-1571 landuse@tchd.org
Tri-County Health: Mail CHECK to Sheila Lynch	Tri-County Health landuse@tchd.org .
UNITED STATES POST OFFICE	MARY C. DOBYNS 56691 E COLFAX AVENUE STRASBURG CO 80136-8115 303-622-9867 mary.c.dobyns@usps.gov
Xcel Energy	Donna George 1123 W 3rd Ave DENVER CO 80223 303-571-3306 Donna.L.George@xcelenergy.com

EXHIBIT 6.5: PROPERTY OWNER AND RESIDENT NOTIFICATION LIST

ATKINSON MARK ERIC AND
ATKINSON LINDSAY ELIZABETH
58810 E 40TH DR
STRASBURG CO 80136-8144

AVITIA JOHN A
4115 FLANDIN CT
STRASBURG CO 80136-8126

BECKEL RONALD E AND
BECKEL LINDA D
58105 E 40TH DR
STRASBURG CO 80136-8123

BEECK ALEX AND
BEECK KORI J
58285 E 40TH DR
STRASBURG CO 80136-8123

BLAUW WILLIAM J AND
BLAUW MARILYN ANN
4300 STRASBURG RD
STRASBURG CO 80136-8005

BREIDING PHILIP S AND
BREIDING JESSICA L
58727 E 40TH DR
STRASBURG CO 80136

BURCHFIELD DOUGLAS A
PO BOX 572
STRASBURG CO 80136

CASTANEDA DOMINGUEZ BLANCA A
4889 HEADLIGHT RD
STRASBURG CO 80136-8108

COIN SHERRIL MARTIN AND COIN PATTI JUNE
4025 FLANDIN COURT
STRASBURG CO 80136

COMANCHE FARMS INC
3600 HEADLIGHT RD
STRASBURG CO 80136-8110

DAMERS RICARDO A WOJCIK
58370 E 40TH DR
STRASBURG CO 80136-8122

DAVIS BRUCE MCWILLIAMS AND
DAVIS SHARON KAY
58805 E 40TH DR
STRASBURG CO 80136-8144

EHLER FAMILY LIMITED LIABILITY COMPANY
78101 BOVEE CIR
PALM DESERT CA 92211-2331

EHLER JOHN H AND EHLER H GAYLE TRUSTEES
OF JOHN H AND H GAYLE EHLER LIVING TRUST
78101 BOVEE CIR
PALM DESERT CA 92211-2331

GALLEGOS MICHAEL J AND
GALLEGOS MINDI L
58311 E 42ND DR
STRASBURG CO 80136-8128

GILLAND KEVIN
58620 E 40TH DR
STRASBURG CO 80136-8144

GOODWIN CHRIS D AND
GOODWIN TERESA L
4032 DEFOE ST
STRASBURG CO 80136-8129

GOODWIN CHRIS D LIVING TRUST 1/2 INT
GOODWIN TERESA L LIVING TRUST 1/2 INT
4032 DEFOE ST
STRASBURG CO 80136-8129

GUERRERO-LOPEZ GERONIMO AND
VILLELA GUERRERO MARIA G
58150 E 40TH DR
STRASBURG CO 80136-8122

HARPER NORMAN C LIVING TRUST
AGREEMENT
58465 E 40TH DR
STRASBURG CO 80136-8123

HUNT MICKEY AND
HUNT KRISTINA
4200 FLANDIN CT
STRASBURG CO 80136-8125

HUTTON CONTRACTING COMPANY
INC
1600 CLIFTY HIGHWAY
HINDSVILLE AR 72738

KRING DANA D
58498 E 42ND DR
STRASBURG CO 80136-8127

LADD ROGER GIBBS AND
LADD MARY C
58148 E 40TH DRIVE
STRASBURG CO 80136

LEE REBECCA
58645 E 40TH DR
STRASBURG CO 80136-8144

LEIKER TROY L AND
LEIKER SHARON L
58413 E 42ND DR
STRASBURG CO 80136

MC CALLEY MATTHEW K AND
MC CALLEY BARBARA A
4207 FLANDIN CT
STRASBURG CO 80136

MC PHERREN PATRICK W
58386 E 42ND DR
STRASBURG CO 80136

NEWBY KENNETH W
PO BOX 830
BENNETT CO 80102-0830

NEWBY KENNETH W
PO BOX 830
BENNETT CO 80102

PACELLO LORI L
58209 E 42ND DRIVE
STRASBURG CO 80136

REYES RAMIREZ LEONEL AND
FLORES MARGARITA
58162 E 42ND DR
STRASBURG CO 80136-8127

RICHTER JEFFREY B AND
RICHTER NANCY D
58480 E 40TH DRIVE
STRASBURG CO 80136

RITTER CHRISTOPHER A AND
RITTER DIANE J
58375 E 40TH DRIVE
STRASBURG CO 80136

ROGERS SCOTT A AND
ROGERS JANE M
PO BOX 61
STRASBURG CO 80136

RUSSELL HOLLY C AND RUSSELL SHANE J
PO BOX 868
STRASBURG CO 80136

SAUR MICHAEL J AND SAUR CHERYL L
4299 FLANDIN COURT
STRASBURG CO 80136-8126

SMITH DONALD LEE
58117 E 42ND DR
STRASBURG CO 80136-8128

THURMOND JOSHUA E AND
THURMOND GAIL M
23609 E FREMONT CIR UNIT 102
AURORA CO 80016

WESTON GILBERT S
5357 LAREDO ST
DENVER CO 80239-6494

WOODWARD WILLIAM D AND
WOODWARD BRENDA
58195 E 40TH DR
STRASBURG CO 80136

YOCKEY ALAN R AND
YOCKEY KAREN L
PO BOX 488
STRASBURG CO 80136-0488

YOCKEY ALAN/KAREN AND
LEE REBECCA
PO BOX 488
STRASBURG CO 80136

Current Resident
2024 STRASBURG RD
Strasburg, CO 80136

Current Resident
2100 WAGNER ST
Strasburg, CO 80136

Current Resident
2157 BASIL ST
Strasburg, CO 80136

Current Resident
2160 ANCE ST
Strasburg, CO 80136

Current Resident
2164 BASIL ST
Strasburg, CO 80136

Current Resident
2165 ASOKA ST
Strasburg, CO 80136

Current Resident
2171 ANCE ST
Strasburg, CO 80136

Current Resident
2172 ASOKA ST
Strasburg, CO 80136

Current Resident
2177 BASIL ST
Strasburg, CO 80136

Current Resident
2180 ANCE ST
Strasburg, CO 80136

Current Resident
2185 ASOKA ST
Strasburg, CO 80136

Current Resident
2192 ASOKA ST
Strasburg, CO 80136

Current Resident
2207 BASIL ST
Strasburg, CO 80136

Current Resident
2210 ANCE ST
Strasburg, CO 80136

Current Resident
2210 WAGNER ST
Strasburg, CO 80136

Current Resident
2211 ANCE ST
Strasburg, CO 80136

Current Resident
2212 ASOKA ST
Strasburg, CO 80136

Current Resident
2214 BASIL ST
Strasburg, CO 80136

Current Resident
2215 ASOKA ST
Strasburg, CO 80136

Current Resident
2220 ANCE ST
Strasburg, CO 80136

Current Resident
2221 ANCE ST
Strasburg, CO 80136

Current Resident
2225 ASOKA ST
Strasburg, CO 80136

Current Resident
2227 BASIL ST
Strasburg, CO 80136

Current Resident
2230 ADAMS LN
Strasburg, CO 80136

Current Resident
2230 ANCE ST
Strasburg, CO 80136

Current Resident
2231 ANCE ST
Strasburg, CO 80136

Current Resident
2232 ASOKA ST
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2234 BASIL ST
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2235 ASOKA ST
Strasburg, CO 80136

Current Resident
2237 BASIL ST
Strasburg, CO 80136

Current Resident
2240 ANCE ST
Strasburg, CO 80136

Current Resident
2241 ADAMS LN
Strasburg, CO 80136

Current Resident
2241 ANCE ST
Strasburg, CO 80136

Current Resident
2242 ASOKA ST
Strasburg, CO 80136

Current Resident
2244 ADAMS LN
Strasburg, CO 80136

Current Resident
2244 BASIL ST
Strasburg, CO 80136

Current Resident
2245 ASOKA ST
Strasburg, CO 80136

Current Resident
2247 BASIL ST
Strasburg, CO 80136

Current Resident
2250 ANCE ST
Strasburg, CO 80136

Current Resident
2251 ANCE ST
Strasburg, CO 80136

Current Resident
2252 ASOKA ST
Strasburg, CO 80136

Current Resident
2254 BASIL ST
Strasburg, CO 80136

Current Resident
2255 ASOKA ST
Strasburg, CO 80136

Current Resident
2257 BASIL ST
Strasburg, CO 80136

Current Resident
2260 ANCE ST
Strasburg, CO 80136

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2262 ASOKA ST
Strasburg, CO 80136

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2265 ASOKA ST
Strasburg, CO 80136

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2270 ANCE ST
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2271 ADAMS LN
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2271 ANCE ST
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2272 ASOKA ST
Strasburg, CO 80136

Current Resident
2274 ADAMS LN
Strasburg, CO 80136

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2274 BASIL ST
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2275 ASOKA ST
Strasburg, CO 80136

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2284 BASIL ST
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2285 ASOKA ST
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Current Resident
2287 BASIL ST
Strasburg, CO 80136

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2290 ADAMS LN
Strasburg, CO 80136

Current Resident
2290 ANCE ST
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Current Resident
2290 WAGNER ST
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2291 ANCE ST
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2292 ASOKA ST
Strasburg, CO 80136

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2294 BASIL ST
Strasburg, CO 80136

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2295 ASOKA ST
Strasburg, CO 80136

Current Resident
2297 BASIL ST
Strasburg, CO 80136

Current Resident
2300 COMANCHE DR
Strasburg, CO 80136

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2300 COMANCHE DR
Strasburg, CO 80136

Current Resident
2301 HEADLIGHT RD
Strasburg, CO 80136

Current Resident
2310 MAIN ST
Strasburg, CO 80136

Current Resident
2310 WAGNER ST
Strasburg, CO 80136

Current Resident
2314 BASIL ST
Strasburg, CO 80136

Current Resident
2317 BASIL ST
Strasburg, CO 80136

Current Resident
2320 ADAMS CT
Strasburg, CO 80136

Current Resident
2320 ANCE ST
Strasburg, CO 80136

Current Resident
2321 ANCE ST
Strasburg, CO 80136

Current Resident
2322 ASOKA ST
Strasburg, CO 80136

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2324 BASIL ST
Strasburg, CO 80136

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2325 ASOKA ST
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2331 ADAMS CT
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2340 ANCE ST
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2344 BASIL ST
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Strasburg, CO 80136

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2360 ANCE ST
Strasburg, CO 80136

Current Resident
2360 COMANCHE DR
Strasburg, CO 80136

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2361 ANCE ST
Strasburg, CO 80136

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2362 ASOKA ST
Strasburg, CO 80136

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2364 BASIL ST
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2365 ASOKA ST
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2367 BASIL ST
Strasburg, CO 80136

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2370 ANCE ST
Strasburg, CO 80136

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2370 MAIN ST
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2371 ADAMS CT
Strasburg, CO 80136

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2374 BASIL ST
Strasburg, CO 80136

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2375 ASOKA ST
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2380 ADAMS CT
Strasburg, CO 80136

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Strasburg, CO 80136

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2390 WAGNER ST
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2391 ANCE ST
Strasburg, CO 80136

Current Resident
2392 ASOKA ST
Strasburg, CO 80136

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2395 ASOKA ST
Strasburg, CO 80136

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2450 ADAMS ST
Strasburg, CO 80136

Current Resident
2470 ADAMS ST
Strasburg, CO 80136

Current Resident
2490 ADAMS ST
Strasburg, CO 80136

Current Resident
2550 STRASBURG RD
Strasburg, CO 80136

Current Resident
2840 WAGNER ST
Strasburg, CO 80136

Current Resident
2840 YERKES CT
Strasburg, CO 80136

Current Resident
2860 YERKES CT
Strasburg, CO 80136

Current Resident
2880 WAGNER ST
Strasburg, CO 80136

Current Resident
2890 YERKES CT
Strasburg, CO 80136

Current Resident
2930 YERKES CT
Strasburg, CO 80136

Current Resident
2933 YERKES CT
Strasburg, CO 80136

Current Resident
2940 WAGNER ST
Strasburg, CO 80136

Current Resident
2941 WAGNER ST
Strasburg, CO 80136

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2960 WAGNER ST
Strasburg, CO 80136

Current Resident
2965 WAGNER ST
Strasburg, CO 80136

Current Resident
2977 YERKES CT
Strasburg, CO 80136

Current Resident
3040 WAGNER ST
Strasburg, CO 80136

Current Resident
3041 WAGNER ST
Strasburg, CO 80136

Current Resident
3060 WAGNER ST
Strasburg, CO 80136

Current Resident
3061 WAGNER ST
Strasburg, CO 80136

Current Resident
3245 STRASBURG RD
Strasburg, CO 80136

Current Resident
3370 STRASBURG RD
Strasburg, CO 80136

Current Resident
3600 HEADLIGHT RD
Strasburg, CO 80136

Current Resident
3803 HEADLIGHT RD
Strasburg, CO 80136

Current Resident
3920 ADAMS ST
Strasburg, CO 80136

Current Resident
3950 ADAMS ST
Strasburg, CO 80136

Current Resident
3980 ADAMS ST
Strasburg, CO 80136

Current Resident
4000 ADAMS ST
Strasburg, CO 80136

Current Resident
4025 FLANDIN CT
Strasburg, CO 80136

Current Resident
4030 ADAMS ST
Strasburg, CO 80136

Current Resident
4032 DE FOE ST
Strasburg, CO 80136

Current Resident
4060 ADAMS ST
Strasburg, CO 80136

Current Resident
4075 ADAMS ST
Strasburg, CO 80136

Current Resident
4080 BURTON ST
Strasburg, CO 80136

Current Resident
4090 ADAMS ST
Strasburg, CO 80136

Current Resident
4091 BURTON ST
Strasburg, CO 80136

Current Resident
4115 FLANDIN CT
Strasburg, CO 80136

Current Resident
4150 HEADLIGHT RD
Strasburg, CO 80136

Current Resident
4200 FLANDIN CT
Strasburg, CO 80136

Current Resident
4207 FLANDIN CT
Strasburg, CO 80136

Current Resident
4220 HEADLIGHT RD
Strasburg, CO 80136

Current Resident
4220 STRASBURG RD
Strasburg, CO 80136

Current Resident
4225 STRASBURG RD
Strasburg, CO 80136

Current Resident
4228 DEFOE ST
Strasburg, CO 80136

Current Resident
4242 DEFOE ST
Strasburg, CO 80136

Current Resident
4256 DEFOE ST
Strasburg, CO 80136

Current Resident
4270 DEFOE ST
Strasburg, CO 80136

Current Resident
4284 DEFOE ST
Strasburg, CO 80136

Current Resident
4298 DEFOE ST
Strasburg, CO 80136

Current Resident
4299 FLANDIN CT
Strasburg, CO 80136

Current Resident
4300 STRASBURG RD
Strasburg, CO 80136

Current Resident
4670 STRASBURG RD
Strasburg, CO 80136

Current Resident
4715 PIGGOTT RD
Strasburg, CO 80136

Current Resident
4889 HEADLIGHT RD
Strasburg, CO 80136

Current Resident
4910 STRASBURG RD
Strasburg, CO 80136

Current Resident
5150 HEADLIGHT RD
Strasburg, CO 80136

Current Resident
5155 STRASBURG RD
Strasburg, CO 80136

Current Resident
56145 E 28TH CT
Strasburg, CO 80136

Current Resident
56295 E 28TH CT
Strasburg, CO 80136

Current Resident
56300 E 33RD CT
Strasburg, CO 80136

Current Resident
56305 E 33RD CT
Strasburg, CO 80136

Current Resident
56360 E 28TH CT
Strasburg, CO 80136

Current Resident
56375 E 28TH CT
Strasburg, CO 80136

Current Resident
56377 E 41ST AVE
Strasburg, CO 80136

Current Resident
56380 E 41ST AVE
Strasburg, CO 80136

Current Resident
56400 E 28TH CT
Strasburg, CO 80136

Current Resident
56400 E 33RD CT
Strasburg, CO 80136

Current Resident
56400 E 35TH AVE
Strasburg, CO 80136

Current Resident
56405 E 33RD CT
Strasburg, CO 80136

Current Resident
56405 E 40TH AVE
Strasburg, CO 80136

Current Resident
56440 E 41ST AVE
Strasburg, CO 80136

Current Resident
56455 E 40TH AVE
Strasburg, CO 80136

Current Resident
56467 E 41ST AVE
Strasburg, CO 80136

Current Resident
56500 E 33RD CT
Strasburg, CO 80136

Current Resident
56500 E 35TH CT
Strasburg, CO 80136

Current Resident
56500 E 40TH AVE
Strasburg, CO 80136

Current Resident
56505 E 33RD CT
Strasburg, CO 80136

Current Resident
56505 E 35TH CT
Strasburg, CO 80136

Current Resident
56505 E 40TH AVE
Strasburg, CO 80136

Current Resident
56511 E 24TH AVE
Strasburg, CO 80136

Current Resident
56520 E 41ST AVE
Strasburg, CO 80136

Current Resident
56530 E 23RD PL
Strasburg, CO 80136

Current Resident
56531 E 24TH AVE
Strasburg, CO 80136

Current Resident
56532 E 23RD AVE
Strasburg, CO 80136

Current Resident
56534 E 24TH AVE
Strasburg, CO 80136

Current Resident
56535 E 22ND PL
Strasburg, CO 80136

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56547 E 23RD AVE
Strasburg, CO 80136

Current Resident
56549 E 23RD PL
Strasburg, CO 80136

Current Resident
56550 E 23RD PL
Strasburg, CO 80136

Current Resident
56552 E 23RD AVE
Strasburg, CO 80136

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56555 E 22ND PL
Strasburg, CO 80136

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56555 E 25TH AVE
Strasburg, CO 80136

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56557 E 41ST AVE
Strasburg, CO 80136

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56560 E 25TH AVE
Strasburg, CO 80136

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56561 E 24TH AVE
Strasburg, CO 80136

Current Resident
56563 E 24TH PL
Strasburg, CO 80136

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56564 E 24TH AVE
Strasburg, CO 80136

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56568 E 22ND PL
Strasburg, CO 80136

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56568 E 24TH PL
Strasburg, CO 80136

Current Resident
56577 E 23RD AVE
Strasburg, CO 80136

Current Resident
56579 E 23RD PL
Strasburg, CO 80136

Current Resident
56580 E 23RD PL
Strasburg, CO 80136

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56582 E 23RD AVE
Strasburg, CO 80136

Current Resident
56585 E 25TH AVE
Strasburg, CO 80136

Current Resident
56588 E 22ND PL
Strasburg, CO 80136

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56590 E 25TH AVE
Strasburg, CO 80136

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56591 E 24TH AVE
Strasburg, CO 80136

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56593 E 24TH PL
Strasburg, CO 80136

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56594 E 24TH AVE
Strasburg, CO 80136

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56597 E 23RD AVE
Strasburg, CO 80136

Current Resident
56598 E 24TH PL
Strasburg, CO 80136

Current Resident
56599 E 23RD PL
Strasburg, CO 80136

Current Resident
56600 E 30TH AVE
Strasburg, CO 80136

Current Resident
56600 E 32ND AVE
Strasburg, CO 80136

Current Resident
56600 E 33RD PL
Strasburg, CO 80136

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56600 E 35TH PL
Strasburg, CO 80136

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56600 E 41ST AVE
Strasburg, CO 80136

Current Resident
56605 E 22ND PL
Strasburg, CO 80136

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56605 E 30TH AVE
Strasburg, CO 80136

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Strasburg, CO 80136

Current Resident
56605 E 33RD PL
Strasburg, CO 80136

Current Resident
56605 E 35TH PL
Strasburg, CO 80136

Current Resident
56607 E 23RD AVE
Strasburg, CO 80136

Current Resident
56609 E 23RD PL
Strasburg, CO 80136

Current Resident
56610 E 23RD PL
Strasburg, CO 80136

Current Resident
56612 E 23RD AVE
Strasburg, CO 80136

Current Resident
56618 E 22ND PL
Strasburg, CO 80136

Current Resident
56620 E 28TH CT
Strasburg, CO 80136

Current Resident
56625 E 22ND PL
Strasburg, CO 80136

Current Resident
56633 E 39TH AVE
Strasburg, CO 80136

Current Resident
56635 E 25TH AVE
Strasburg, CO 80136

Current Resident
56637 E 23RD AVE
Strasburg, CO 80136

Current Resident
56638 E 22ND PL
Strasburg, CO 80136

Current Resident
56639 E 23RD PL
Strasburg, CO 80136

Current Resident
56640 E 23RD PL
Strasburg, CO 80136

Current Resident
56640 E 25TH AVE
Strasburg, CO 80136

Current Resident
56641 E 24TH AVE
Strasburg, CO 80136

Current Resident
56642 E 23RD AVE
Strasburg, CO 80136

Current Resident
56643 E 24TH PL
Strasburg, CO 80136

Current Resident
56644 E 24TH AVE
Strasburg, CO 80136

Current Resident
56647 E 41ST AVE
Strasburg, CO 80136

Current Resident
56648 E 24TH PL
Strasburg, CO 80136

Current Resident
56650 E 35TH AVE
Strasburg, CO 80136

Current Resident
56655 E 22ND PL
Strasburg, CO 80136

Current Resident
56655 E 35TH PL
Strasburg, CO 80136

Current Resident
56657 E 23RD AVE
Strasburg, CO 80136

Current Resident
56658 E 22ND PL
Strasburg, CO 80136

Current Resident
56659 E 23RD PL
Strasburg, CO 80136

Current Resident
56670 E 23RD PL
Strasburg, CO 80136

Current Resident
56672 E 23RD AVE
Strasburg, CO 80136

Current Resident
56675 E 22ND PL
Strasburg, CO 80136

Current Resident
56675 E 25TH AVE
Strasburg, CO 80136

Current Resident
56680 E 25TH AVE
Strasburg, CO 80136

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56681 E 24TH AVE
Strasburg, CO 80136

Current Resident
56683 E 24TH PL
Strasburg, CO 80136

Current Resident
56684 E 24TH AVE
Strasburg, CO 80136

Current Resident
56685 E 22ND PL
Strasburg, CO 80136

Current Resident
56687 E 23RD AVE
Strasburg, CO 80136

Current Resident
56688 E 24TH PL
Strasburg, CO 80136

Current Resident
56689 E 23RD PL
Strasburg, CO 80136

Current Resident
56690 E 23RD PL
Strasburg, CO 80136

Current Resident
56692 E 23RD AVE
Strasburg, CO 80136

Current Resident
56698 E 22ND PL
Strasburg, CO 80136

Current Resident
56700 E 33RD PL
Strasburg, CO 80136

Current Resident
56700 E 35TH PL
Strasburg, CO 80136

Current Resident
56701 E 28TH AVE
Strasburg, CO 80136

Current Resident
56702 E 23RD AVE
Strasburg, CO 80136

Current Resident
56703 E 39TH AVE
Strasburg, CO 80136

Current Resident
56705 E 33RD PL
Strasburg, CO 80136

Current Resident
56705 E 35TH PL
Strasburg, CO 80136

Current Resident
56707 E 32ND AVE
Strasburg, CO 80136

Current Resident
56707 E 41ST AVE
Strasburg, CO 80136

Current Resident
56708 E 22ND PL
Strasburg, CO 80136

Current Resident
56715 E 22ND PL
Strasburg, CO 80136

Current Resident
56722 E 23RD AVE
Strasburg, CO 80136

Current Resident
56725 E 25TH AVE
Strasburg, CO 80136

Current Resident
56728 E 22ND PL
Strasburg, CO 80136

Current Resident
56730 E 25TH AVE
Strasburg, CO 80136

Current Resident
56733 E 24TH PL
Strasburg, CO 80136

Current Resident
56734 E 24TH AVE
Strasburg, CO 80136

Current Resident
56735 E 22ND PL
Strasburg, CO 80136

Current Resident
56737 E 23RD AVE
Strasburg, CO 80136

Current Resident
56745 E 25TH AVE
Strasburg, CO 80136

Current Resident
56748 E 22ND PL
Strasburg, CO 80136

Current Resident
56752 E 23RD AVE
Strasburg, CO 80136

Current Resident
56755 E 22ND PL
Strasburg, CO 80136

Current Resident
56757 E 23RD AVE
Strasburg, CO 80136

Current Resident
56765 E 25TH AVE
Strasburg, CO 80136

Current Resident
56768 E 22ND PL
Strasburg, CO 80136

Current Resident
56770 E 25TH AVE
Strasburg, CO 80136

Current Resident
56770 E 37TH PL
Strasburg, CO 80136

Current Resident
56773 E 24TH PL
Strasburg, CO 80136

Current Resident
56775 E 30TH AVE
Strasburg, CO 80136

Current Resident
56777 E 23RD AVE
Strasburg, CO 80136

Current Resident
56785 E 24TH AVE
Strasburg, CO 80136

Current Resident
56788 E 22ND PL
Strasburg, CO 80136

Current Resident
56795 E 25TH AVE
Strasburg, CO 80136

Current Resident
56800 E 32ND AVE
Strasburg, CO 80136

Current Resident
56800 E 33RD PL
Strasburg, CO 80136

Current Resident
56800 E 35TH PL
Strasburg, CO 80136

Current Resident
56805 E 33RD PL
Strasburg, CO 80136

Current Resident
56805 E 35TH PL
Strasburg, CO 80136

Current Resident
56827 E 41ST AVE
Strasburg, CO 80136

Current Resident
56850 E 30TH AVE
Strasburg, CO 80136

Current Resident
56880 E 37TH PL
Strasburg, CO 80136

Current Resident
56885 E 30TH AVE
Strasburg, CO 80136

Current Resident
56887 E 41ST AVE
Strasburg, CO 80136

Current Resident
56900 E 33RD PL
Strasburg, CO 80136

Current Resident
56905 E 33RD PL
Strasburg, CO 80136

Current Resident
56909 E 42ND CT
Strasburg, CO 80136

Current Resident
56910 E 42ND CT
Strasburg, CO 80136

Current Resident
56920 E 42ND CT
Strasburg, CO 80136

Current Resident
56921 E 24TH AVE
Strasburg, CO 80136

Current Resident
56929 E 42ND CT
Strasburg, CO 80136

Current Resident
56936 E 42ND CT
Strasburg, CO 80136

Current Resident
56938 E 42ND CT
Strasburg, CO 80136

Current Resident
56940 E 42ND CT
Strasburg, CO 80136

Current Resident
56949 E 42ND CT
Strasburg, CO 80136

Current Resident
56951 E 24TH AVE
Strasburg, CO 80136

Current Resident
56981 E 24TH AVE
Strasburg, CO 80136

Current Resident
57001 E 24TH AVE
Strasburg, CO 80136

Current Resident
57031 E 24TH AVE
Strasburg, CO 80136

Current Resident
57061 E 24TH AVE
Strasburg, CO 80136

Current Resident
57091 E 24TH AVE
Strasburg, CO 80136

Current Resident
57121 E 24TH AVE
Strasburg, CO 80136

Current Resident
57141 E 24TH AVE
Strasburg, CO 80136

Current Resident
57161 E 24TH AVE
Strasburg, CO 80136

Current Resident
57181 E 24TH AVE
Strasburg, CO 80136

Current Resident
57201 E 24TH AVE
Strasburg, CO 80136

Current Resident
57240 E 24TH AVE
Strasburg, CO 80136

Current Resident
57251 E 24TH AVE
Strasburg, CO 80136

Current Resident
57335 E 42ND CT
Strasburg, CO 80136

Current Resident
57397 E 42ND CT
Strasburg, CO 80136

Current Resident
57402 E 42ND CT
Strasburg, CO 80136

Current Resident
57469 E 42ND CT
Strasburg, CO 80136

Current Resident
57474 E 42ND CT
Strasburg, CO 80136

Current Resident
57531 E 42ND CT
Strasburg, CO 80136

Current Resident
57536 E 42ND CT
Strasburg, CO 80136

Current Resident
57603 E 42ND CT
Strasburg, CO 80136

Current Resident
57608 E 42ND CT
Strasburg, CO 80136

Current Resident
57665 E 42ND CT
Strasburg, CO 80136

Current Resident
57670 E 42ND CT
Strasburg, CO 80136

Current Resident
57700 E 24TH AVE
Strasburg, CO 80136

Current Resident
58105 E 40TH DR
Strasburg, CO 80136

Current Resident
58117 E 42ND AVE
Strasburg, CO 80136

Current Resident
58148 E 40TH DR
Strasburg, CO 80136

Current Resident
58150 E 40TH DR
Strasburg, CO 80136

Current Resident
58162 E 42ND DR
Strasburg, CO 80136

Current Resident
58195 E 40TH DR
Strasburg, CO 80136

Current Resident
58209 E 42ND DR
Strasburg, CO 80136

Current Resident
58260 E 40TH DR
Strasburg, CO 80136

Current Resident
58274 E 42ND AVE
Strasburg, CO 80136

Current Resident
58285 E 40TH DR
Strasburg, CO 80136

Current Resident
58311 E 42ND AVE
Strasburg, CO 80136

Current Resident
58370 E 40TH AVE
Strasburg, CO 80136

Current Resident
58375 E 40TH DR
Strasburg, CO 80136

Current Resident
58386 E 42ND DR
Strasburg, CO 80136

Current Resident
58413 E 42ND DR
Strasburg, CO 80136

Current Resident
58465 E 40TH DR
Strasburg, CO 80136

Current Resident
58480 E 40TH DR
Strasburg, CO 80136

Current Resident
58498 E 42ND DR
Strasburg, CO 80136

Current Resident
58600 E 44TH DR
Strasburg, CO 80136

Current Resident
58605 E 44TH DR
Strasburg, CO 80136

Current Resident
58620 E 40TH DR
Strasburg, CO 80136

Current Resident
58645 E 40TH DR
Strasburg, CO 80136

Current Resident
58700 E 44TH DR
Strasburg, CO 80136

Current Resident
58707 E 44TH DR
Strasburg, CO 80136

Current Resident
58727 E 40TH DR
Strasburg, CO 80136

Current Resident
58770 E 40TH DR
Strasburg, CO 80136

Current Resident
58805 E 40TH DR
Strasburg, CO 80136

Current Resident
58810 E 40TH DR
Strasburg, CO 80136

Current Resident
5885 HEADLIGHT RD
Strasburg, CO 80136

CERTIFICATE OF POSTING

I, J. Gregory Barnes do hereby certify that Adams County staff posted the property at a property northeast of the intersection of 38th Avenue and Headlight Road on June 18, 2018 in accordance with the requirements of the Adams County Zoning Regulations.

J. Gregory Barnes

ADAMS COUNTY
COLORADO

Community & Economic Development Department
4430 South Adams County Parkway,
1st Floor, Suite W2000
Brighton, CO 80601-8205
PHONE 720.523.6800 FAX 720.523.6998

MEMORANDUM

To: Board of County Commissioners

From: J. Gregory Barnes, Planner II

Subject: Comanche Vista Estates, Filing 5 / Case # PLT2017-00019

Date: July 10, 2018

If the Board of County Commissioners does not concur with the staff recommendation of Approval, the following findings may be adopted as part of a decision of Denial:

ALTERNATIVE RECOMMENDED FINDINGS

1. The final plat is inconsistent and conforms to the approved sketch plan.
2. The final plat is not in conformance with the subdivision design standards.
3. The applicant has not provided evidence that a sufficient water supply has been acquired in terms of quantity, quality, and dependability for the type of subdivision proposed, as determined in accordance with the standards set forth in the water supply standards.
4. The applicant has not provided evidence that provision has been made for a public sewage disposal system and, if other methods of sewage disposal are proposed, adequate evidence indicating that the system complies with state and local laws and regulations.
5. The applicant has not provided evidence to show all areas of the proposed subdivision, which may involve soil or topographical conditions presenting hazards or requiring special precautions have been identified by the applicant and the proposed uses of these areas are compatible with such conditions.
6. The proposed or constructed drainage improvements are inadequate and do not comply with these standards and regulations.
7. Adequate public facilities or infrastructure, or cash-in-lieu, for impacts reasonably related to the proposed subdivision have not been constructed or financially guaranteed through cash-in-lieu or a subdivision improvements agreement so the proposed subdivision will not negatively impact the levels of service of the County.
8. The final plat is inconsistent with the Adams County Comprehensive Plan and any available area plan.
9. The final plat is inconsistent with the purposes of these standards and regulations.
10. The overall density of development within the proposed subdivision does not conform to the zone district density allowances.
11. The proposed subdivision is incompatible with the surrounding area, harmonious with the character of the neighborhood, not detrimental to the immediate area, not

ADAMS COUNTY
COLORADO

Community & Economic Development Department
4430 South Adams County Parkway,
1st Floor, Suite W2000
Brighton, CO 80601-8205
PHONE 720.523.6800 FAX 720.523.6998

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. The proposed subdivision has not established an adequate level of compatibility by:

a. Incorporating natural physical features into the development design and providing sufficient open spaces considering the type and intensity of use;
b. Incorporating site planning techniques to foster the implementation of the County's plans and encourage a land use pattern to support a balanced transportation system, including auto, bike and pedestrian traffic, public or mass transit, and the cost effective delivery of other services consistent with adopted plans, policies and regulations of the County;
c. Incorporating physical design features in the subdivision to provide a transition between the project and adjacent land uses through the provision of an attractive entryway, edges along public streets, architectural design, and appropriate height and bulk restrictions on structures; and
d. Incorporating identified environmentally sensitive areas, including but not limited to, wetlands and wildlife corridors, into the project design.

Comanche Vista Estates, Filing 5

PLT2017-00019

East 38th Avenue & Harvest Road

July 17, 2018

Board of County Commissioners Public Hearing

Community and Economic Development Department

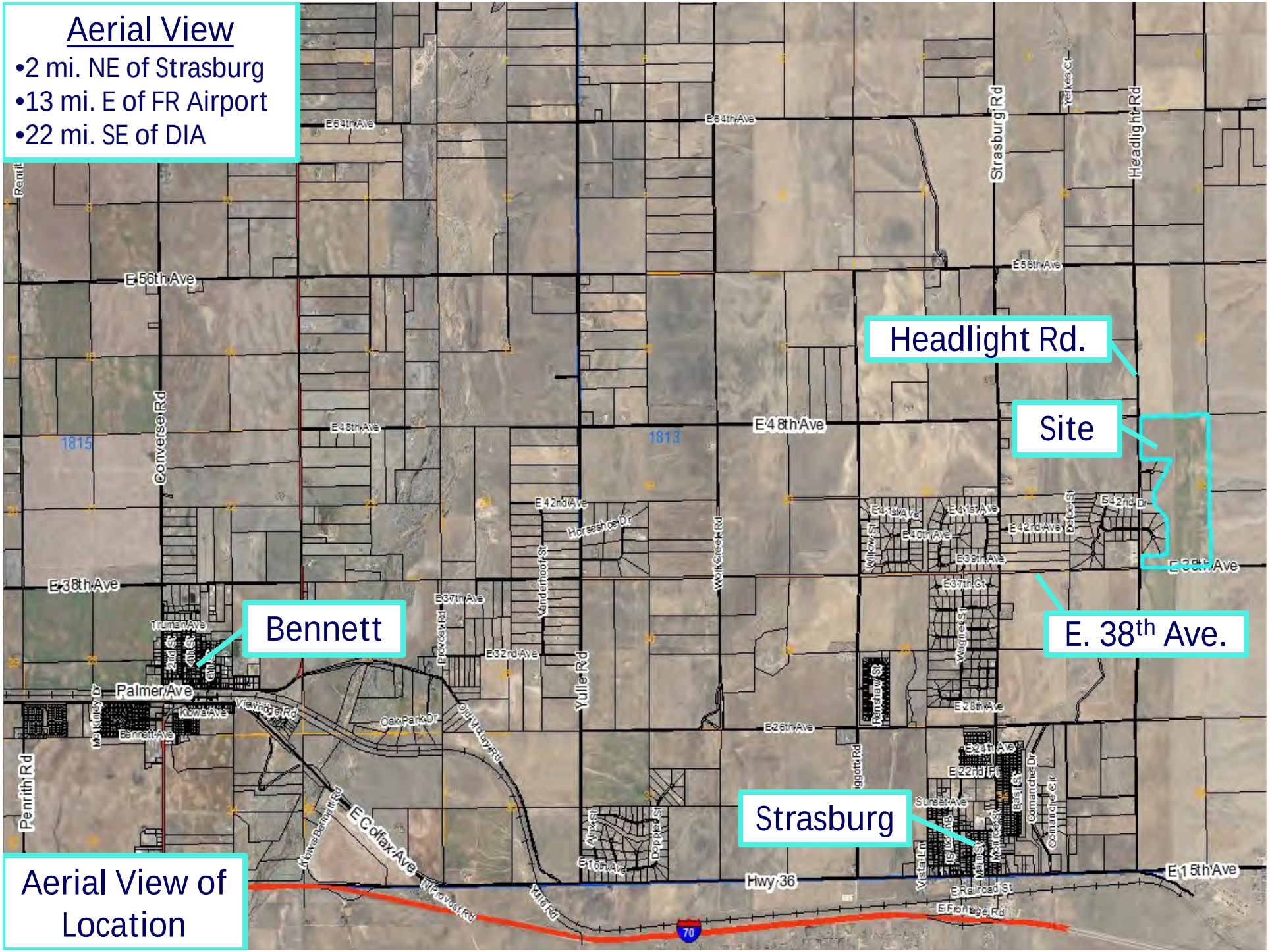
Case Manager: Greg Barnes

Request

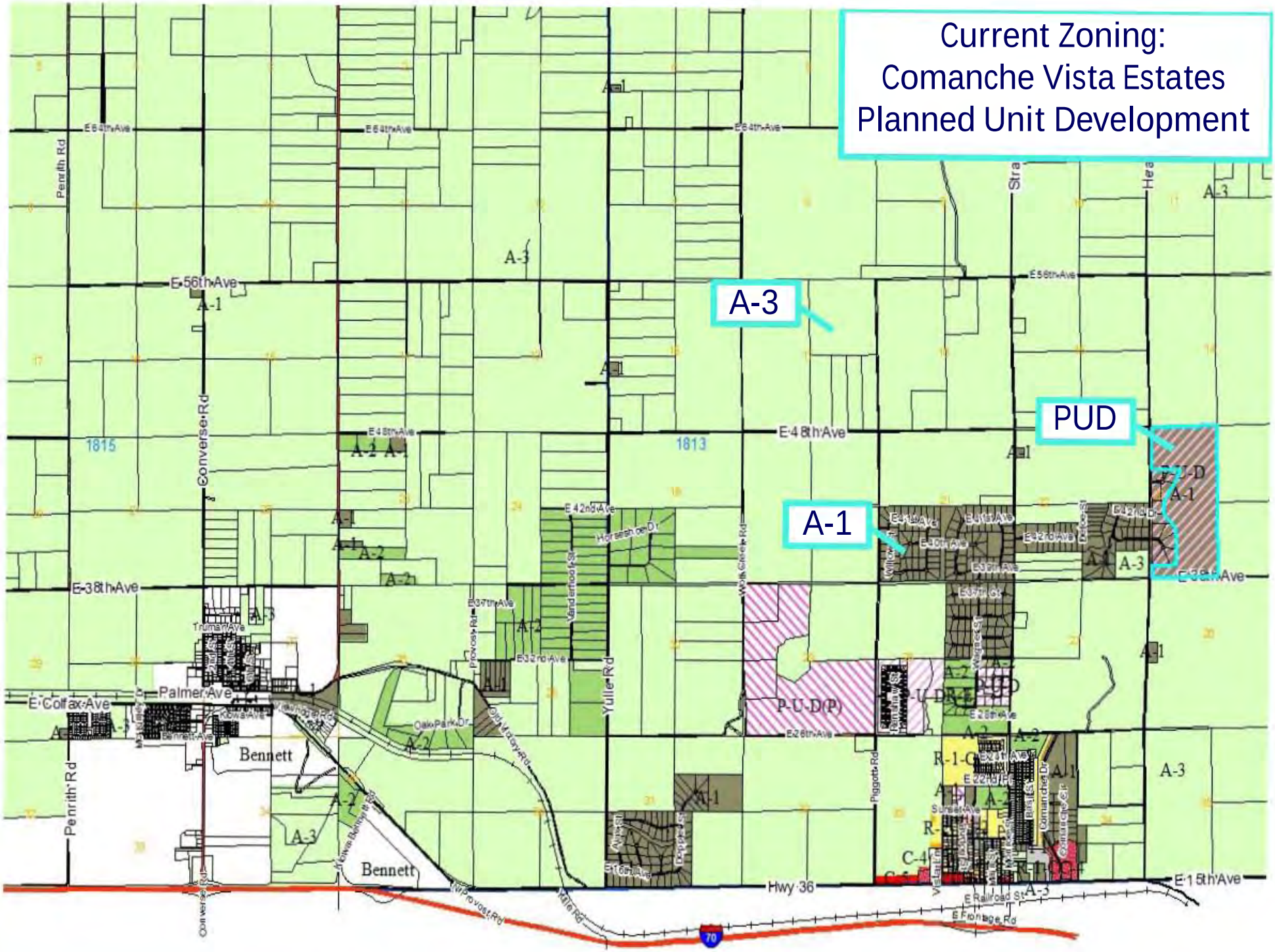
Final Plat for Minor Subdivision to create one lot on 5 acres.

Aerial View

- 2 mi. NE of Strasburg
- 13 mi. E of FR Airport
- 22 mi. SE of DIA



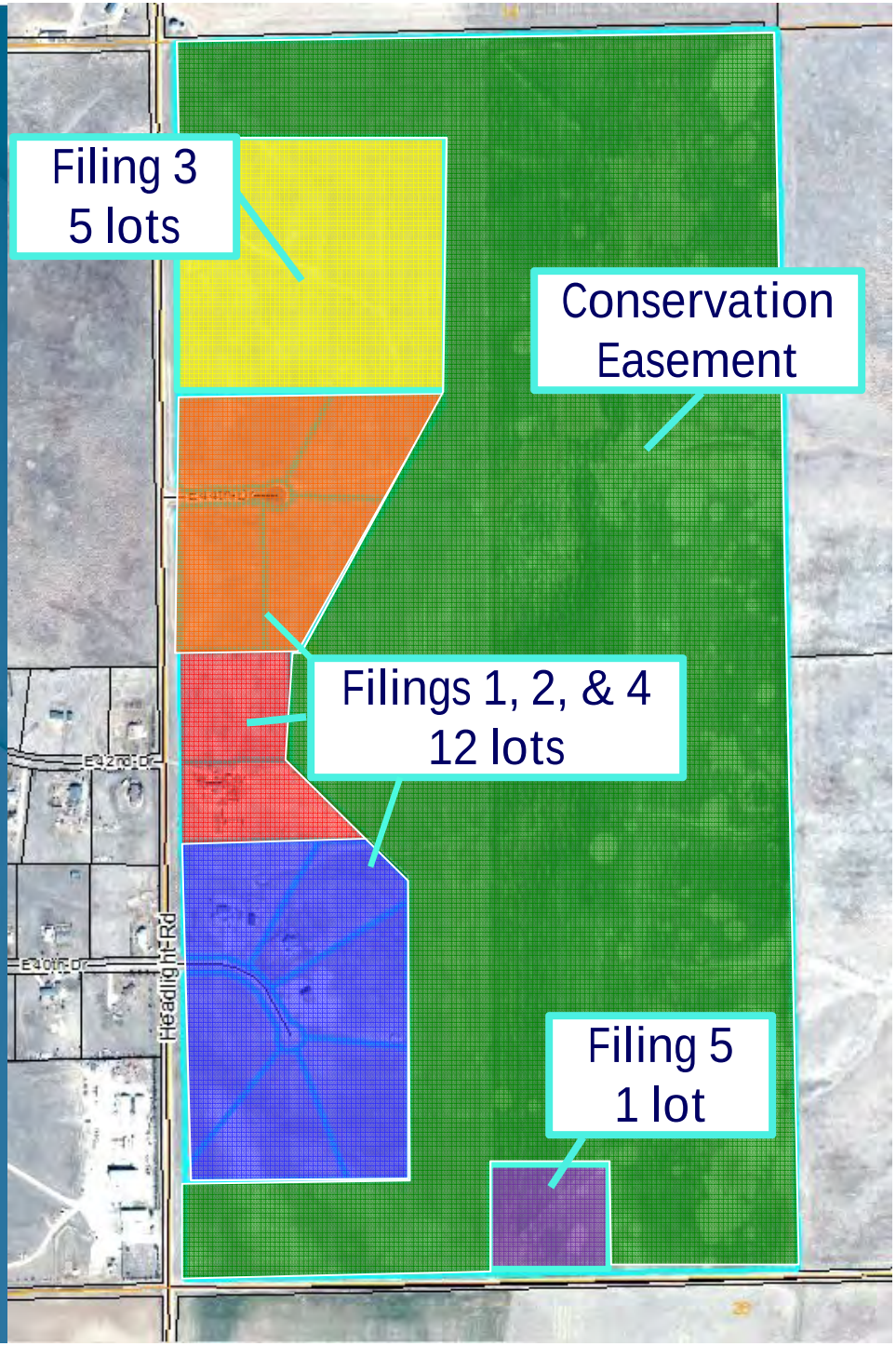
Aerial View of Location

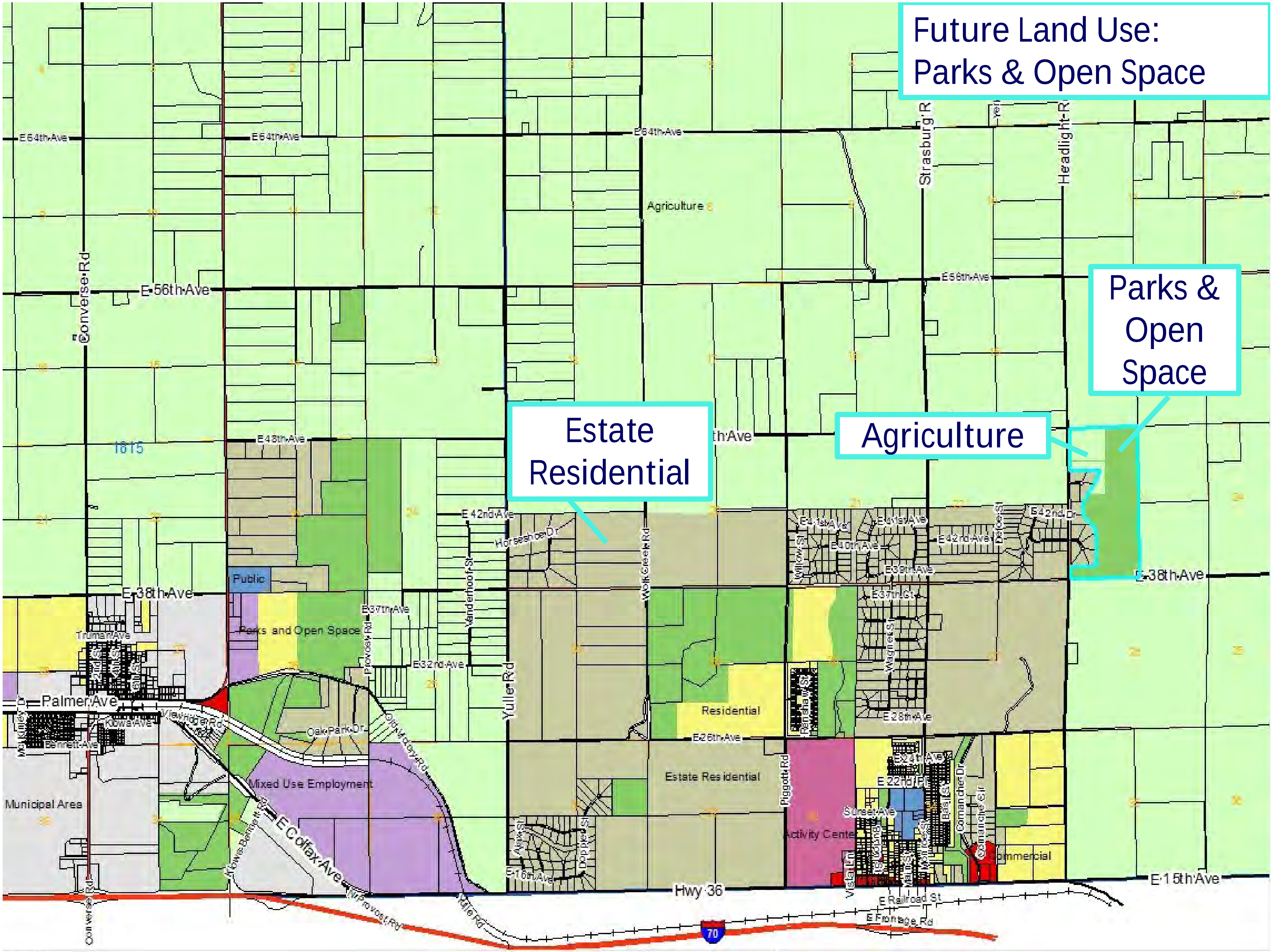

Current Zoning:
Comanche Vista Estates
Planned Unit Development
A-3
PUD
A-1
E 64th Ave
E 56th Ave
E 48th Ave
E 42nd Ave
E 38th Ave
E 32nd Ave
E 26th Ave
E 15th Ave
Converse Rd
Penrith Rd
Yuma Rd
Piggott Rd
Palmer Ave
E Colfax Ave
Bennett
Hwy 36
E Railroad St
E Frontage Rd
P-U-D(P)
1815
1813

Background

Comanche Vista Estates PUD

- Development Plan on 307 acres (Aug 2003)
  - 18 single-family lots (min. 5-acre lots)
  - 217 acres conservation easement
- Filings 1, 2, & 4: Fully-approved
  - 12 lots (2003-2007)
- Filing 3: Preliminary approval only
  - 5 lots (2017)
- Filing 5 (Subject final plat)
  - 1 lot (2018)





Future Land Use:
Parks & Open Space
Parks & Open Space
Agriculture
Estate Residential
E 64th Ave
E 56th Ave
E 48th Ave
E 42nd Ave
E 38th Ave
E 37th Ave
E 32nd Ave
E 26th Ave
E 15th Ave
Palmer Ave
Converse Rd
Strasburg Rd
Headlight Rd
Yulle Rd
Wolf Creek Rd
Horseshoe Dr
Vandernoof St
Piggott Rd
E Colfax Ave
Hwy 36
Public
Parks and Open Space
Residential
Estate Residential
Mixed Use Employment
Municipal Area
Activity Center
Commercial
Agriculture
70

Criteria for Minor Subdivision Final Plat Approval

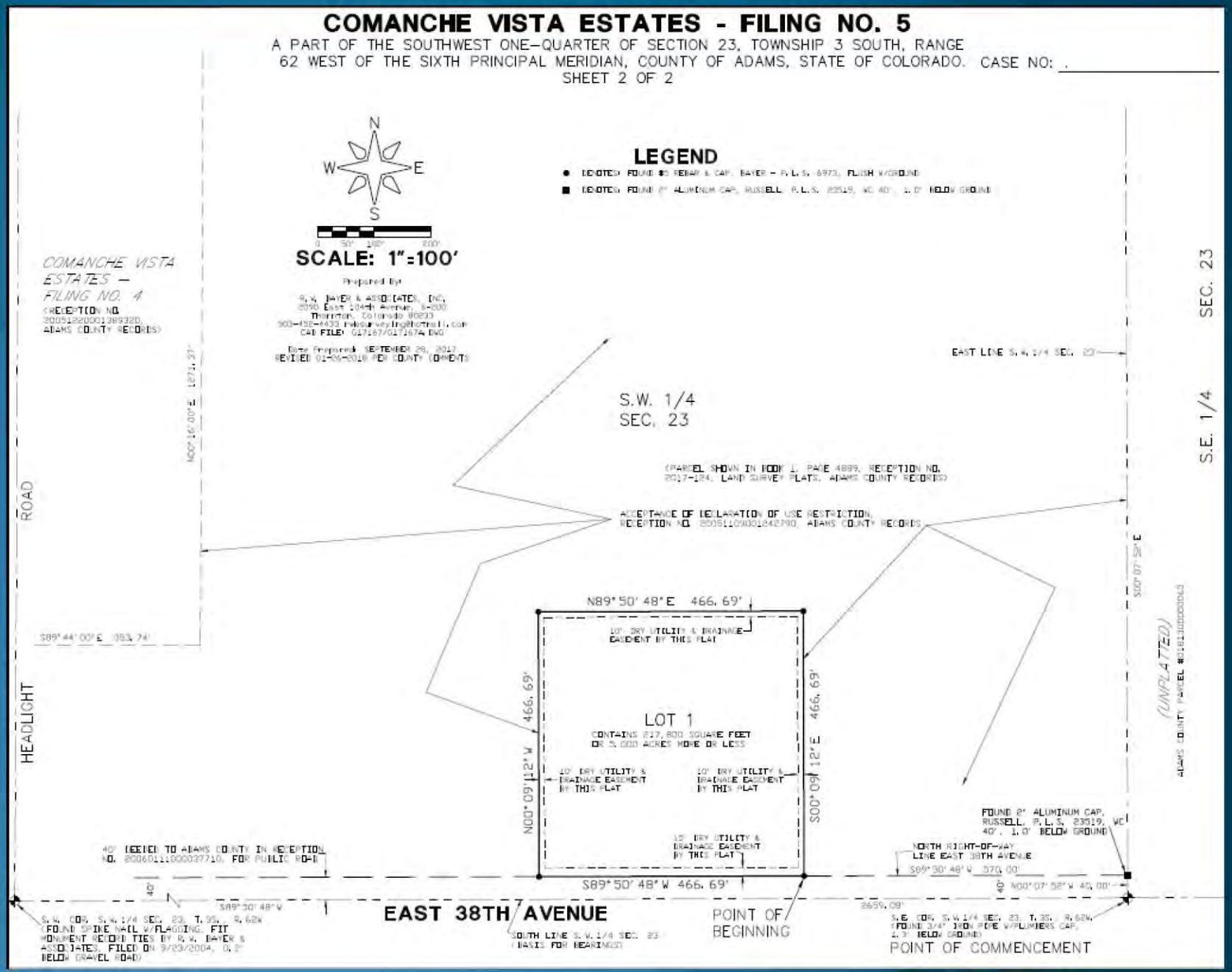
Section 2-02-18-03-05

1. Conforms to approved sketch plan
2. Conforms to Subdivision Design Standards
3. Sufficient water supply
4. Established sewage disposal
5. Identified soil & topographical issues
6. Adequate drainage improvements
7. Adequate public facilities and infrastructure
8. Consistent with Comprehensive Plan
9. Consistent with Development Standards
10. Conforms to zone district density standards
11. Compatible & harmonious to surrounding area

COMANCHE VISTA ESTATES - FILING NO. 5

A PART OF THE SOUTHWEST ONE-QUARTER OF SECTION 23, TOWNSHIP 3 SOUTH, RANGE 62 WEST OF THE SIXTH PRINCIPAL MERIDIAN, COUNTY OF ADAMS, STATE OF COLORADO. CASE NO: _____

SHEET 2 OF 2



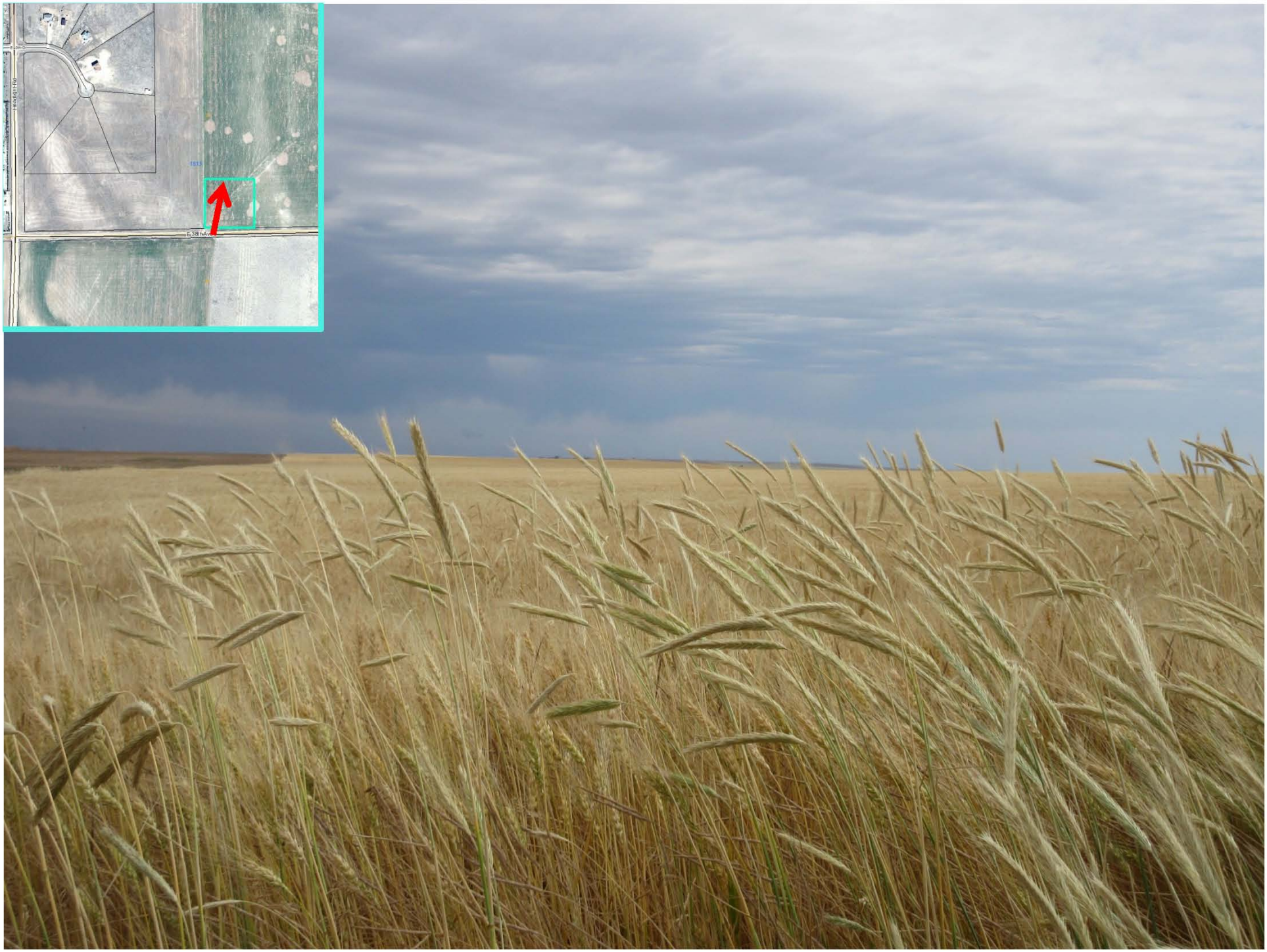
Development Standards

Comanche Vista Estates PUD

- Minimum Lot Size:
  - 5 acres
- Consistent with Development Plan:
  - Lot Boundaries match approved PUD

Analysis

- Water:
  - Well permits through CDWR
- Sewage:
  - Individual Septic Systems through TCHD
- Electric Service:
  - Provided by IREA


E 38th Ave
1813


E 38th Ave

Referral Period

Notices Sent	Comments Received
46	0

2,000 foot referral distance

No concerns:

IREA
Strasburg Fire
Xcel

Concern, but no objection:

CGS
Tri-County Health

Staff Analysis

- Consistent with Comprehensive Plan
- Compliant with Devt. & Subd. Design Standards
- Consistent with approved PUD
- Compatible with surrounding area
- Water, Sewage, & Electric Service Provided

Planning Commission Update

PLT2017-00019 – Comanche Vista Estates, Filing 5

Case heard on June 28, 2018.

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Approval of the final plat (PLT2017-00019 Comanche Vista Estates, Filing 5) with:

- 11 findings-of-fact, and
- 1 condition.

COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

CASE NO.: RCU2017-00042

CASE NAME: VERIZON HAILSTORM

TABLE OF CONTENTS

COMMUNITY AND ECONOMIC DEVELOPMENT DEPARTMENT

STAFF REPORT

Board of County Commissioners July 17, 2018

CASE No.: **RCU2017-00042**	CASE NAME: **Verizon Hailstorm**

Owner's Name:	Alex Chlebek
Applicant's Name:	Centerline Solutions
Applicant's Address:	16035 Table Mountain Parkway, Golden, CO 80403
Location of Request:	4992 East 100th Avenue
Nature of Request:	A conditional use permit to allow a commercial telecommunications tower on the property
Zone Districts:	Agriculture-1 (A-1)
Comprehensive Plan:	Urban Residential
Site Size:	1,200 square feet portion of a 14 acre parcel
Proposed Uses:	Commercial Telecommunications Tower
Existing Use:	Vacant
Hearing Date(s):	**PC: June 28, 2018 / 6:00 p.m.**
	BOCC: July 17, 2018 /9:30 a.m.
Report Date:	June 29, 2018
Case Manager:	Greg Barnes
PC Recommendation:	APPROVAL with 8 Findings-of-Fact, 1 Condition Precedent, 6 Conditions, and 1 Note
Staff Recommendation:	APPROVAL with 8 Findings-of-Fact, 1 Condition Precedent, 6 Conditions, and 1 Note

SUMMARY OF APPLICATION

Background

Centerline Solutions, the applicant, is requesting a conditional use permit to allow a commercial telecommunications tower on the subject property. According to the applicant and the application documents, the proposed tower and associated antennae will be designed to

look similar to a silo, which will blend with the surrounding neighborhood. None of the associated antennae will be visible from outside the silo structure. Verizon Wireless will be the main carrier using the tower; however co-location opportunities will be provided for other carriers.

The tower would occupy approximately 1,200 square feet of a fourteen (14) acre parcel. Specifically, the tower will be located on the southeastern section of the larger property (see Exhibit 3.2) approximately five-hundred fifty (550) feet from East 100th Avenue. Elevation plans, submitted with the application, show the tower will be seventy (70) feet in height (see Exhibit 3.2). The applicant is proposing to construct a six-foot high wooden fence around the perimeter of the tower site, and to landscape the exterior perimeter of the fence with shrubs. Landscape plans submitted with the application show the shrubs are projected to reach a mature height of three (3) feet, and will be planted twelve (12) feet apart.

Site Characteristics:

The subject property is located on the southeastern corner of East 100th Avenue and Riverdale Road. Currently, the property is vacant. The site will have access onto East 100th Avenue through an easement. The properties to the west and south of the site are in the municipal boundaries of the City of Thornton. The properties to the north and east are in unincorporated Adams County, and developed as single-family residential or agricultural. These properties are zoned A-1.

Development Standards and Regulations Requirements:

Per Section 3-07-01 of the Adams County Development Standards and Regulations, a conditional use permit is required for a commercial telecommunications tower in the A-1 zone district. Section 4-09-02-07 of the County's Development Standards and Regulations outlines design and performance standards for telecommunication facilities. These standards include maximum height, landscaping, screening, setbacks from property lines, separation from other freestanding facilities, and setbacks from residential uses. The elevation plans, provided with the application, show the tower is proposed to be 70 feet in height and will be designed to resemble a silo. The maximum height allowed in the A-1 zone district for dwellings is thirty-five (35) feet; however, agricultural structures are allowed to be seventy (70) feet in height. Per Section 4-09-02-07(3a) of the Development Standards, the Board of County Commissioners, through the conditional use permit, may grant an exception to the height of the telecommunication tower to exceed the maximum height allowed in the zone district. The subject request includes allowing the height of the tower to be 70 feet.

Per Section 4-09-02-07(3) of the County's Development Standards and Regulations, freestanding telecommunication towers shall not be located closer than the height of the tower from any property line. The proposed telecommunication tower will be located 77 feet from the nearest property line to the south, thus conforming to the required setback standards. Section 4-09-02-07(3d) of the County's Development Standards and Regulations requires new telecommunication towers to be located no closer than 1,000 feet from the nearest telecommunications tower. From the information submitted by the applicant, the proposed location of the tower conforms to the County's spacing requirement, as the nearest tower is

located approximately 1,260 feet. The applicant also provided a coverage map of the area to demonstrate the need for the proposed tower.

Landscaping is required to screen the telecommunication tower as outlined in Section 4-09-02-07(3b) of the County's Development Standards and Regulations. The site plan submitted with the application shows all equipment associated with the telecommunication tower will be located and enclosed inside the structure or inside the proposed six-foot screen fence. The landscape plan, provided with the application, shows installation of seven (7) shrubs along the exterior of the fence. This is to enhance the aesthetic view of the property. The proposed screening and landscaping conform to the County's requirements outlined in Section 4-09-02-07(3) of the Development Standards and Regulations for landscaping and screening.

The County's Development Standards requires a bond to be in place to ensure removal of the tower if it is abandoned or is no longer needed. Staff has recommended a condition of approval that requires the applicant to provide such a bond in the amount of $30,000.

Future Land Use Designation/Goals of the Comp-Plan for the Area

The future land use designation on the property is Urban Residential. Per Chapter 5 of the Adams County Comprehensive Plan, Urban Residential designated areas are intended to provide a variety of housing types at a density greater than one dwelling unit per acre. In addition, complementary and supporting uses like neighborhood-serving retail, schools, and community facilities are also appropriate in Urban Residential, provided that those uses are compatible with residential neighborhoods. The request to allow a telecommunications tower on the subject property is consistent with the County's Comprehensive Plan, as the use will enhance provision of telecommunication services to surrounding area residents.

Surrounding Zoning Designations and Existing Use Activity:

Northwest **Thornton** **Single-Family Residential**	**North** **A-1** **Single-Family Residential**	**Northeast** **PUD** **Single-Family Residential**
West **Thornton** **Mobile Home Park**	**Subject Property** **A-1** **Vacant**	**East** **A-1** **Single-Family Residential, Nursery, Agricultural**
Southwest **A-1** **Commercial Radio Towers**	**South** **Thornton** **Vacant**	**Southeast** **A-1** **Single-Family Residential**

Compatibility with the Surrounding Land Uses:

The tower is proposed to be located on the southeastern corner of a larger 14 acre lot, and approximately 550 feet from the nearest public street. There is a 50-acre parcel located directly south of the proposed location of the tower. This parcel is owned by the City of Thornton, and is currently vacant. The closest adjoining properties to the tower are used as a plant nursery,

farming, and single-family residential dwelling. There is no residential dwelling located within 500 feet of the tower. The tower will be compatible to the surrounding uses.

PLANNING COMMISSION UPDATE:

The Planning Commission (PC) considered this case on June 28, 2018, and voted (7-0) to recommend approval of the request. Mr. Mark McGarey, the applicant's representative, spoke at the meeting and had no concerns with the staff report or presentation. At the hearing, the PC asked staff about the current use of the property and also if trees were needed to improve compatibility of the tower to the surrounding area. Staff informed the PC that the property is currently vacant, and the location of the tower is approximately 550 feet away from the closest street. This makes the tower hardly visible from public view. The tower will also be enclosed in a silo structure with a six-foot solid screen fence around it.

One resident spoke during the public hearing and expressed concerns with issues with drainage along the driveway at the northern edge of the property. Staff informed the PC that an access permit would be required at the time of building permit review for the telecommunication tower structure.

Staff Recommendations:

Based upon the application, the criteria for approval of a conditional use permit, the County's Comprehensive Plan, and a recent site visit, staff recommends approval of the request with 8 findings-of-fact, one condition precedent, six conditions, and one note.

Findings-of-fact for Approval:

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 proposed 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 available and adequate to serve the needs of the conditional use as designed and proposed.

Recommended Conditions Precedent:

1. The applicant shall submit a performance bond in the amount of $30,000 for removal. The bond documents shall be submitted, and approved by the Director of Community and Economic Development prior to approval of any associated building permit.

Recommended Conditions:

1. The applicant shall obtain a building permit for the telecommunications tower.
2. The conditional use permit shall expire on July 17, 2028.
3. The height of the freestanding telecommunications tower shall not exceed 70 feet.
4. The tower shall provide for co-location opportunities for other carriers.
5. Any telecommunications facility, that ceases to be in operation for a consecutive period of six months or more, shall be removed from the site within 90 days of the end of such period of non-use. The County shall have the right to enter the property to remove the tower should it cease to operate or abandoned.
6. An access permit shall be obtained for the proposed driveway along East 100th Avenue.

Recommended Notes to the Applicant:

1. All applicable building, zoning, health, engineering, and fire codes shall be adhered to with this request.

PUBLIC COMMENTS

Property Owners and Current Residents Notified	Number of Responses
923	1

Staff sent notices to 88 property owners and 835 current residents within 750 feet of the subject request, and has received no responses. One member of the public spoke at the public hearing, and voiced concern regarding drainage along the access property's access point on East 100th Avenue.

COUNTY AGENCY COMMENTS

County staff reviewed the request and determined that the conditional use permit will conform to the County's Development Standards and Regulations. Staff has recommended a condition precedent to require a bond for removal of the tower.

REFERRAL AGENCY COMMENTS

Responding without Concerns:

CDOT
CDPHE
Colorado Geological Survey
City of Thornton
Thornton Fire Department
Tri-County Health Department
Xcel Energy

Notified but not Responding / Considered a Favorable Response:

Adams 14 Schools
Century Link
Colorado Division of Wildlife
Comcast
Lower Clear Creek Ditch Company
Metro Wastewater Reclamation
Regional Transportation District
South Adams County Fire District

Exhibit 2.1: Aerial Map

LEGEND

- Special Zoning Conditions
- 3 Section Numbers
- 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)
- Airport Noise Overlay

ADAMS COUNTY COLORADO

This map is made possible by the Adams County GIS group, which assumes no responsibility for its accuracy

Verizon Hailstorm

RCU2017-00042

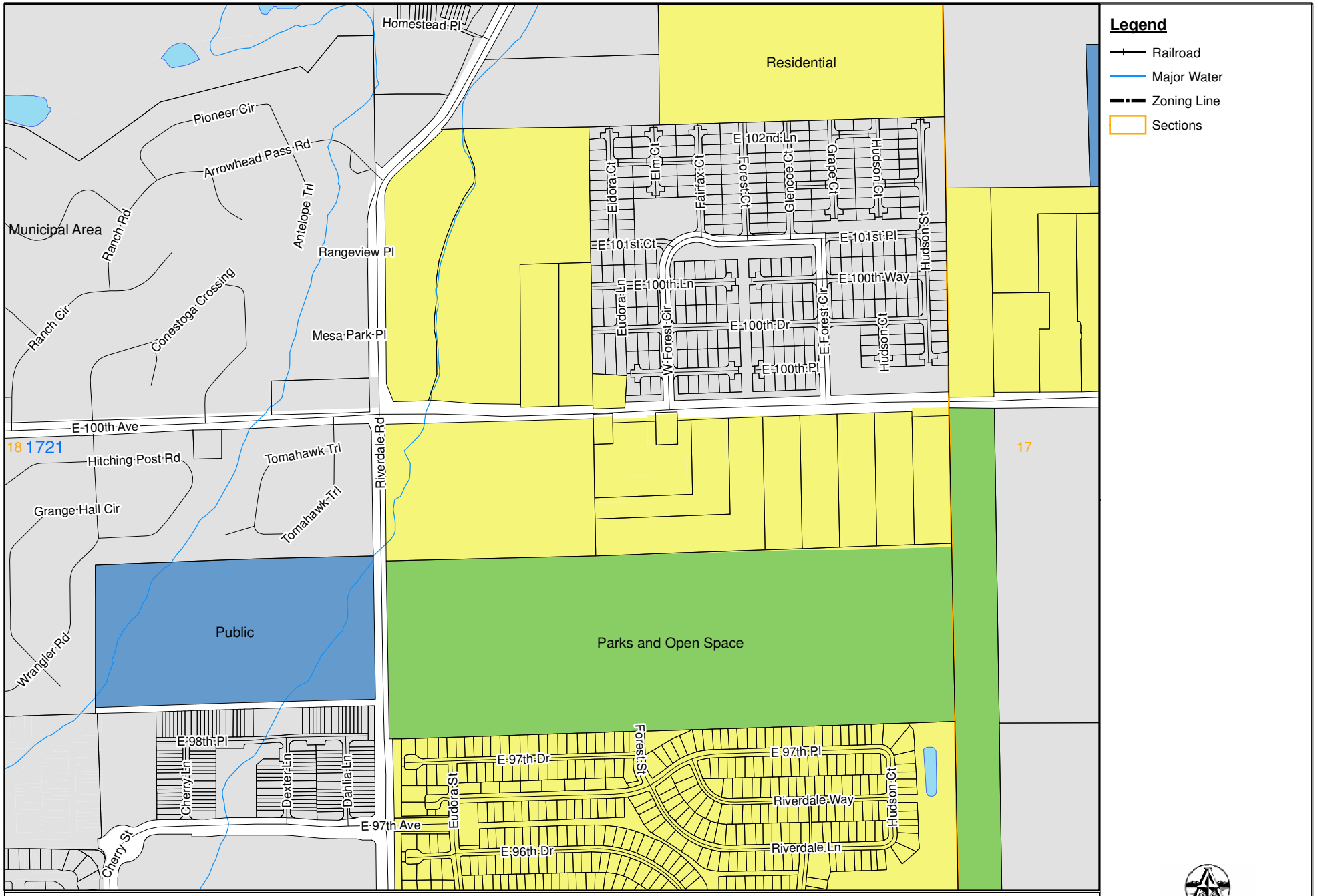
N

For display purposes only.

Exhibit 2.2 Zoning Map

Verizon Hailstorm

RCU2017-00042



Verizon Hailstorm

RCU2017-00042

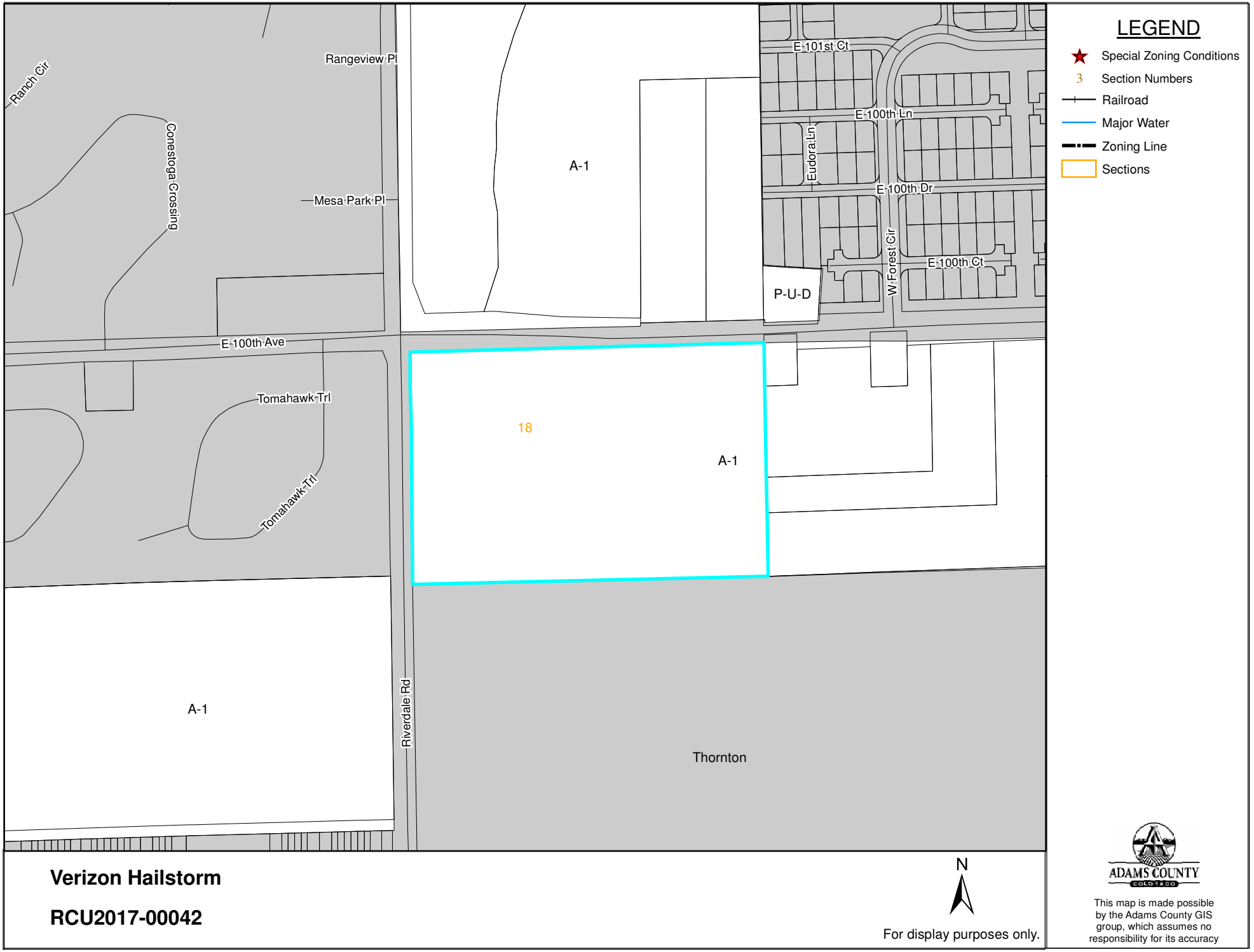
N

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

Exhibit 2.4: Simple Map



Verizon Hailstorm

RCU2017-00042

16035 Table Mountain Pkwy
Golden, CO 8040

To: Community & Economic Development
Department, Zoning/Permitting
Adams County

From: Greg Dibona

Subject: Proposed Verizon tower site

Date: 10/18/17

Location: 4992 E.100 Ave

Project Valuation: $200,000

Project Narrative:

Verizon Wireless has identified 4992 E. 100th Ave, Denver as a location for a new telecommunications facility designed as a silo that will enhance wireless coverage in the area. Verizon Wireless proposes to install (12) antennas, twelve (12) Remote Radio Heads (RRHs) and two (2) Over-voltage Protection Units (OVPs) concealed within the proposed 65' tower disguised as a silo. The RRH's and OVPs will be mounted behind the antenna. None of the antenna equipment will be visible from outside of the silo. A lightning rod will be added to the top of the structure, bringing the total height to 70'.

Greg Dibona
Centerline Solutions
847.257.2489
gdibona@centerlinesolutions.com

verizon

SITE NAME: DEN HAILSTORM

SITE ADDRESS: 4992 EAST 100TH AVENUE
DENVER, CO 80229

ADAMS COUNTY

PROJECT DATA

JURISDICTION:	-	ADAMS COUNTY
PARCEL NUMBER:	-	0172118400001
ZONING DESIGNATION:	-	A-1 ARGICULTURE
OCCUPANCY GROUP:	-	U
CONSTRUCTION TYPE:	-	OUTDOOR EQUIPMENT
FULLY SPRINKLERED:	-	NO (OUTDOOR EQUIPMENT)
NO. OF STORIES:	-	70'-0" ± STEALTH STRUCTURE

LEGAL DESCRIPTION:

SITUATED IN THE SOUTHEAST QUARTER OF SECTION 18, TOWNSHIP 2 SOUTH, RANGE 67 WEST OF THE 6TH P.M. COUNTY OF ADAMS, STATE OF COLORADO
GOVERNING CODES IF APPLICABLE:
2012 IBC, 2012 IFC, 2012 IMC, 2009 IECC, 2014 NEC.

A.D.A. COMPLIANCE:
NOT REQUIRED PER IBC 1103.2.9

PROJECT DESCRIPTION

NEW UNOCCUPIED TELECOMMUNICATIONS SITE CONSISTING OF NEW ANTENNAS ON A NEW VERIZON WIRELESS STEALTH STRUCTURE WITH NEW EQUIPMENT AT THE BASE, ALL WITHIN A WOOD PICKET FENCED COMPOUND.

ISSUED FOR: ZONING

DRAWING INDEX

T1	TITLE SHEET
LS1	LAND SURVEY
LS2	LAND SURVEY
Z1	OVERALL SITE PLAN & EXISTING CONDITIONS PHOTOS
Z2	ENLARGED SITE PLAN, EQUIPMENT PLAN & ANTENNA DETAIL
Z3	EAST & SOUTH ELEVATIONS
L1	ENLARGED LANDSCAPE PLAN & PLANTING SCHEDULE

GENERAL CONTRACTOR NOTE

CONTRACTOR SHALL VERIFY ALL PLANS AND EXISTING DIMENSIONS AND CONDITIONS ON THE JOB SITE AND SHALL IMMEDIATELY NOTIFY THE ARCHITECT IN WRITING OF ANY DISCREPANCIES BEFORE PROCEEDING WITH THE WORK OR BE RESPONSIBLE FOR SAME.

DRAWING SCALES SHOWN ARE ACCURATE WHEN PLOTTED ON 24"X36" SHEET. FOR 11"X17" SHEETS USE APPROPRIATE SCALE FACTOR 1/2 THAT OF SCALE SHOWN OR CONTACT CENTERLINE SOLUTIONS FOR FURTHER INFORMATION. DIMENSIONS SHOWN TAKE PRECEDENCE.

CALL BEFORE YOU DIG. COLORADO LAW REQUIRES 2 WORKING DAYS NOTICE FOR CONSTRUCTION PHASE: 811 OR 1-800-922-1987.

THESE DRAWINGS MAY NOT SHOW ALL UNDERGROUND PIPING AND UTILITIES. THE CONTRACTOR SHALL EXERCISE EXTREME CARE DURING ALL EXCAVATION AND OTHER CONSTRUCTION ACTIVITIES.

VERIZON WIRELESS IS RESPONSIBLE FOR ALL UTILITY LOCATES AND UTILITY RELOCATIONS REQUIRED FOR THIS INSTALLATION. VERIZON WIRELESS WILL SCHEDULE AND COORDINATE ALL WORK WITH THE OWNER TO ENSURE NO DISRUPTION TO OWNERS OPERATIONS.

VERIZON SHALL BE ABBREVIATED "VZW" THROUGHOUT.

PROJECT TEAM

PROPERTY OWNER:
ALEX CHLEBEK
PH: 720.289.3179

APPLICANT:
VERIZON WIRELESS
3131 S. VAUGHN WAY, SUITE 550
AURORA, CO 80014

CONSTRUCTION MANAGER:
VERIZON WIRELESS
MARK WILSON
PH: 303.501.2348

RF ENGINEER:
KEVIN BROWN
VERIZON WIRELESS
PH: 301.787.7316

SITE ACQUISITION FIRM:
CENTERLINE SOLUTIONS, LLC
GREG DIBONA
PH: 847.267.2489

A&E FIRM:
CENTERLINE SOLUTIONS, LLC
BRAD BRYANT
PH: 303.993.3293 EXT. 1383

ENGINEER OF RECORD:
CENTERLINE SOLUTIONS, LLC
KHRISTOPHER SCOTT, PE.
PH: 303.993.3293

CIVIL SURVEYOR:
DALEY LAND SURVEYING, INC.
17011 LINCOLN AVENUE STE. 361
PARKER, CO 80134-3144
ROB DALEY, PLS

VICINITY MAP

APPROVAL BLOCK

TITLE	SIGNATURE	DATE
OWNER		
ENGINEER		
PROJECT MANAGER		

ACKNOWLEDGEMENT OR "SIGN-OFF" BY PARTIES TO THE CONSTRUCTION DRAWINGS DOES NOT CONSTITUTE ALTERATION OF THE LEASE TERMS.

DRIVING DIRECTIONS TO SITE

FROM THE VERIZON OFFICE:
3131 S. VAUGHN WAY, AURORA, COLORADO

DEPART ON I-225 NORTH TO I-70 WEST. CONTINUE ONTO I-270 WEST. TAKE THE YORK STREET EXIT. FOLLOW SIGNS TO I-76 AND MERGE ONTO I-76 EAST. TAKE EXIT 11 TOWARD WEST 98TH AVENUE. STAYING ON THE LEFT, FOLLOW WEST 98TH AVENUE. CONTINUE ON WEST 98TH AVENUE AS IT TURNS INTO MCKAY ROAD. TURN LEFT ONTO EAST 100TH AVENUE. SITE IS LOCATED AT CORNER OF EAST 100TH AVENUE AND RIVERDALE ROAD.

UTILITIES

POWER COMPANY:
Xcel Energy®
CONTACT: TBD
WK: / CELL:

TELCO COMPANY:
TBD
CONTACT: TBD
WK: / CELL:

COLORADO 811 KNOW WHAT'S BELOW. CALL BEFORE YOU DIG.

verizon
3131 S. VAUGHN WAY, SUITE 550
AURORA, CO 80014

PROJECT INFORMATION:
SITE NAME:
DEN HAILSTORM
4229 EAST 100TH AVE.
DENVER, CO 80229
ADAMS COUNTY

REV:	DATE:	DESCRIPTION:	BY:
1	08/04/17	90% ZONING	SA
2	12/12/17	95% ZONING	KR
3	03/21/18	95% ZONING	GW
4	05/08/18	100% ZONING	BB

PLANS PREPARED BY:

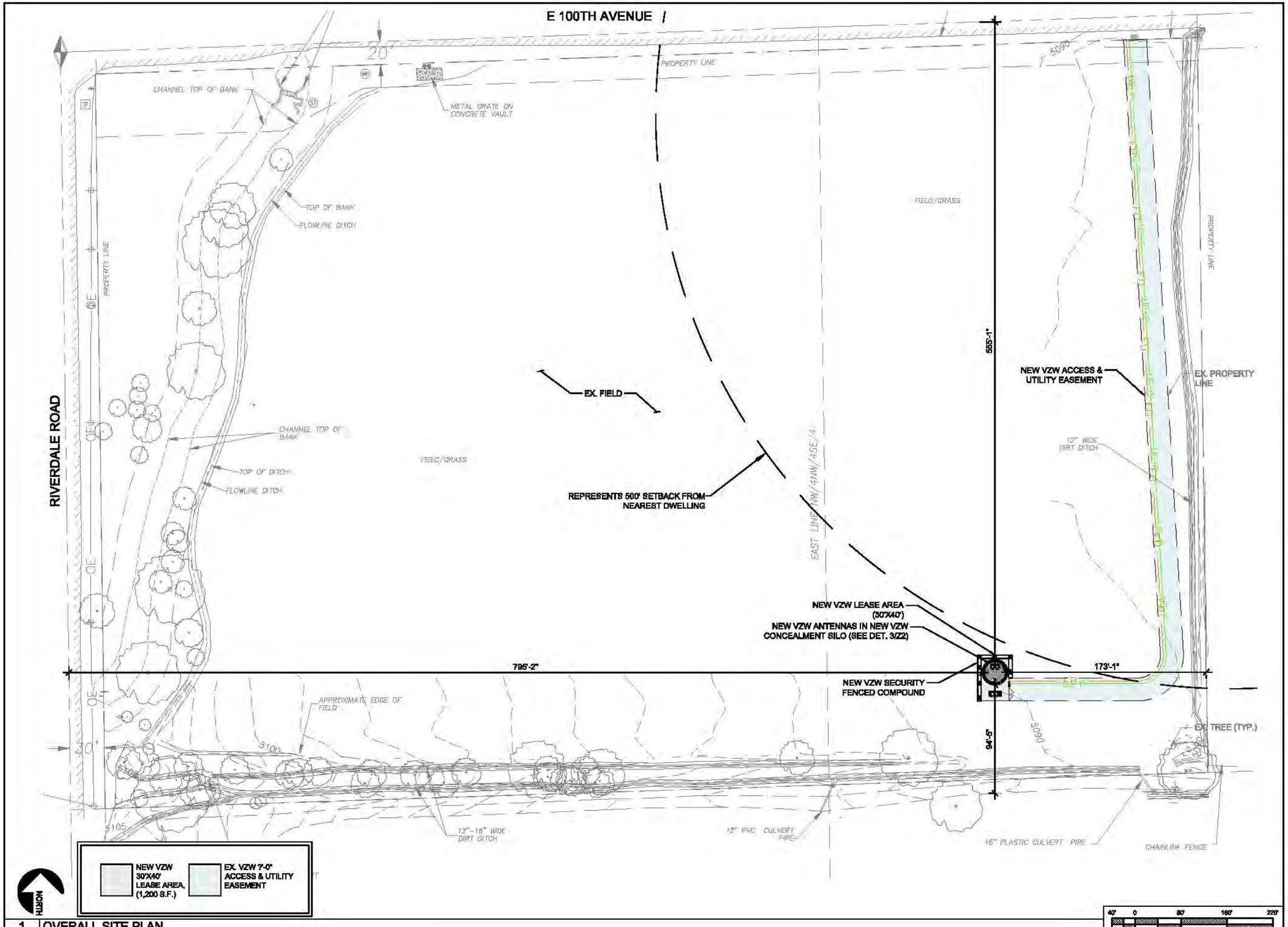
16035 TABLE MOUNTAIN PARKWAY
GOLDEN, CO 80403
303-993-3293
WWW.CENTERLINESOLUTIONS.COM

LICENSURE NO:

DRAWN BY:	CHK BY:	APV BY:
MC	BB	KS

SHEET TITLE:
TITLE SHEET

SHEET NUMBER:
T1



1 OVERALL SITE PLAN

SCALE: 1" = 20'-0"

verizon

3131 S. VAUGHN WAY, SUITE 550
AURORA, CO 80014

PROJECT INFORMATION:

SITE NAME:

DEN HAILSTORM

4229 EAST 100TH AVE.
DENVER, CO 80229

ADAMS COUNTY

REV:	DATE:	DESCRIPTION:	BY:
1	08/04/17	90% ZONING	SA
2	12/12/17	95% ZONING	KR
3	03/21/18	95% ZONING	GW
4	05/08/18	100% ZONING	BB

PLANS PREPARED BY:

16035 TABLE MOUNTAIN PARKWAY
GOLDEN, CO 80403
303-993-3283
WWW.CENTERLINESOLUTIONS.COM

LICENSURE NO:

DRAWN BY:	CHK BY:	APV BY:
MC	BB	KS

SHEET TITLE:

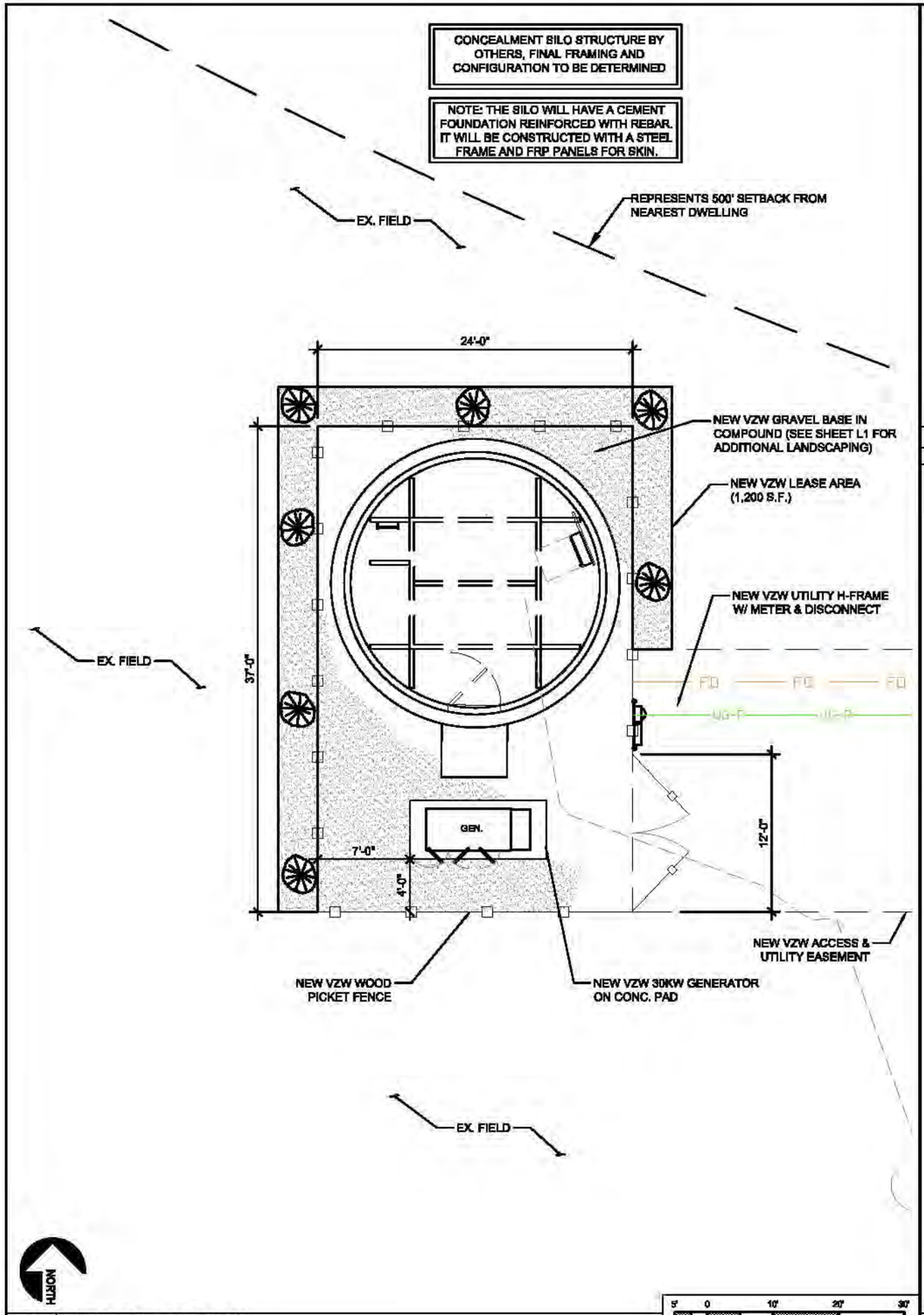
OVERALL SITE PLAN & EXISTING CONDITIONS

SHEET NUMBER:

Z1

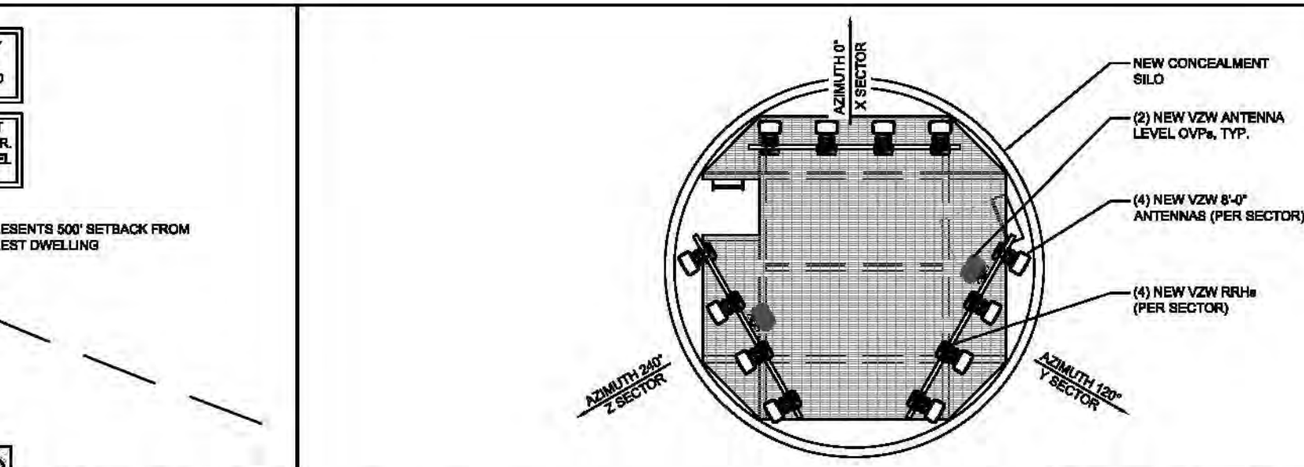
CONCEALMENT SILO STRUCTURE BY OTHERS, FINAL FRAMING AND CONFIGURATION TO BE DETERMINED

NOTE: THE SILO WILL HAVE A CEMENT FOUNDATION REINFORCED WITH REBAR. IT WILL BE CONSTRUCTED WITH A STEEL FRAME AND FRP PANELS FOR SKIN.



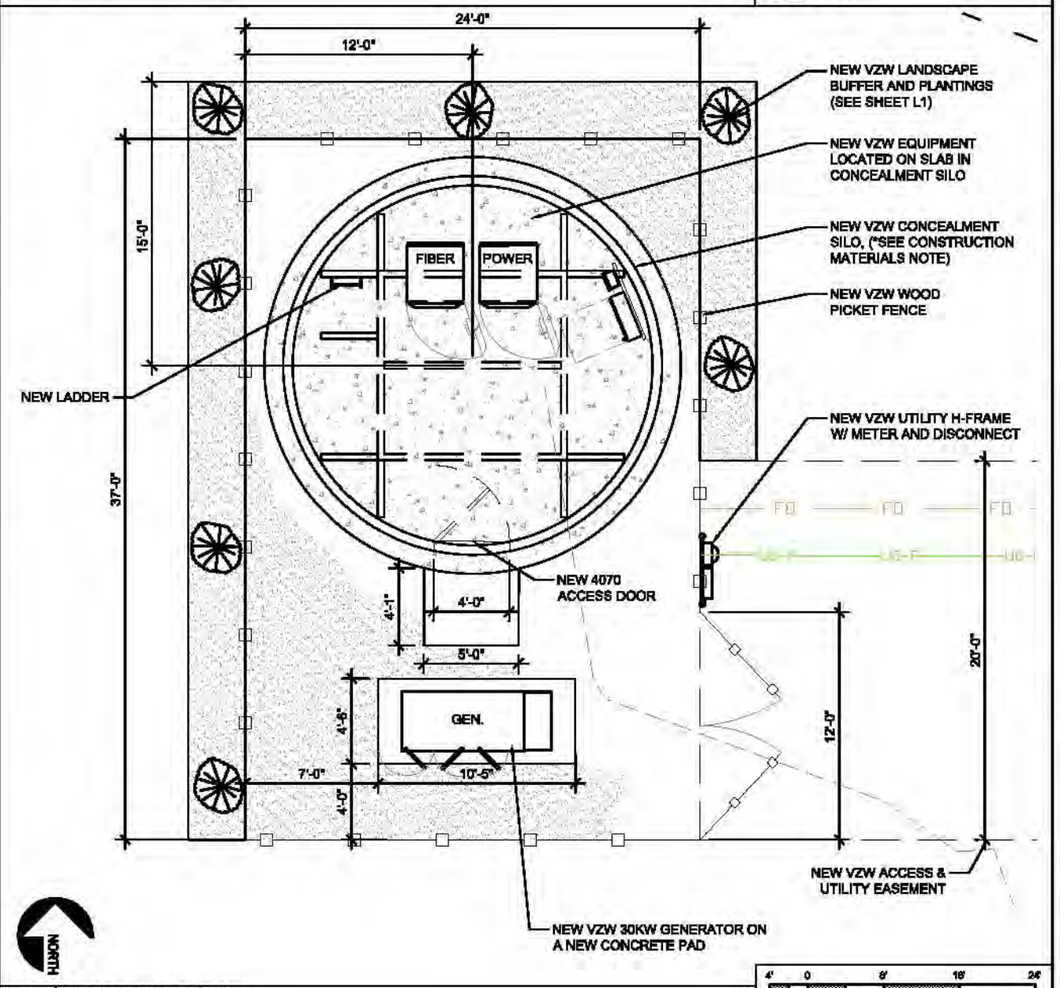
1 ENLARGED SITE PLAN

SCALE: 1" = 20'-0"



3 ANTENNA DETAIL

SCALE: 1/8"=1'-0"



2 EQUIPMENT PLAN

SCALE: 1/8" = 1'-0"

verizon

3131 S. VAUGHN WAY, SUITE 550
AURORA, CO 80014

PROJECT INFORMATION:

SITE NAME:

DEN HAILSTORM

4229 EAST 100TH AVE.
DENVER, CO 80229

ADAMS COUNTY

REV:	DATE:	DESCRIPTION:	BY:
1	08/04/17	90% ZONING	SA
2	12/12/17	95% ZONING	KR
3	03/21/18	95% ZONING	GW
4	05/08/18	100% ZONING	BB

PLANS PREPARED BY:

16035 TABLE MOUNTAIN PARKWAY
GOLDEN, CO 80403
303-993-3283
WWW.CENTERLINESOLUTIONS.COM

LICENSURE NO:

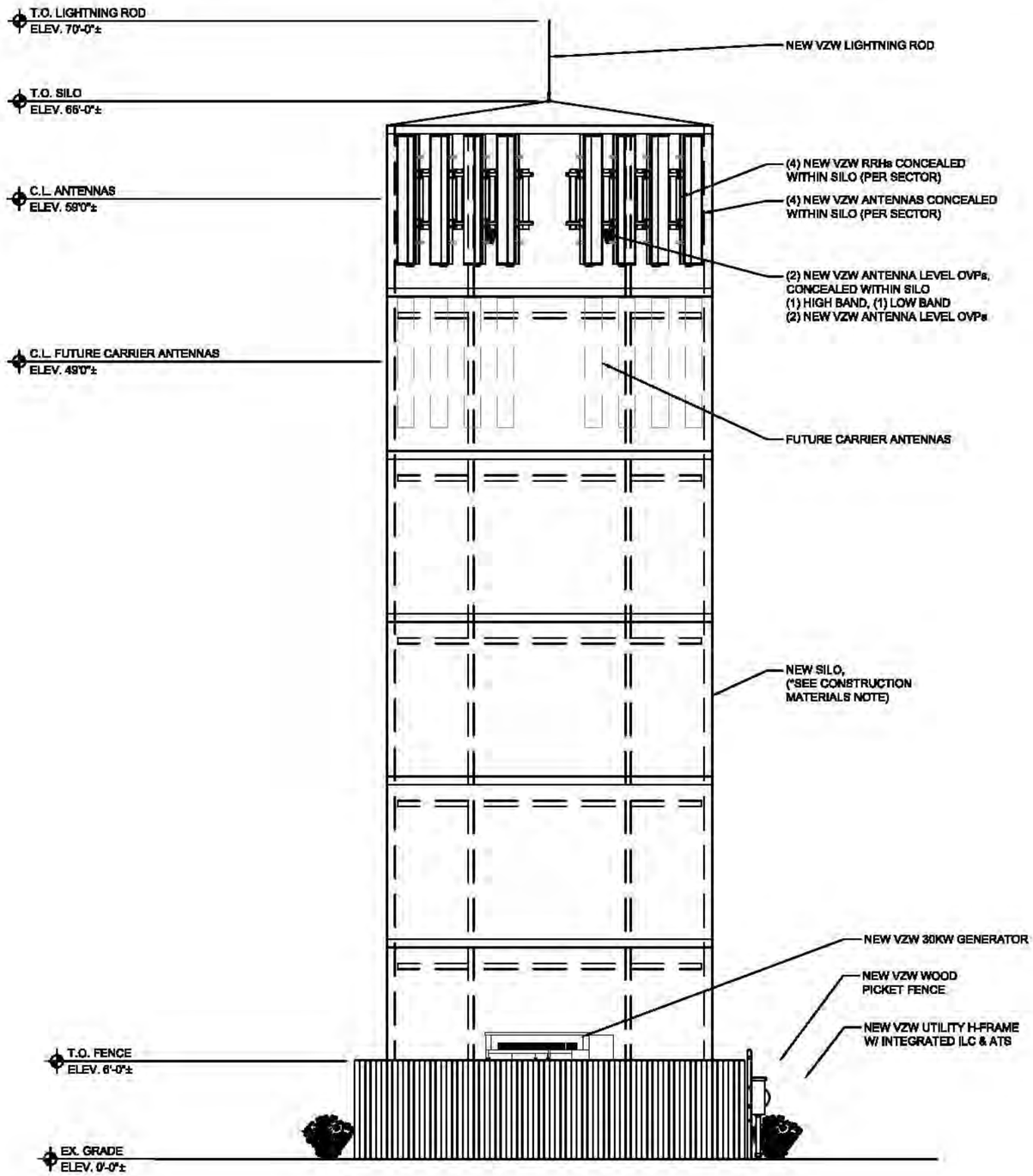
DRAWN BY:	CHK BY:	APV BY:
MC	BB	KS

SHEET TITLE:

ENLARGED SITE PLAN
EQUIPMENT PLAN &
ANTENNA DETAIL

SHEET NUMBER:

Z2



CONCEALMENT SILO STRUCTURE BY OTHERS, FINAL FRAMING AND CONFIGURATION TO BE DETERMINED

*NOTE: THE SILO WILL HAVE A CEMENT FOUNDATION REINFORCED WITH REBAR. IT WILL BE CONSTRUCTED WITH A STEEL FRAME AND FRP PANELS FOR SKIN.

1 SOUTH ELEVATION
SCALE: 1/8" = 1'-0"

4' 0 8' 16' 24'
SCALE: 1/8"=1'-0"

verizon
3131 S. VAUGHN WAY, SUITE 550
AURORA, CO 80014

PROJECT INFORMATION:

SITE NAME:
DEN HAILSTORM

4229 EAST 100TH AVE.
DENVER, CO 80229
ADAMS COUNTY

REV:	DATE:	DESCRIPTION:	BY:
1	08/04/17	90% ZONING	SA
2	12/12/17	95% ZONING	KR
3	03/21/18	95% ZONING	GW
4	05/08/18	100% ZONING	BB

PLANS PREPARED BY:

16035 TABLE MOUNTAIN PARKWAY
GOLDEN, CO 80403
303-993-3283
WWW.CENTERLINESOLUTIONS.COM

LICENSURE NO:

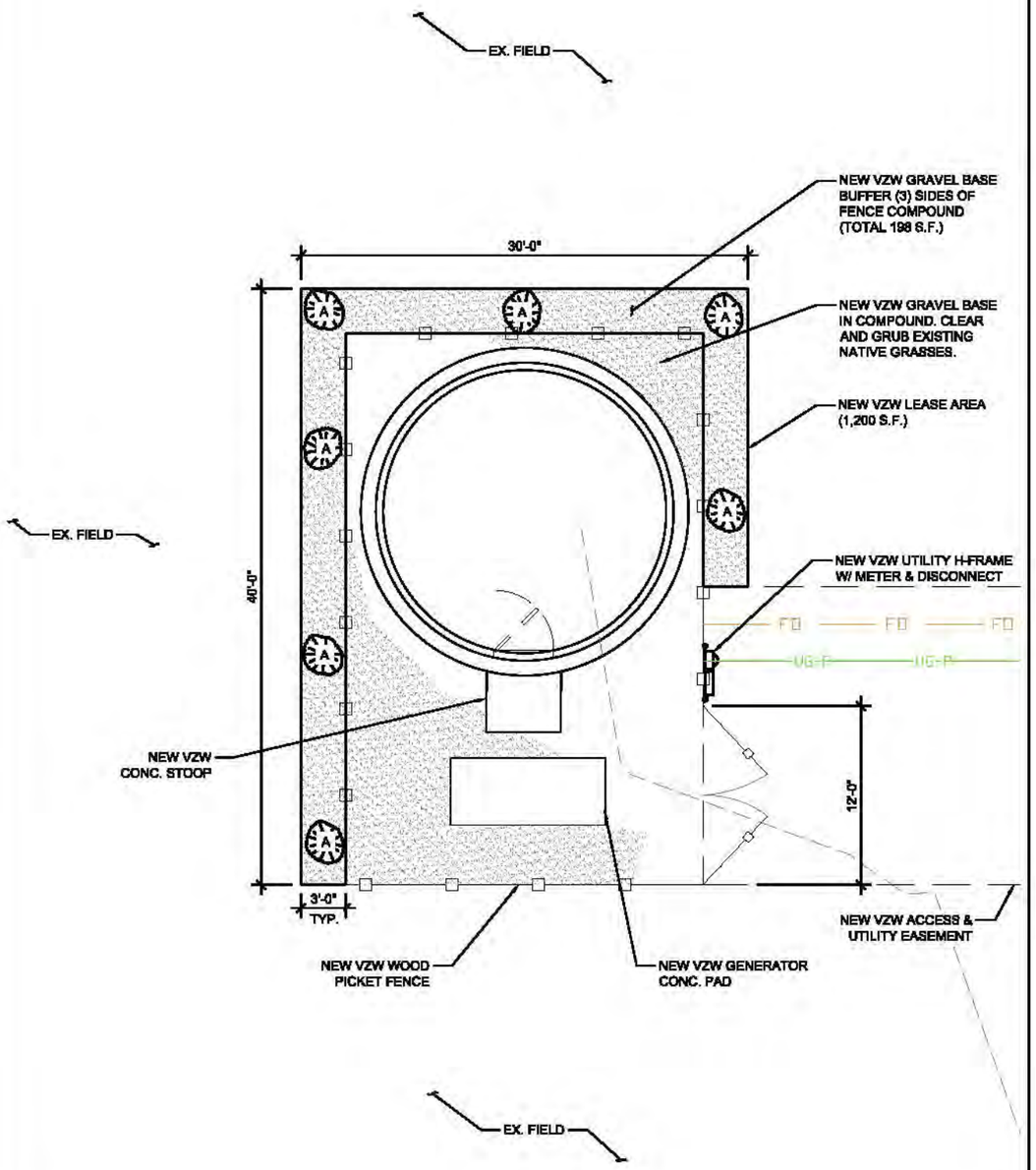
DRAWN BY:	CHK BY:	APV BY:
MC	BB	KS

SHEET TITLE:

SITE ELEVATIONS

SHEET NUMBER:

Z3



1 ENLARGED SITE AREA - LANDSCAPE PLAN

SCALE: 1" = 20'-0"

PLANTING SCHEDULE				
IDENT.	No.	NAME (COMMON, *BOTANICAL - VARIETY*)	SIZE	WATER
A	7	ROCKY MOUNTAIN PENSTEMON *PENSTEMON STRICTUS*	2 GAL.	LOW

2 PLANTING SCHEDULE

SCALE: N.T.S.

verizon
3131 S. VAUGHN WAY, SUITE 550
AURORA, CO 80014

PROJECT INFORMATION:

SITE NAME:

DEN HAILSTORM

4229 EAST 100TH AVE.
DENVER, CO 80229

ADAMS COUNTY

REV:	DATE:	DESCRIPTION:	BY:
1	08/04/17	90% ZONING	SA
2	12/12/17	95% ZONING	KR
3	03/21/18	95% ZONING	GW
4	05/08/18	100% ZONING	BB

PLANS PREPARED BY:

16035 TABLE MOUNTAIN PARKWAY
GOLDEN, CO 80403
303-993-3283
WWW.CENTERLINESOLUTIONS.COM

LICENSURE NO:

DRAWN BY:	CHK BY:	APV BY:
MC	BB	KS

SHEET TITLE:

ENLARGED LANDSCAPE PLAN & PLANTING SCHEDULE

SHEET NUMBER:

L1

Community & Economic
Development Department
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000
Brighton, CO 80601-8204
PHONE 720.523.6800
FAX 720.523.6998

Development Review Team Comments

Date: 11/22/2017

Project Number: RCU2017-00042

Project Name: Verizon Hailstorm

Note to Applicant:

The following review comments and information from the Development Review Team is based on the information you submitted for a Conditional Use Permit. A resubmittal is required. The Development Review Team comments may change if you provide different information during your resubmittal. Please provide the requested information, a response to each review comment, and the attached resubmittal form. Please contact the case manager if you have any questions:

Commenting Division: Building Review

Name of Reviewer: Justin Blair

Date: 10/23/2017

Email: jblair@adcogov.org

No Comment

Commenting Division: Engineering Review

Name of Reviewer: Greg Labrie

Date: 10/23/2017

Email: glabrie@adcogov.org

Resubmittal Required

ENG1: The applicant was required to obtain an access permit/approval onto E. 100th Avenue from the City of Thornton. The permit and/or approval letter was not submitted with the RCU Application.

Commenting Division: Environmental Analyst Review

Name of Reviewer: Jen Rutter

Date: 11/15/2017

Email: jrutter@adcogov.org

No Comment

Commenting Division: Parks Review

Name of Reviewer: Aaron Clark

Date: 10/26/2017

Email: aclark@adcogov.org

No Comment

Commenting Division: Planner Review

Name of Reviewer: Greg Barnes

Date: 11/22/2017

Email: gjbarnes@adcogov.org

Resubmittal Required

PLN01: PROPERTY INFO - The request is located on a 14 acre parcel, which is zoned Agricultural-1 (A-1) and within the Mineral Conservation Overlay district.

PLN02: PROPOSED USE - Commercial telecommunications towers are permitted in the A-1 zone district conditionally, through the conditional use permit process. Criteria for approval of a conditional use permit can be found in Chapter 2 of the Adams County Development Standards and Regulations (DSR).

PLN03: MINERAL CONSERVATION OVERLAY - This site is located within the Mineral Conservation Overlay District. Section 3-37 of the DSR prohibits the construction of permanent structures within the district's boundaries. Should this application proceed, exemption from the Mineral Conservation Overlay District must be obtained. Please see Section 3-37-03-02 "Areas Exempt by the Board of Adjustment" and file a separate variance application before this conditional use permit shall proceed to the Planning Commission and Board of County Commissioners for public hearings.

PLN04: BUILDING MATERIALS - Please provide a description of the building materials used on the structure.

PLN05: COVERAGE MAPS - The coverage maps that were provided seem to be unclear. Will you please provide maps that show coverage both with and without the proposed tower?

PLN06: Please provide a landscape plan. A bond is expected to be provided once landscaping is finalized.

PLN07: REMOVAL BOND - Additionally, a bond is required for removal of the facility (per Section 4-09-02-07). Please provide an estimate for review.

PLN08: SETBACKS – Page Z1 of the site plan submittal illustrates the distance from the center of the structure to the property lines. Please amend this to show the distance of the perimeter of the structure to the property lines.

PLN09: LIGHTING – Will lighting be installed on the structure?

PLN10: LEGAL DESCRIPTION – Please provide a legal description of the proposed lease area that can be copied and pasted into legal notices. There appears to be a legal description on the site plan. A Microsoft Word version is preferred.

Commenting Division: ROW Review

Name of Reviewer: Marissa Hillje

Date: 11/03/2017

Email: mhillje@adcogov.org

Resubmittal Required

ROW1: RIGHT-OF-WAY DEDICATION: Riverdale Rd and E 100th Ave are City of Thornton roads. City of Thornton shall be contacted for additional right-of-way dedication requirements.

ROW2: The access easement shown on the site plan should be recorded and reception number noted on the site plan.

ROW3: TITLE COMMITMENT: Please submit a title commitment which should be used to depict the applicable recordings on the site plan. Please send Adams County a copy of the title commitment with your application dated no later than 30 days to review in order to ensure that any other party's interests are not encroached upon.

Community & Economic
Development Department
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000
Brighton, CO 80601-8204
PHONE 720.523.6800
FAX 720.523.6998

Development Review Team Comments

Date: 4/20/2018

Project Number: RCU2017-00042

Project Name: Verizon Hailstorm

Note to Applicant:

The following review comments and information from the Development Review Team is based on the information you submitted for the conditional use permit application. At this time, it is requested that you resubmit. Please contact the case manager if you have any questions:

Commenting Division: Building Review #2

Name of Reviewer: Justin Blair

Date: 04/02/2018

Email: jblair@adcogov.org

Complete

BSD1- Building permits will be required for the construction of the tower.

Commenting Division: Engineering Review #1

Name of Reviewer: Greg Labrie

Date: 10/23/2017

Email: glabrie@adcogov.org

Resubmittal Required

ENG1: The applicant was required to obtain an access permit/approval onto E. 100th Avenue from the City of Thornton. The permit and/or approval letter was not submitted with the RCU Application.

Commenting Division: Planner Review #2

Name of Reviewer: Greg Barnes

Date: 04/19/2018

Email: gjbarnes@adcogov.org

Resubmittal Required

PLN06A: Landscaping shall be required as required by Section 4-09-02-07(3b) of the Adams County development Standards and Regulations. A minimum of 10% of the site (120 square feet) of landscaping is required. The landscaping should not be enclosed by fencing. Without required landscaping, staff may not be supportive of this request.
PLN07A A bond for removal of the facility must be submitted prior to the issuance of a building permit. We will be recommending a condition precedent of approval to require the bond be in place before a building permit can be issued.

Commenting Division: Engineering Review #2

Name of Reviewer: Greg Labrie

Date: 04/19/2018

Email: glabrie@adcogov.org

Complete

ENG1: As a condition of approval the applicant must submit plans showing the location, material, and width of the proposed access road. Clearly showing how it will tie into the existing road. The plans will also need to show the proposed culvert, detailing the length and material which needs to be RCP and a minimum of 18" diameter. These plans are required to be submitted to the City of Thornton for review and approval. Adams County will require verification from the City of Thornton that the plans were approved.

Commenting Division: ROW Review #2

Name of Reviewer: Marissa Hillje

Date: 04/02/2018

Email: mhillje@adcogov.org

Complete

No other ROW concerns

Commenting Division: Notifications and Referrals Review #2

Name of Reviewer: Greg Barnes

Date: 04/20/2018

Email: gjbarnes@adcogov.org

Resubmittal Required

Commenting Division: Planner Review #1

Name of Reviewer: Greg Barnes

Date: 11/22/2017

Email: gjbarnes@adcogov.org

Resubmittal Required

PLN01: PROPERTY INFO - The request is located on a 14 acre parcel, which is zoned Agricultural-1 (A-1) and within the Mineral Conservation Overlay district.

PLN02: PROPOSED USE - Commercial telecommunications towers are permitted in the A-1 zone district conditionally, through the conditional use permit process. Criteria for approval of a conditional use permit can be found in Chapter 2 of the Adams County Development Standards and Regulations (DSR).

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PLN09: LIGHTING – Will lighting be installed on the structure?

PLN10: LEGAL DESCRIPTION – Please provide a legal description of the proposed lease area that can be copied and pasted into legal notices. There appears to be a legal description on the site plan. A Microsoft Word version is preferred.

Commenting Division: Notifications and Referrals Review #1

Name of Reviewer: Greg Barnes

Date: 11/22/2017

Email: gjbarnes@adcogov.org

Resubmittal Required

Commenting Division: ROW Review #1

Name of Reviewer: Marissa Hillje

Date: 11/03/2017

Email: mhillje@adcogov.org

Resubmittal Required

ROW!: RIGHT-OF-WAY DEDICATION: Riverdale Rd and E 100th Ave are City of Thornton roads. City of Thornton shall be contacted for additional right-of-way dedication requirements.

ROW2: The access easement shown on the site plan should be recorded and reception number noted on the site plan.

ROW3: TITLE COMMITMENT: Please submit a title commitment which should be used to depict the applicable recordings on the site plan. Please send Adams County a copy of the title commitment with your application dated no later than 30 days to review in order to ensure that any other party's interests are not encroached upon.

COLORADO GEOLOGICAL SURVEY

1801 19th Street
Golden, Colorado 80401

Karen Berry
State Geologist

November 17, 2017

Greg Barnes
Adams County
Community & Economic Development
4430 S. Adams County Parkway, Suite W2000A
Brighton, CO 80601

Location:
NW SE Section 18,
T2S, R67W, 6th P.M.
39.877, -104.9295

Subject: Verizon Hailstorm – CUP Application for a Telecommunications Tower
Case No. RCU2017-00042, Adams County, CO; CGS Unique No. AD-18-0006

Dear Mr. Barnes:

Colorado Geological Survey has reviewed the Verizon Hailstorm CUP referral for a 65 ft. commercial telecommunications facility designed to look like a grain silo at 4992 E. 100th Ave., Thornton. With this referral, we received a Request for Comments (October 30, 2017), a location and zoning map, a project description (Centerline Solutions, October 18, 2017), and an Overall Site Plan and Existing Conditions map and Site Elevations (Centerline, August 4, 2017).

The site is approximately 13.5 acres. The proposed Verizon access and utility easement is located along the eastern and southern property boundaries, with the proposed tower centered about 90 feet north and 184 feet west of the southeastern corner. Lower Clear Creek Canal traverses the western portion of the property.

The property is located within Adams County's Mineral Conservation Overlay District, near the edge of a mapped T1 resource. The resource is described* as a stream terrace deposit, resource classification coarse aggregate, consisting of relatively clean and sound gravel. A determination regarding whether this deposit constitutes an economically viable mineral resource would require a site-specific investigation consisting of drilling, sampling, laboratory testing, and analysis. This analysis is outside the scope of CGS review. However, several factors appear to preclude extraction of any potential resource on the subject site: the relatively small size of the property, the presence of the ditch, and nearby residential development (due to noise, air quality, and visual impact concerns). Additionally, the proposed Verizon lease area and access & utility easement are located near the perimeter of the site and would not appear to preclude future resource extraction.

CGS is available to review any analysis required by the county regarding the presence or absence of a resource of commercial quality and quantity. Thank you for the opportunity to review and comment on this project. If you have questions or require additional review, please call me at 303-384-2643, or e-mail carlson@mines.edu.

Sincerely,

Jill Carlson, C.E.G.
Engineering Geologist

* Sand, Gravel and Quarry Aggregate Resources Map, Eastlake Quadrangle, Special Publication 5-B, Atlas of Sand, Gravel, and Quarry Aggregate Resources, Colorado Front Range Counties; Schwochow et al, Colorado Geological Survey Special Publication 5-B, 1974.

Greg Barnes

From: Loeffler - CDOT, Steven [steven.loeffler@state.co.us]
Sent: Tuesday, October 31, 2017 8:18 AM
To: Greg Barnes
Subject: RCU2017-00042, Verizon Hailstorm

Greg,

I have reviewed the referral named above requesting a CUP for a commercial telecommunications tower to be located at 4992 East 100th Ave. and have no objections.

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
2000 S Holly Street, Denver, CO 80222
steven.loeffler@state.co.us | www.codot.gov | www.cotrip.org

Greg Barnes

From: Kuster - CDPHE, Kent [kent.kuster@state.co.us]
Sent: Monday, November 06, 2017 7:12 AM
To: Greg Barnes
Subject: RCU2017-00042

November 6, 2017

Greg Barnes, Case Manager

Community and Economic Development Department

4430 South Adams County Parkway, Suite W2000

Brighton, CO 80601-8204

Re: Case No. RCU2017-00042

Dear Mr. Barnes,

The Colorado Department of Public Health and Environment has no comment for Case No. RCU2017-00042. However, we recommend that the contractor(s) comply with all state and federal environmental rules and regulations. This may require obtaining a permit for regulated activities before emitting or discharging a pollutant into the air or water, dispose of hazardous waste or engaging in certain regulated activities.

Sincerely,

Kent Kuster

Environmental Specialist

Colorado Department of Public Health and Environment

--

Kent Kuster

Environmental Protection Specialist

Colorado Department of Public Health and Environment

4300 Cherry Creek Drive South

Denver, CO 80246-1530

303-692-3662 | kent.kuster@state.co.us

November 21, 2017

Greg Barnes
Adams County Community and Economic Development
4430 South Adams County Parkway, Suite W2000A
Brighton, CO 80601

RE: Verizon Hailstorm, RCU2017-00042
TCHD Case No. 4655

Dear Mr. Barnes,

Thank you for the opportunity to review and comment on the Conditional Use Permit Application for a communications tower, designed to appear as a grain silo, located at 4992 East 100th Avenue. 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 no comments.

Please feel free to contact me at 720-200-1575 or kboyer@tchd.org if you have any questions on TCHD's comments.

Sincerely,

Kathy Boyer, REHS
Environmental Health Specialist III

cc: Sheila Lynch, Monte Deatrich, TCHD

City of Thornton

DEVELOPMENT REVIEW MEMORANDUM

DATE: November 9, 2017

TO: Katelyn Puga, Planning Technician

FROM: Martin Postma, Senior Policy Analyst (Policy Planning Division)

SUBJECT: Verizon Hailstorm (Adams County Case# RCU2017-00042))

LOCATION: SEC 100th and Riverdale Road

Policy Planning has reviewed the above-mentioned referral and has the following comments regarding the 2012 Thornton Comprehensive Plan and other long range planning documents, as they pertain to this application.

I. Comprehensive Plan

The developer proposes to install a cell phone tower disguised as an agricultural silo on land which is located within Thornton's growth area but is not annexed into Thornton at this time.

Thornton does not object to the installation of the facility as proposed.

cc: Glenda Lainis, Policy Planning Manager

Greg Barnes

From: Bob Sullivan [Bob.Sullivan@cityofthornton.net]
Sent: Thursday, November 02, 2017 7:14 PM
To: Greg Barnes
Cc: Stephanie Harpring; Grant Penland
Subject: RE: For Review: Verizon Hailstorm (RCU2017-00042)

Greg,

The Thornton Fire Department does not have any comments regarding this submittal.

Thank you,

Bob Sullivan
Deputy Fire Marshal
Thornton Fire Department
9500 Civic Center Drive
Thornton, CO 80229

Office: 303-538-7651
Fax: 303-538-7660
Email: bob.sullivan@cityofthornton.net

www.cityofthornton.net

From: Greg Barnes [mailto:GJBarnes@adcogov.org]
Sent: Friday, October 27, 2017 3:49 PM
To: Greg Barnes <GJBarnes@adcogov.org>
Subject: For Review: Verizon Hailstorm (RCU2017-00042)

Request for Comments

Case Name: Verizon Hailstorm
Case Number: RCU2017-00042

October 30, 2017

Right of Way & Permits
1123 West 3rd Avenue
Denver, Colorado 80223
Telephone: **303.571.3306**
Facsimile: 303. 571.3284
donna.l.george@xcelenergy.com

November 16, 2017

Adams County Community and Economic Development Department
4430 South Adams County Parkway, 3rd Floor, Suite W3000
Brighton, CO 80601

Attn: Greg Barnes

Re: Verizon Hailstorm, Case # RCU2017-00042

Public Service Company of Colorado's (PSCo) Right of Way & Permits Referral Desk has reviewed the conditional use permit documentation for **Verizon Hailstorm** and has **no apparent conflict**.

Should the project require any new electric service 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). It is then the responsibility of the developer to contact the Designer assigned to the project for approval of design details. Additional easements may need to be acquired by separate document for new facilities.

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.

If you have any questions about this referral response, please contact me at (303) 571-3306.

Donna George
Contract Right of Way Referral Processor
Public Service Company of Colorado

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

Request for Comments

Case Name: Verizon Hailstorm
Case Number: RCU2017-00042

October 30, 2017

The Adams County Planning Commission is requesting comments on the following request: **Conditional use permit application for a commercial telecommunications tower, which will be designed to appear as a grain silo, in the A-1 zone district and Mineral Conservation Overlay District.**

This request is located at 4992 East 100th Avuenue. The Assessor's Parcel Number is 0172118400001. The legal description of the site is: THE NORTHWEST QUARTER (NW 1/4) OF THE NORTHWEST QUARTER (NW 1/4) OF THE SOUTHEAST QUARTER (SE 1/4) AND THE WEST ONE-HALF(W 1/2) OF THE NORTHEAST QUARTER (NE 1/4) OF THE NORTHWEST QUARTER (NW 1/4) OF THE SOUTHEAST QUARTER (SE 1/4) OF SECTION EIGHTEEN (18), TOWNSHIP TWO (2) SOUTH, RANGE SIXTY-SEVEN (67) WEST, EXCEPT ANY PORTION LYING WITHIN THE COUNTY ROADS AND THE RIGHT OF WAY FOR THE D L AND N W RAILROAD. COUNTY OF ADAMS, STATE OF COLORADO.

Applicant Information: Centerline solutions
Greg Dibona
16035 Table Mountain Parkway
Golden, CO 80403

Please forward any written comments on this application to the Community and Economic Development Department at 4430 South Adams County Parkway, Suite W2000A Brighton, CO 80601-8216, (720) 523-6800 by 11/21/2017 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 GJBarnes@adcogov.org.

Once comments have been received and the staff report written, the staff report and notice of public hearing dates may be forwarded to you for your information upon request.

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
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: Verizon Hailstorm
Case Number: RCU2017-00042

Planning Commission Hearing Date: 06/28/2018 at 6:00 p.m.
Board of County Commissioners Hearing Date: 07/17/2018 at 9:30 a.m.

June 7, 2018

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 application for a commercial telecommunications tower, which will be designed to appear as a grain silo, in the A-1 zone district and Mineral Conservation Overlay District.**

The proposed use will be a commercial telecommunications tower. This request is located at 4992 E 100th Avenue on 14.1 acres. The Assessor's Parcel Number is 0172118400001.

Applicant Information: Centerline Solutions
Greg Dibona
16035 Table Mountain Parkway
Golden, CO 80403

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 Community and Economic Development Department, 4430 South 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.

Greg Barnes
Case Manager

PUBLICATION REQUEST

Verizon Hailstorm

Case Number: **RCU2017-00042**

Planning Commission Hearing Date: **06/28/2018 at 6:00 p.m.**

Board of County Commissioners Hearing Date: **07/17/2018 at 10:00 a.m.**

Request: Conditional use permit application for a commercial telecommunications tower, which will be designed to appear as a grain silo, in the A-1 zone district and Mineral Conservation Overlay District.

Location: **4992 E 100TH AVE**

Parcel Number(s): **0172118400001**

Case Manager: **Greg Barnes**

Case Technician: **Megan Ulibarri**

Applicant: **Centerline solutions**
GREG DIBONA **847-257-2489**
16035 TABLE MOUNTAIN PARKWAY
GOLDEN, CO 80403

Owner: **CHELBEK ALEX**
3685 E 121ST AVE
THORNTON, CO 802413585

Legal Description: THE NORTHWEST QUARTER (NW 1/4) OF THE NORTHWEST QUARTER (NW 1/4) OF THE SOUTHEAST QUARTER (SE 1/4) AND THE WEST ONE-HALF(W 1/2) OF THE NORTHEAST QUARTER (NE 1/4) OF THE NORTHWEST QUARTER (NW 1/4) OF THE SOUTHEAST QUARTER (SE 1/4) OF SECTION EIGHTEEN (18), TOWNSHIP TWO (2) SOUTH, RANGE SIXTY-SEVEN (67) WEST, EXCEPT ANY PORTION LYING WITHIN THE COUNTY ROADS AND THE RIGHT OF WAY FOR THE D L AND N W RAILROAD. COUNTY OF ADAMS, STATE OF COLORADO.

Referral Listing
Case Number RCU2017-00042
Verizon Hailstorm

Agency	Contact Information
Adams County Development Services - Building	Justin Blair 4430 S Adams County Pkwy Brighton CO 80601 720-523-6825 JBlair@adcogov.org
ADAMS COUNTY SCHOOL DISTRICT 14	Patrick Sanchez 5291 E. 60th Avenue COMMERCE CITY CO 80022 303-853-3204 psanchez@adams14.org
CDPHE - AIR QUALITY	Richard Coffin 4300 CHERRY CREEK DRIVE SOUTH DENVER CO 80246-1530 303.692.3127 richard.coffin@state.co.us
CDPHE - WATER QUALITY PROTECTION SECT	Patrick Pfaltzgraff 4300 CHERRY CREEK DRIVE SOUTH WQCD-B2 DENVER CO 80246-1530 303-692-3509 patrick.j.pfaltzgraff@state.co.us
CDPHE SOLID WASTE UNIT	Andy Todd 4300 CHERRY CREEK DR SOUTH HMWMD-CP-B2 DENVER CO 80246-1530 303.691.4049 Andrew.Todd@state.co.us
Century Link, Inc	Brandyn Wiedreich 5325 Zuni St, Rm 728 Denver CO 80221 720-578-3724 720-245-0029 brandyn.wiedrich@centurylink.com
CITY OF THORNTON	JASON O'SHEA 9500 CIVIC CENTER DR THORNTON CO 80229 0
CITY OF THORNTON	JASON O'SHEA 9500 CIVIC CENTER DR THORNTON CO 80229 0

Agency	Contact Information
CITY OF THORNTON	JIM KAISER 12450 N WASHINGTON THORNTON CO 80241 720-977-6266
CITY OF THORNTON	JIM KAISER 12450 N WASHINGTON THORNTON CO 80241 720-977-6266
CITY OF THORNTON	Lori Hight 9500 CIVIC CENTER DRIVE THORNTON CO 80229 303-538-7670 developmentsubmittals@cityofthornton.net.
CITY OF THORNTON	Lori Hight 9500 CIVIC CENTER DRIVE THORNTON CO 80229 303-538-7670 developmentsubmittals@cityofthornton.net.
Code Compliance Supervisor	Eric Guenther eguenther@adcogov.org 720-523-6856 eguenther@adcogov.org
COLORADO DEPT OF TRANSPORTATION	Steve Loeffler 2000 S. Holly St. Region 1 Denver CO 80222 303-757-9891 steven.loeffler@state.co.us
COLORADO DIVISION OF WILDLIFE	Eliza Hunholz Northeast Regional Engineer 6060 BROADWAY DENVER CO 80216-1000 303-291-7454 eliza.hunholz@state.co.us
COLORADO DIVISION OF WILDLIFE	Serena Rocksund 6060 BROADWAY DENVER CO 80216 3039471798 serena.rocksund@state.co.us
COMCAST	JOE LOWE 8490 N UMITILLA ST FEDERAL HEIGHTS CO 80260 303-603-5039 thomas_lowe@cable.comcast.com
COUNTY ATTORNEY- Email	Christine Francescani CFrancescani@adcogov.org 6884
Engineering Department - ROW	Transportation Department PWE - ROW 303.453.8787

Agency	Contact Information
Engineering Division	Transportation Department PWE 6875
ENVIRONMENTAL ANALYST	Jen Rutter PLN 6841
LOWER CLEAR CREEK DITCH CO.	Jason Wright PO BOX 701 Eastlake CO 80614 720-977-6506
METRO WASTEWATER RECLAMATION	CRAIG SIMMONDS 6450 YORK ST. DENVER CO 80229 303-286-3338 CSIMMONDS@MWRD.DST.CO.US
NS - Code Compliance	Joaquin Flores 720.523.6207 jflores@adcogov.org
Parks and Open Space Department	Nathan Mosley mpedrucci@adcogov.org aclark@adcogov.org (303) 637-8000 nmosley@adcogov.org
REGIONAL TRANSPORTATION DIST.	CHRIS QUINN 1560 BROADWAY SUITE 700 DENVER CO 80202 303-299-2439 chris.quinn@rtd-denver.com
SHERIFF'S OFFICE: SO-HQ	MICHAEL McINTOSH nblair@adcogov.org, aoverton@adcogov.org; mkaiser@adcogov.org snielson@adcogov.org (303) 654-1850 aoverton@adcogov.org; mkaiser@adcogov.org; snielson@adcogov.org
Sheriff's Office: SO-SUB	SCOTT MILLER TFuller@adcogov.org, smiller@adcogov.org aoverton@adcogov.org; mkaiser@adcogov.org 720-322-1115 smiller@adcogov.org
SOUTH ADAMS CO. FIRE DISTRICT	Randall Weigum 6050 Syracuse Street COMMERCE CITY CO 80022 720-573-9790 FAX: 303-288-5977 rweigum@sacfd.org
THORNTON FIRE DEPARTMENT	Chad Mccollum 9500 Civic Center Drive THORNTON CO 80229-4326 303-538-7602 firedept@cityofthornton.net

Agency	Contact Information
THORNTON FIRE DEPARTMENT	Chad Mccollum 9500 Civic Center Drive THORNTON CO 80229-4326 303-538-7602 firedept@cityofthornton.net
TRI-COUNTY HEALTH DEPARTMENT	Sheila Lynch 6162 S WILLOW DR, SUITE 100 GREENWOOD VILLAGE CO 80111 720-200-1571 landuse@tchd.org
TRI-COUNTY HEALTH DEPARTMENT	MONTE DEATRICH 4201 E. 72ND AVENUE SUITE D COMMERCE CITY CO 80022 (303) 288-6816 mdeatrich@tchd.org
Tri-County Health: Mail CHECK to Sheila Lynch	Tri-County Health landuse@tchd.org .
Xcel Energy	Donna George 1123 W 3rd Ave DENVER CO 80223 303-571-3306 Donna.L.George@xcelenergy.com
Xcel Energy	Donna George 1123 W 3rd Ave DENVER CO 80223 303-571-3306 Donna.L.George@xcelenergy.com

CURRENT RESIDENT
10201 RIVERDALE RD LOT 251
THORNTON CO 80229-2900

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4210 E 100TH AVE LOT 696
THORNTON CO 80229-3038

CURRENT RESIDENT
4210 E 100TH AVE LOT 697
THORNTON CO 80229-3038

CURRENT RESIDENT
4210 E 100TH AVE LOT 698
THORNTON CO 80229-3038

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4210 E 100TH AVE LOT 699
THORNTON CO 80229-3038

CURRENT RESIDENT
4210 E 100TH AVE LOT 700
THORNTON CO 80229-3038

CURRENT RESIDENT
4210 E 100TH AVE LOT 701
THORNTON CO 80229-3038

CURRENT RESIDENT
4210 E 100TH AVE LOT 702
THORNTON CO 80229-3038

CURRENT RESIDENT
4210 E 100TH AVE LOT 703
THORNTON CO 80229-3038

CURRENT RESIDENT
4210 E 100TH AVE LOT 704
THORNTON CO 80229-3038

CURRENT RESIDENT
4210 E 100TH AVE LOT 705
THORNTON CO 80229-3038

CURRENT RESIDENT
4210 E 100TH AVE LOT 706
THORNTON CO 80229-3038

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4210 E 100TH AVE LOT 707
THORNTON CO 80229-3038

CURRENT RESIDENT
4210 E 100TH AVE LOT 708
THORNTON CO 80229-3038

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4210 E 100TH AVE LOT 709
THORNTON CO 80229-3038

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4210 E 100TH AVE LOT 710
THORNTON CO 80229-3038

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4210 E 100TH AVE LOT 711
THORNTON CO 80229-3038

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4210 E 100TH AVE LOT 712
THORNTON CO 80229-3038

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4210 E 100TH AVE LOT 713
THORNTON CO 80229-3038

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4210 E 100TH AVE LOT 741
THORNTON CO 80229-3039

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THORNTON CO 80229-3039

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THORNTON CO 80229-3039

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4210 E 100TH AVE LOT 746
THORNTON CO 80229-3039

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4210 E 100TH AVE LOT 747
THORNTON CO 80229-3039

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THORNTON CO 80229-3039

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4210 E 100TH AVE LOT 750
THORNTON CO 80229-3039

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4210 E 100TH AVE LOT 751
THORNTON CO 80229-3039

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4210 E 100TH AVE LOT 752
THORNTON CO 80229-3039

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4210 E 100TH AVE LOT 753
THORNTON CO 80229-3039

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4210 E 100TH AVE LOT 760
THORNTON CO 80229-3039

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4210 E 100TH AVE LOT 761
THORNTON CO 80229-3039

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4210 E 100TH AVE LOT 762
THORNTON CO 80229-3039

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4210 E 100TH AVE LOT 763
THORNTON CO 80229-3039

CURRENT RESIDENT
4210 E 100TH AVE LOT 764
THORNTON CO 80229-3039

CURRENT RESIDENT
4210 E 100TH AVE LOT 765
THORNTON CO 80229-3039

CURRENT RESIDENT
4211 E 100TH AVE LOT 292
THORNTON CO 80229-3040

CURRENT RESIDENT
4211 E 100TH AVE LOT 293
THORNTON CO 80229-3040

CURRENT RESIDENT
4211 E 100TH AVE LOT 294
THORNTON CO 80229-3040

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4211 E 100TH AVE LOT 295
THORNTON CO 80229-3040

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4211 E 100TH AVE LOT 296
THORNTON CO 80229-3040

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4211 E 100TH AVE LOT 297
THORNTON CO 80229-3040

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4211 E 100TH AVE LOT 298
THORNTON CO 80229-3040

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4211 E 100TH AVE LOT 299
THORNTON CO 80229-3040

CURRENT RESIDENT
4210 E 100TH AVE LOT 497
THORNTON CO 80229-3041

CURRENT RESIDENT
4210 E 100TH AVE LOT 498
THORNTON CO 80229-3041

CURRENT RESIDENT
4210 E 100TH AVE LOT 499
THORNTON CO 80229-3041

CURRENT RESIDENT
4210 E 100TH AVE LOT 564
THORNTON CO 80229-3042

CURRENT RESIDENT
4210 E 100TH AVE LOT 565
THORNTON CO 80229-3042

CURRENT RESIDENT
4210 E 100TH AVE LOT 645
THORNTON CO 80229-3043

CURRENT RESIDENT
4210 E 100TH AVE LOT 646
THORNTON CO 80229-3043

CURRENT RESIDENT
4210 E 100TH AVE LOT 647
THORNTON CO 80229-3043

CURRENT RESIDENT
4210 E 100TH AVE LOT 648
THORNTON CO 80229-3043

CURRENT RESIDENT
4210 E 100TH AVE LOT 649
THORNTON CO 80229-3043

CURRENT RESIDENT
4210 E 100TH AVE LOT 650
THORNTON CO 80229-3043

CURRENT RESIDENT
4210 E 100TH AVE LOT 651
THORNTON CO 80229-3043

CURRENT RESIDENT
4210 E 100TH AVE LOT 652
THORNTON CO 80229-3043

CURRENT RESIDENT
4210 E 100TH AVE LOT 678
THORNTON CO 80229-3044

CURRENT RESIDENT
4210 E 100TH AVE LOT 679
THORNTON CO 80229-3044

CURRENT RESIDENT
4210 E 100TH AVE LOT 680
THORNTON CO 80229-3044

CURRENT RESIDENT
4210 E 100TH AVE LOT 681
THORNTON CO 80229-3044

CURRENT RESIDENT
4210 E 100TH AVE LOT 682
THORNTON CO 80229-3044

CURRENT RESIDENT
4210 E 100TH AVE LOT 683
THORNTON CO 80229-3044

CURRENT RESIDENT
4210 E 100TH AVE LOT 684
THORNTON CO 80229-3044

CURRENT RESIDENT
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THORNTON CO 80229-3044

CURRENT RESIDENT
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THORNTON CO 80229-3044

CURRENT RESIDENT
4210 E 100TH AVE LOT 739
THORNTON CO 80229-3045

CURRENT RESIDENT
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THORNTON CO 80229-3045

CURRENT RESIDENT
4210 E 100TH AVE LOT 530
THORNTON CO 80229-3046

CURRENT RESIDENT
4210 E 100TH AVE LOT 531
THORNTON CO 80229-3046

CURRENT RESIDENT
4210 E 100TH AVE LOT 532
THORNTON CO 80229-3046

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4210 E 100TH AVE LOT 533
THORNTON CO 80229-3046

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4210 E 100TH AVE LOT 534
THORNTON CO 80229-3046

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4210 E 100TH AVE LOT 535
THORNTON CO 80229-3046

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4210 E 100TH AVE LOT 536
THORNTON CO 80229-3046

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4210 E 100TH AVE LOT 537
THORNTON CO 80229-3046

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4210 E 100TH AVE LOT 538
THORNTON CO 80229-3046

CURRENT RESIDENT
4210 E 100TH AVE LOT 591
THORNTON CO 80229-3047

CURRENT RESIDENT
4210 E 100TH AVE LOT 592
THORNTON CO 80229-3047

CURRENT RESIDENT
4210 E 100TH AVE LOT 766
THORNTON CO 80229-3048

CURRENT RESIDENT
5115 E 100TH AVE
THORNTON CO 80229-3103

CURRENT RESIDENT
5100 E 100TH AVE
THORNTON CO 80229-3104

CURRENT RESIDENT
5150 E 100TH AVE
DENVER CO 80229-3104

CURRENT RESIDENT
5240 E 100TH AVE
DENVER CO 80229-3106

CURRENT RESIDENT
4901 E 100TH AVE
THORNTON CO 80229-3109

CURRENT RESIDENT
4993 E 100TH AVE
THORNTON CO 80229-3109

CURRENT RESIDENT
5015 E 100TH AVE
THORNTON CO 80229-3110

CURRENT RESIDENT
5490 E 100TH AVE
DENVER CO 80229-3405

CURRENT RESIDENT
4884 E 101ST CT
THORNTON CO 80229-3440

CURRENT RESIDENT
4894 E 101ST CT
THORNTON CO 80229-3440

CURRENT RESIDENT
4904 E 101ST CT
THORNTON CO 80229-3440

CURRENT RESIDENT
4914 E 101ST CT
THORNTON CO 80229-3440

CURRENT RESIDENT
4924 E 101ST CT
THORNTON CO 80229-3440

CURRENT RESIDENT
4887 E 100TH LN
THORNTON CO 80229-3441

CURRENT RESIDENT
4897 E 100TH LN
THORNTON CO 80229-3441

CURRENT RESIDENT
4907 E 100TH LN
THORNTON CO 80229-3441

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4917 E 100TH LN
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4927 E 100TH LN
THORNTON CO 80229-3441

CURRENT RESIDENT
4937 E 100TH LN
THORNTON CO 80229-3441

CURRENT RESIDENT
5007 E 100TH LN
THORNTON CO 80229-3442

CURRENT RESIDENT
4882 E 100TH LN
THORNTON CO 80229-3448

CURRENT RESIDENT
4892 E 100TH LN
THORNTON CO 80229-3448

CURRENT RESIDENT
4912 E 100TH LN
THORNTON CO 80229-3449

CURRENT RESIDENT
4922 E 100TH LN
THORNTON CO 80229-3449

CURRENT RESIDENT
4932 E 100TH LN
THORNTON CO 80229-3449

CURRENT RESIDENT
5002 E 100TH LN
THORNTON CO 80229-3450

CURRENT RESIDENT
5012 E 100TH LN
THORNTON CO 80229-3450

CURRENT RESIDENT
5022 E 100TH LN
THORNTON CO 80229-3450

CURRENT RESIDENT
5102 E 100TH LN
THORNTON CO 80229-3451

CURRENT RESIDENT
4885 E 100TH DR
THORNTON CO 80229-3458

CURRENT RESIDENT
4895 E 100TH DR
THORNTON CO 80229-3458

CURRENT RESIDENT
4915 E 100TH DR
THORNTON CO 80229-3459

CURRENT RESIDENT
4925 E 100TH DR
THORNTON CO 80229-3459

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4935 E 100TH DR
THORNTON CO 80229-3459

CURRENT RESIDENT
4880 E 100TH DR
THORNTON CO 80229-3460

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4890 E 100TH DR
THORNTON CO 80229-3460

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4900 E 100TH DR
THORNTON CO 80229-3460

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THORNTON CO 80229-3460

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4920 E 100TH DR
THORNTON CO 80229-3460

CURRENT RESIDENT
4930 E 100TH DR
THORNTON CO 80229-3460

CURRENT RESIDENT
5000 E 100TH DR
THORNTON CO 80229-3461

CURRENT RESIDENT
5010 E 100TH DR
THORNTON CO 80229-3461

CURRENT RESIDENT
5020 E 100TH DR
THORNTON CO 80229-3461

CURRENT RESIDENT
5100 E 100TH DR
THORNTON CO 80229-3462

CURRENT RESIDENT
5110 E 100TH DR
THORNTON CO 80229-3462

CURRENT RESIDENT
5120 E 100TH DR
THORNTON CO 80229-3462

CURRENT RESIDENT
5005 E 100TH DR
THORNTON CO 80229-3465

CURRENT RESIDENT
5015 E 100TH DR
THORNTON CO 80229-3465

CURRENT RESIDENT
5025 E 100TH DR
THORNTON CO 80229-3465

CURRENT RESIDENT
5105 E 100TH DR
THORNTON CO 80229-3466

CURRENT RESIDENT
5115 E 100TH DR
THORNTON CO 80229-3466

CURRENT RESIDENT
4918 E 100TH CT
THORNTON CO 80229-3471

CURRENT RESIDENT
4928 E 100TH CT
THORNTON CO 80229-3471

CURRENT RESIDENT
4938 E 100TH CT
THORNTON CO 80229-3471

CURRENT RESIDENT
5008 E 100TH CT
THORNTON CO 80229-3472

CURRENT RESIDENT
5018 E 100TH CT
THORNTON CO 80229-3472

CURRENT RESIDENT
5028 E 100TH CT
THORNTON CO 80229-3472

CURRENT RESIDENT
5108 E 100TH CT
THORNTON CO 80229-3473

CURRENT RESIDENT
5118 E 100TH CT
THORNTON CO 80229-3473

CURRENT RESIDENT
5128 E 100TH CT
THORNTON CO 80229-3473

CURRENT RESIDENT
5013 E 100TH CT
THORNTON CO 80229-3474

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THORNTON CO 80229-3474

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5033 E 100TH CT
THORNTON CO 80229-3474

CURRENT RESIDENT
5113 E 100TH CT
THORNTON CO 80229-3475

CURRENT RESIDENT
5123 E 100TH CT
THORNTON CO 80229-3475

CURRENT RESIDENT
5133 E 100TH CT
THORNTON CO 80229-3475

CURRENT RESIDENT
4923 E 100TH CT
THORNTON CO 80229-3485

CURRENT RESIDENT
4933 E 100TH CT
THORNTON CO 80229-3485

CURRENT RESIDENT
4943 E 100TH CT
THORNTON CO 80229-3485

ADEMOVIC SENAD AND
ADEMOVIC NEDZIBA
4885 E 100TH DRIVE
THORNTON CO 80229

AL RASHIDI KIM AND
AL RASHIDI ABDULRAHMAN
4922 E 100TH LN
DENVER CO 80229-3449

AMC PINE LAKES RANCH LLC
PO BOX 790830
SAN ANTONIO TX 78279-0830

ARAGON JOHN AND
ARAGON GINA
5012 E 100TH LANE
THORNTON CO 80229

BEHNEN MICHAEL J AND
BEHNEN SARAH K
4769 E 98TH PL
THORNTON CO 80229-3225

BEJARANO HORACIO
4993 E 100TH AVENUE
THORNTON CO 80229

BUSSEY GREGORY A
5028 E 100TH CT
DENVER CO 80229-3472

CANO LUIS ALBERTO MARTINEZ
5123 E 100TH CT
THORNTON CO 80229-3475

CARRENDER EMILY
4938 E 100TH CT
THORNTON CO 80229-3471

CASTILLO JOSE M AND
BOOTH SARAH
4943 E 100TH CT
THORNTON CO 80229-3485

CHABALIN ALEXEI
4918 E 100TH CT
THORNTON CO 80229-3471

CHELBEK ALEX
3685 E 121ST AVE
THORNTON CO 80241-3585

CHENG SO YAM HUI
4789 E 98TH PL
THORNTON CO 80229-3225

CITY OF THORNTON
9500 CIVIC CENTER DR
THORNTON CO 80229

CONTRERAS SANTOS IRVING
4907 E 100TH LN
THORNTON CO 80229-3441

COOK-READ JULIE ANN
4793 E 98TH PL
THORNTON CO 80229-3225

CORAL PROPERTIES LLC
3801 E FLORIDA AVE SUITE 400
DENVER CO 80210

CRANDALL STEVE D JR AND LESLIE A
5025 E 100TH DR
THORNTON CO 80229

CSH 2016-1 BORROWER LLC
8665 E HARTFORD DR STE 200
SCOTTSDALE AZ 85255-7807

DIETZ CHRISTOPHER R AND
MEYERDIERKS LISA I
4894 E 101ST COURT
THORNTON CO 80229

FARMINGTON HOMEOWNERS ASSOCIATION INC
5855 WADSWORTH BY-PASS BLDG B NO. 100
ARVADA CO 80003

FISCHER JAMES
4912 E 100TH LN
THORNTON CO 80229-3449

FREDERICK EARL E/FREDERICK SHARLENE
MCMINN REVOCABLE TRUST
1313 N LEA AVE
ROSWELL NM 88201-5036

GAMUEDA ANTHONY ET AL
5991 E 100TH AVE
DENVER CO 80229-3403

GRACIANO JUAN AND
TRINIDAD MARIA DE JESUS CARDENAS
4917 E 100TH LN
THORNTON CO 80229-3441

HABEL ANDREW T
4923 E 100TH CT
THORNTON CO 80229

HERNANDEZ MARISOL
4932 E 100TH LN
THORNTON CO 80229-3449

HERRERA JOSE AND YOLANDA
5118 E 100TH CT
THORNTON CO 80229

HOOVER JEDEDIAH D
4779 E 98TH PL
THORNTON CO 80229-3225

HUI KA WAI
4777 E 98TH PL
THORNTON CO 80229-3225

JARVIS WAYNE AND JARVIS DEBBIE
5013 E 100TH COURT
THORNTON CO 80229

KEALY CATHERINE A
4910 E 100TH DRIVE
THORNTON CO 80229

KHAU TRUC TRUNG DANG
5008 E 100TH CT
THORNTON CO 80229-3472

KSE RADIO VENTURES LLC
1000 CHOPPER CIR
DENVER CO 80204-5805

LABONTE JASON RYAN AND
LABONTE LEAH MARIE
4765 E 98TH PL
THORNTON CO 80229-3225

LAURINA PETER
5133 E 100TH CT
THORNTON CO 80229-3475

LEWIS RICHARD F AND LEWIS PHYLLIS M
30185 E 166TH AVE
BRIGHTON CO 80603-8477

MARTIN REGGIE LEE
5128 E 100TH CT
DENVER CO 80229-3473

MARTINEZ SERGIO GARCIA
5113 E 100TH CT
THORNTON CO 80229-3475

MASIH TARIQ
4900 E 100TH DR
THORNTON CO 80229-3460

MATTHEWS DEREK A
4882 E 100TH LANE
THORNTON CO 80229

MCMINN J MICHAEL
5015 E 100TH DR
DENVER CO 80229-3465

MERCURY FOUR LLC
2419 S DAHLIA LN
DENVER CO 80222-6119

MONTANO SORAIDA
5033 E 100TH CT
DENVER CO 80229-3474

MONTOYA FRANK KIKO AND
MONTOYA DARCI M
4884 E 101ST COURT
THORNTON CO 80229

NGUYEN BINH MINH THI
9446 STEELE DR
THORNTON CO 80229-3924

ORONIA ENEDINA AND
ORONIA MARIA E
5105 E 100TH DR
THORNTON CO 80229-3466

PHOUTHAVONG ERICKSON
4895 E 100TH DR
THORNTON CO 80229-3458

POLANCO INES M
4915 E 100TH DR
THORNTON CO 80229-3459

PORTILLO JOSE AND
HERRERA-GALLEGOS HERMENEGILDA
4890 E 100TH DR
THORNTON CO 80229-3460

POWERS ERIC G AND
POWERS ROSLYN
4887 E 100TH LANE
THORNTON CO 80229

QUEZADA RODRIGO AND
QUEZADA RITA
5007 E 100TH LANE
THORNTON CO 80229

QUINTO RAY R AND QUINTO AGNES B TRUSTEES
OF THE QUINTO FAMILY REVOCABLE TRUST
10961 DESERT LAWN DR NO. 333
CALIMESA CA 92320

RAN JIANGUANG AND
MAILES SHIRA A
4937 E 100TH LN
THORNTON CO 80229-3441

RICH MATTHEW AND
RICH COURTNEY
5022 E 100TH LANE
THORNTON CO 80229

RIVER VALLEY VILLAGE HOMEOWNERS
ASSOCIATION INC/C/O HOMEOWNERS ASSOC
2323 S TROY SUITE 5-310
AURORA CO 80014

ROCKY MOUNTAIN HOME SOLUTIONS LLC
5023 W 120TH AVE STE 216
BROOMFIELD CO 80020-5606

ROCKY MOUNTAIN INVESTORS LLC
10532 W 84TH PL
ARVADA CO 80005-4708

RODRIGUEZ MARIA T
5015 E 100TH AVE
THORNTON CO 80229

ROMERO JEANNETTE I
5023 E 100TH COURT
THORNTON CO 80229

ROSA CARIN KAY
11587 JASPER ST
COMMERCE CITY CO 80022-8714

ROSA DONALD J
5150 E 100TH AVE
DENVER CO 80229-3104

ROSA JOHN S JR
5240 E 100TH AVE
DENVER CO 80229-3106

ROYBAL JOSE R
4928 E 100TH CT
DENVER CO 80229-3471

RUTLEDGE EDWIN DEAN
5115 E 100TH AVE
DENVER CO 80229-3103

SCHINDLER STEVEN AND
SCHINDLER TRACY
5120 E 100TH DR
THORNTON CO 80229-3462

SCHNABEL MICHAEL
16684 MINERS WAY
BROOMFIELD CO 80023-4689

SEPULVEDA MARCO
4892 E 100TH LANE
THORNTON CO 80229

SOTO JESUS AND
PENA ALVARADO ESMERALDA
4924 E 101ST CT
THORNTON CO 80229-3440

STEVENS GARY WILLIAM
4773 E 98TH PL
THORNTON CO 80229-3225

SURE FIX PROPERTIES LLC
7787 MCINTYRE COURT
ARVADA CO 80007

TOMKO CHARLES SCOTT
12570 2ND ST
THORNTON CO 80241-3801

TORRES JOSUE
4795 E 98TH PL
THORNTON CO 80229-3225

TURNER RONALD L
5000 E 100TH DRIVE
THORNTON CO 80229

TYRA D1 LLC
C/O SCOTT WOLF
LONGMONT CO 80503-9009

VALDEZ-PEREZ ANTONIO AND
VALDEZ SANDRO
4904 E 101ST CT
THORNTON CO 80229-3440

VILLALPANDO CARLOS
4933 E 100TH CT
THORNTON CO 80229-3485

VILLALPANDO JOSE AND
HERRERA MARIA
5102 E 100TH LN
DENVER CO 80229-3451

VILLANUEVA JANEL RAE
4925 E 100TH DR
DENVER CO 80229-3459

VUTOV MICHAEL DIMITER
4935 E 100TH DR
THORNTON CO 80229-3459

WALTER JEREMY
5100 E 100TH AVE
DENVER CO 80229-3104

WEAVER PATRICIA ANN
5020 E 100TH DRIVE
THORNTON CO 80229

WENDLAND DARCY A
2525 E 104TH AVE UNIT 314
DENVER CO 80233-6196

WONG CHOI FUNG AND
HUI KA LOK
4791 E 98TH PL
DENVER CO 80229-3225

WOOD STEPHANIE J
4930 E 100TH DRIVE
THORNTON CO 80229

WOOD STEPHEN DAVID
4785 E 98TH PL
THORNTON CO 80229-3225

XU MING FU
5108 E 100TH CT
THORNTON CO 80229-3473

YU XIUYANG AND LU WEINING
14048 WILLOW WOOD CT
BROOMFIELD CO 80020-6176

CERTIFICATE OF POSTING

I, J. Gregory Barnes do hereby certify that I posted the property at 4992 East 100th Avenue on June 5, 2018 in accordance with the requirements of the Adams County Zoning Regulations.

J. Gregory Barnes

ADAMS COUNTY
COLORADO

Community & Economic Development Department
4430 South Adams County Parkway,
1st Floor, Suite W2000
Brighton, CO 80601-8205
PHONE 720.523.6800 FAX 720.523.6998

MEMORANDUM

To: Board of County Commissioners

From: J. Gregory Barnes, Planner II

Subject: Verizon Hailstorm / Case # RCU2017-00042

Date: July 10, 2018

If the Board of County Commissioners does not concur with the Staff recommendation of Approval, the following findings may be adopted as part of a decision of Denial:

ALTERNATIVE RECOMMENDED FINDINGS FOR DENIAL

1. The conditional use is not permitted in the applicable zone district.
2. The conditional use is inconsistent with the purposes of these standards and regulations.
3. The conditional use will not comply with the requirements of these standards and regulations, including but not limited to, all applicable performance standards.
4. The conditional use is incompatible with the surrounding area, not harmonious with the character of the neighborhood, detrimental to the immediate area, detrimental to the future development of the area, and detrimental to the health, safety, or welfare of the inhabitants of the area and the County.
5. The conditional use permit has not addressed all off-site impacts.
6. The site is unsuitable for the proposed conditional use including inadequate usable space, inadequate access, and presence of environmental constraints.
7. The site plan for the proposed conditional use will not 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 not available and adequate to serve the needs of the conditional use as designed and proposed.

Verizon Hailstorm

RCU2017-00042

4992 E. 100th Avenue

July 17, 2018

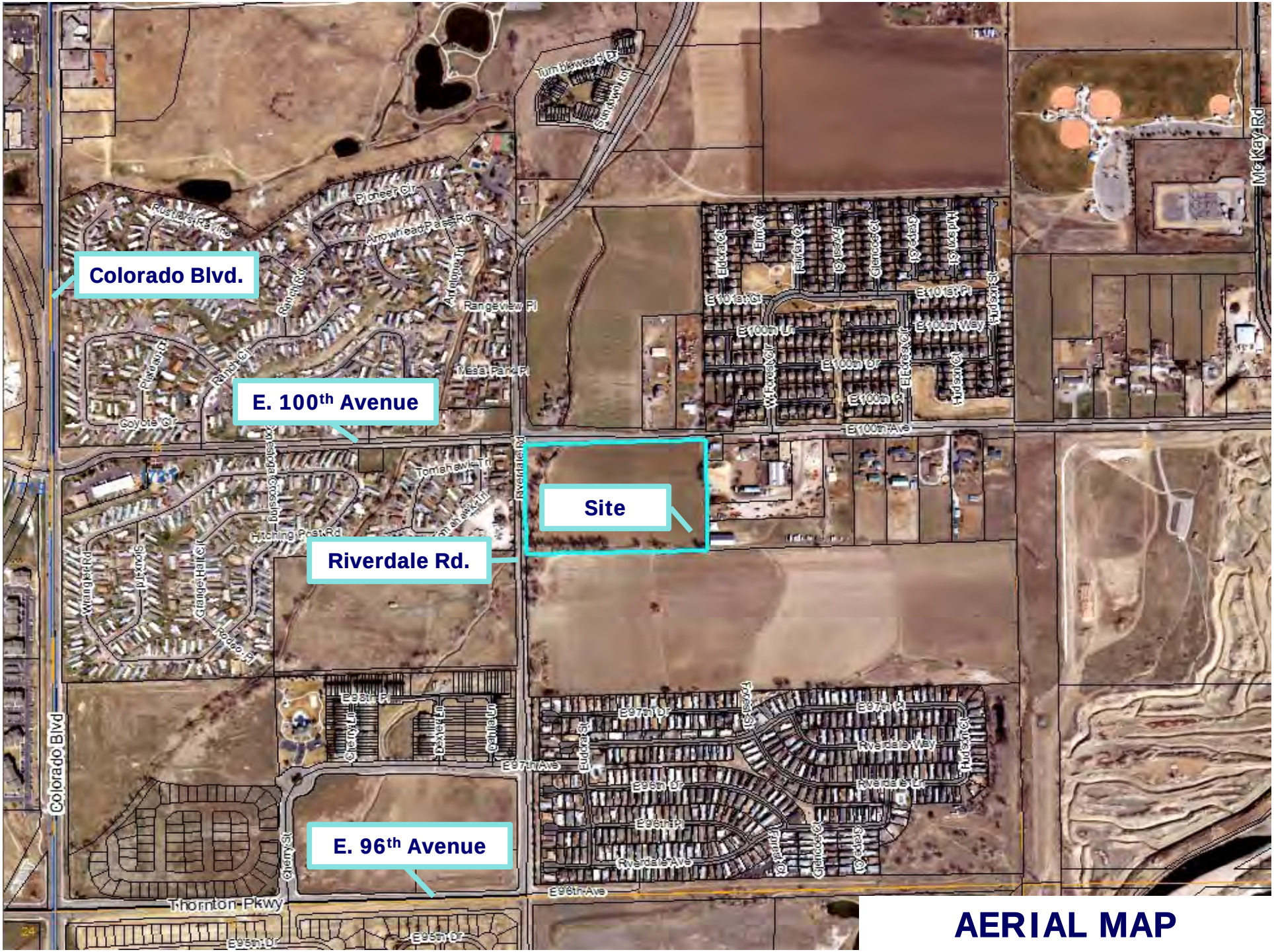
Board of County Commissioners Public Hearing

Community and Economic Development Department

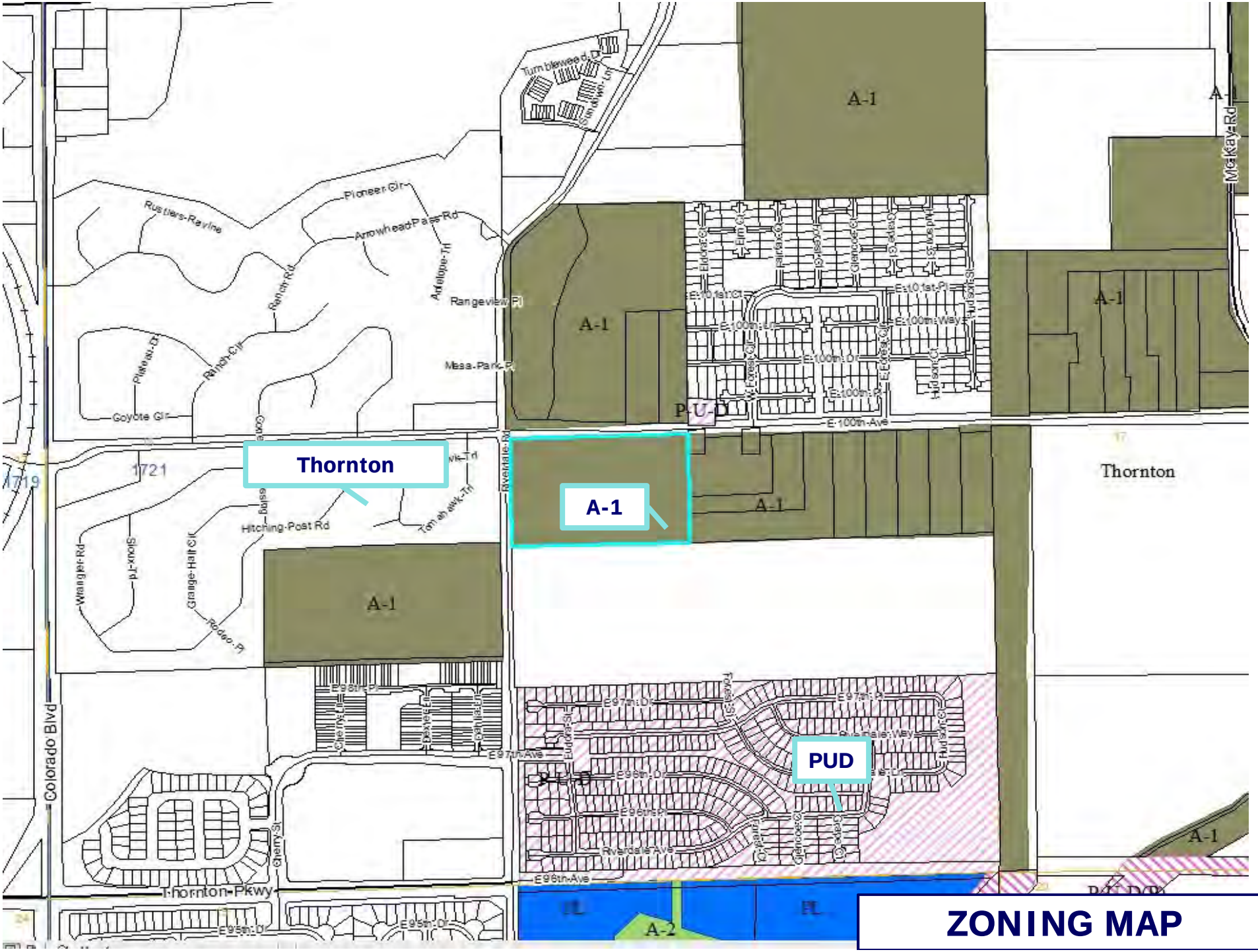
Case Manager: Greg Barnes

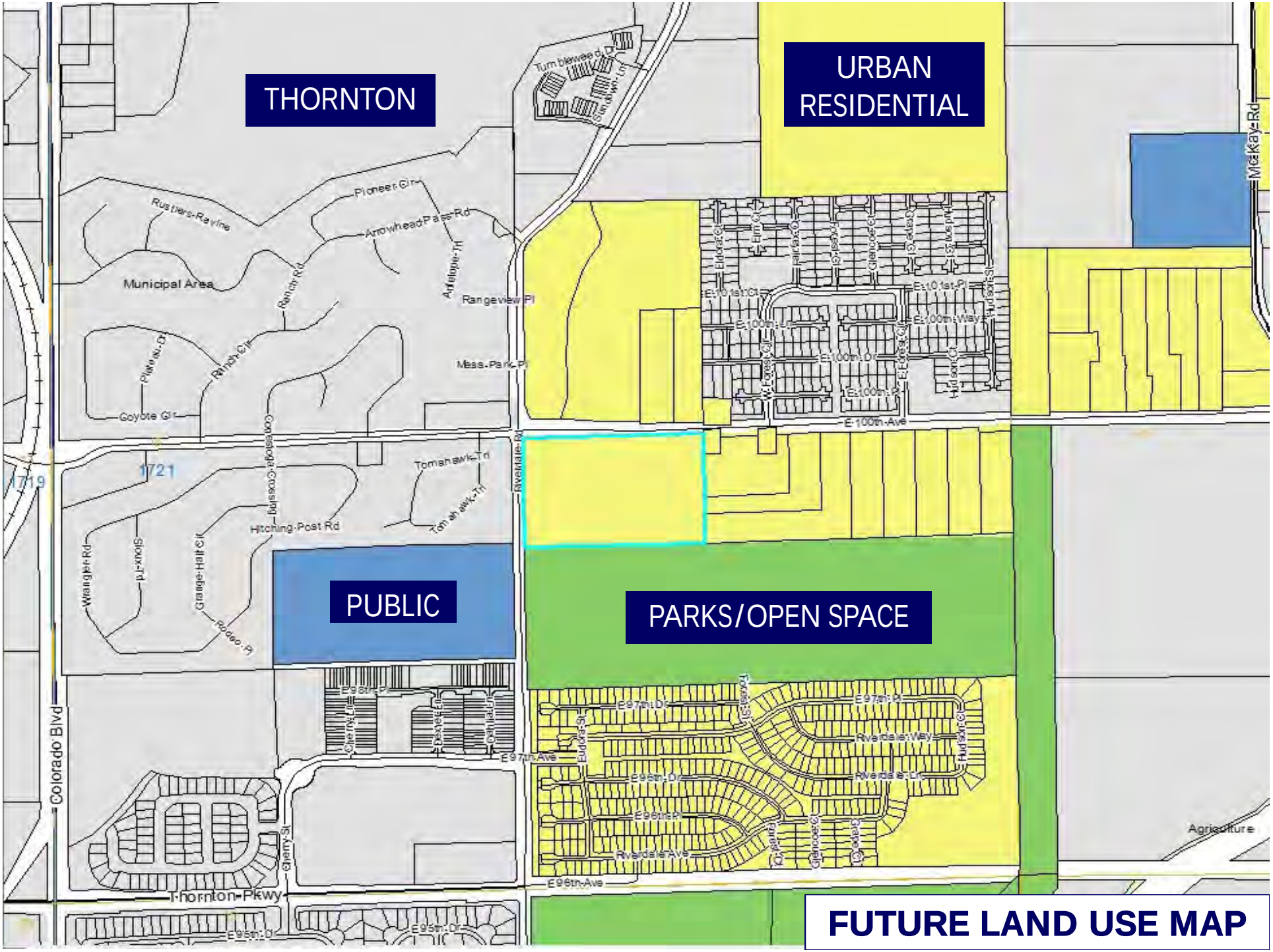
Request

Conditional Use Permit for a commercial telecommunications tower in the Agricultural-1 (A-1) zone district.


Colorado Blvd.
E. 100th Avenue
Site
Riverdale Rd.
E. 96th Avenue
Colorado Blvd
Thornton Pkwy
E100th Ave
E98th Ave
E97th Ave
Mc Kay Rd

AERIAL MAP


Thornton
A-1
PUD
ZONING MAP

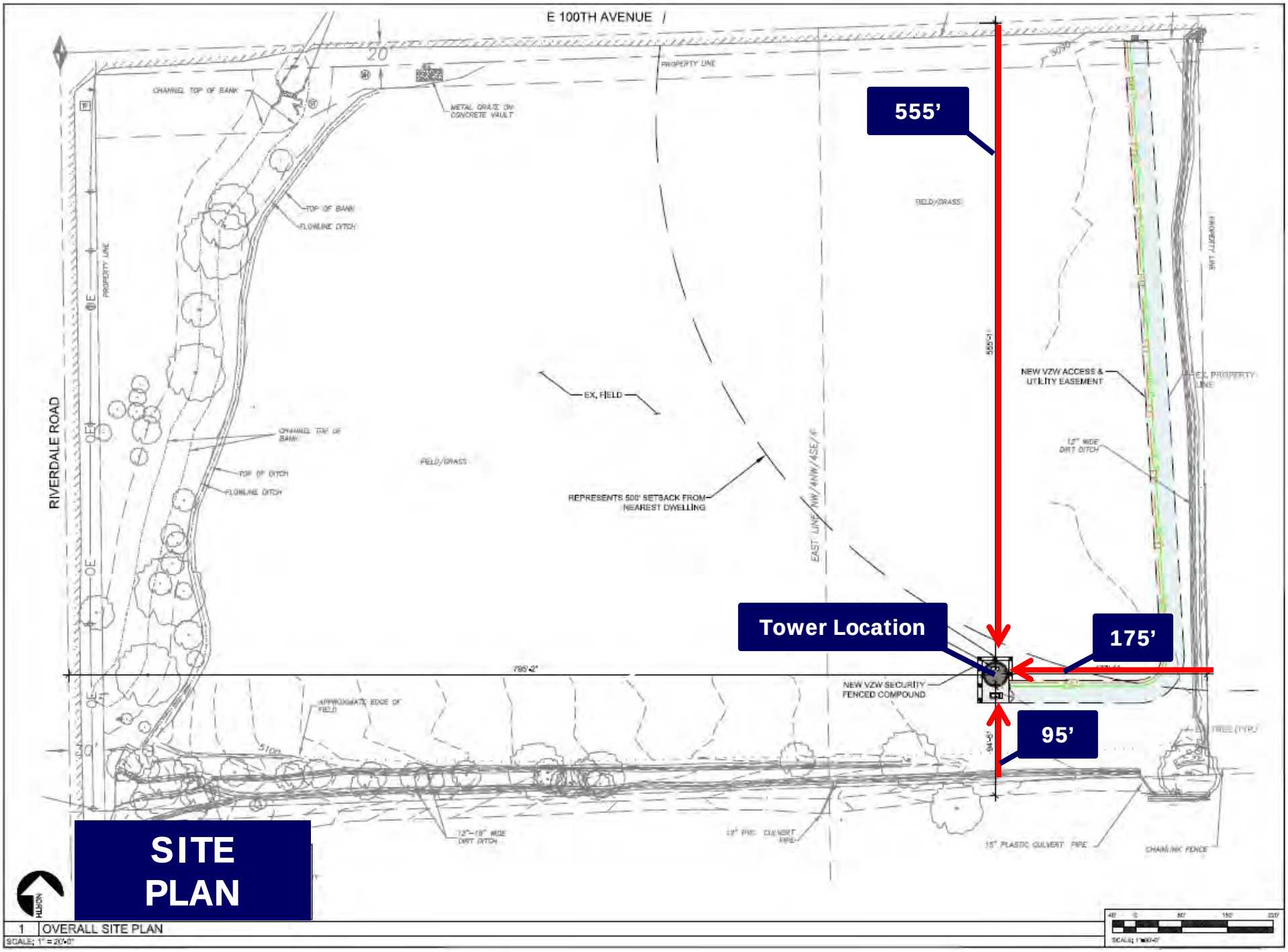

THORNTON
URBAN RESIDENTIAL
PUBLIC
PARKS/OPEN SPACE
Municipal Area
Colorado Blvd
Thornton Pkwy
E 100th Ave
E 97th Ave
E 96th Ave
Riverdale Rd
McKay Rd
Agriculture
FUTURE LAND USE MAP

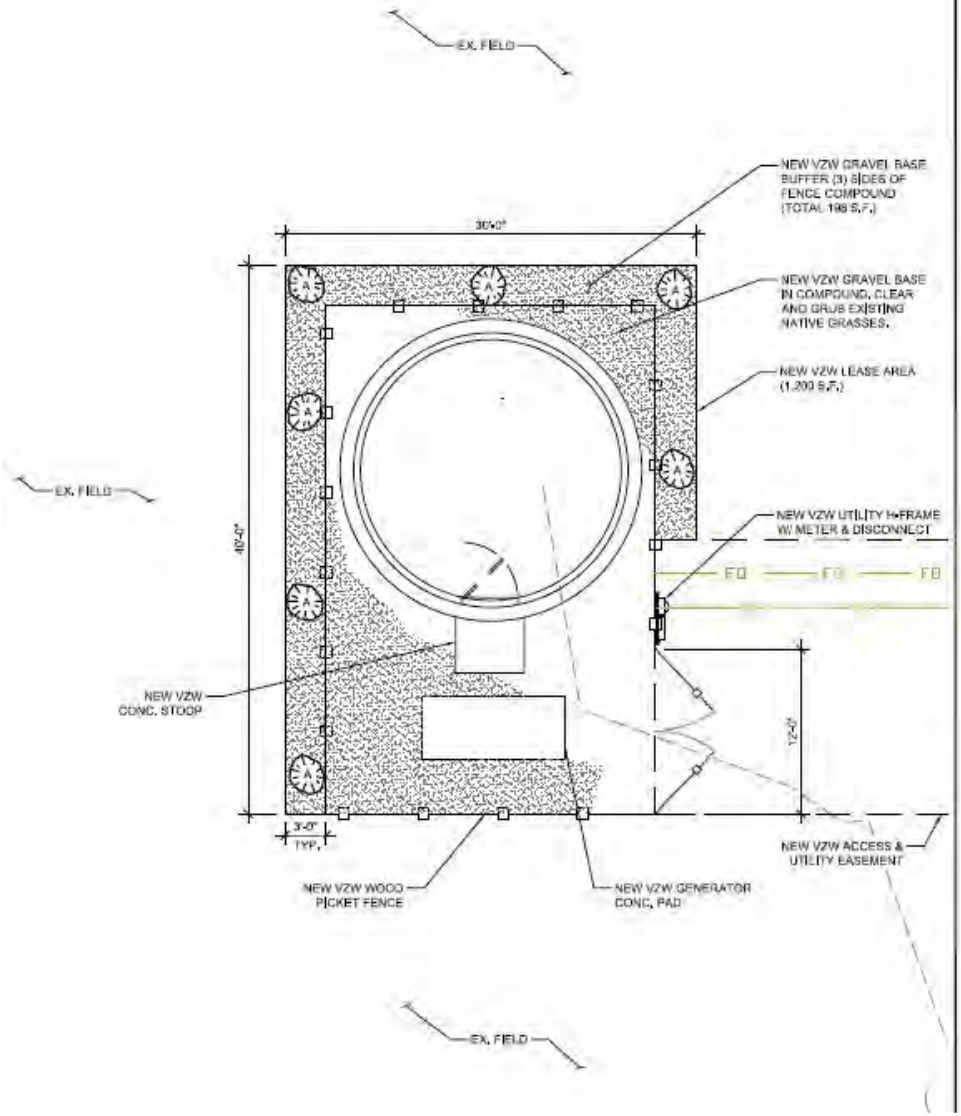
Criteria for Conditional Use

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


East 100th Avenue
E 100th Ave
Riverdale Road
Riverdale Rd
Tower Location
SITE


E 100TH AVENUE
RIVERDALE ROAD
555'
175'
95'
Tower Location
NEW VZW ACCESS & UTILITY EASEMENT
NEW VZW SECURITY FENCED COMPOUND
EX. FIELD
FIELD/GRASS
REPRESENTS 500' SETBACK FROM NEAREST DWELLING
EAST LINE NW/4NW/4SE/4
PROPERTY LINE
CHANNEL TOP OF BANK
TOP OF BANK
FLOWLINE DITCH
TOP OF DITCH
METAL GRATE ON CONCRETE VAULT
12" WIDE DIRT DITCH
12"-18" WIDE DIRT DITCH
12" PVC CULVERT PIPE
15" PLASTIC CULVERT PIPE
CHAIN-LINK FENCE
APPROXIMATE EDGE OF FIELD
OE
SITE PLAN
1 OVERALL SITE PLAN
SCALE: 1" = 20'-0"



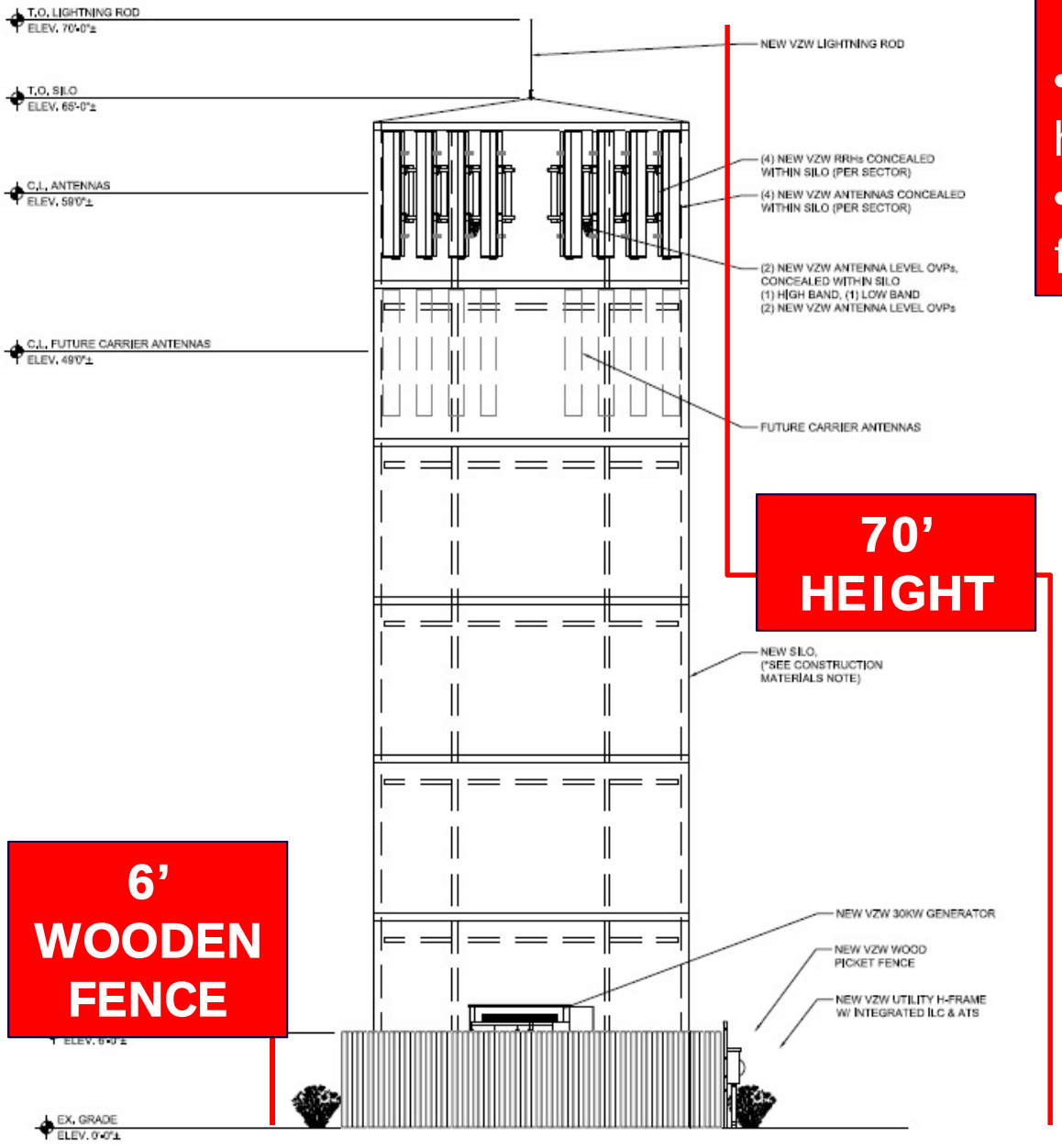
PLANTING SCHEDULE				
IDENT.	No.	NAME (COMMON, *BOTANICAL - VARIETY*)	SIZE	WATER
A	7	ROCKY MOUNTAIN PENSTEMON *PENSTEMON STRICTUS*	2 GAL.	LOW

LANDSCAPE PLAN

- Rocky Mountain Penstemon
- Ultimate height: 3.5 feet

A-1 ZONE STANDARDS

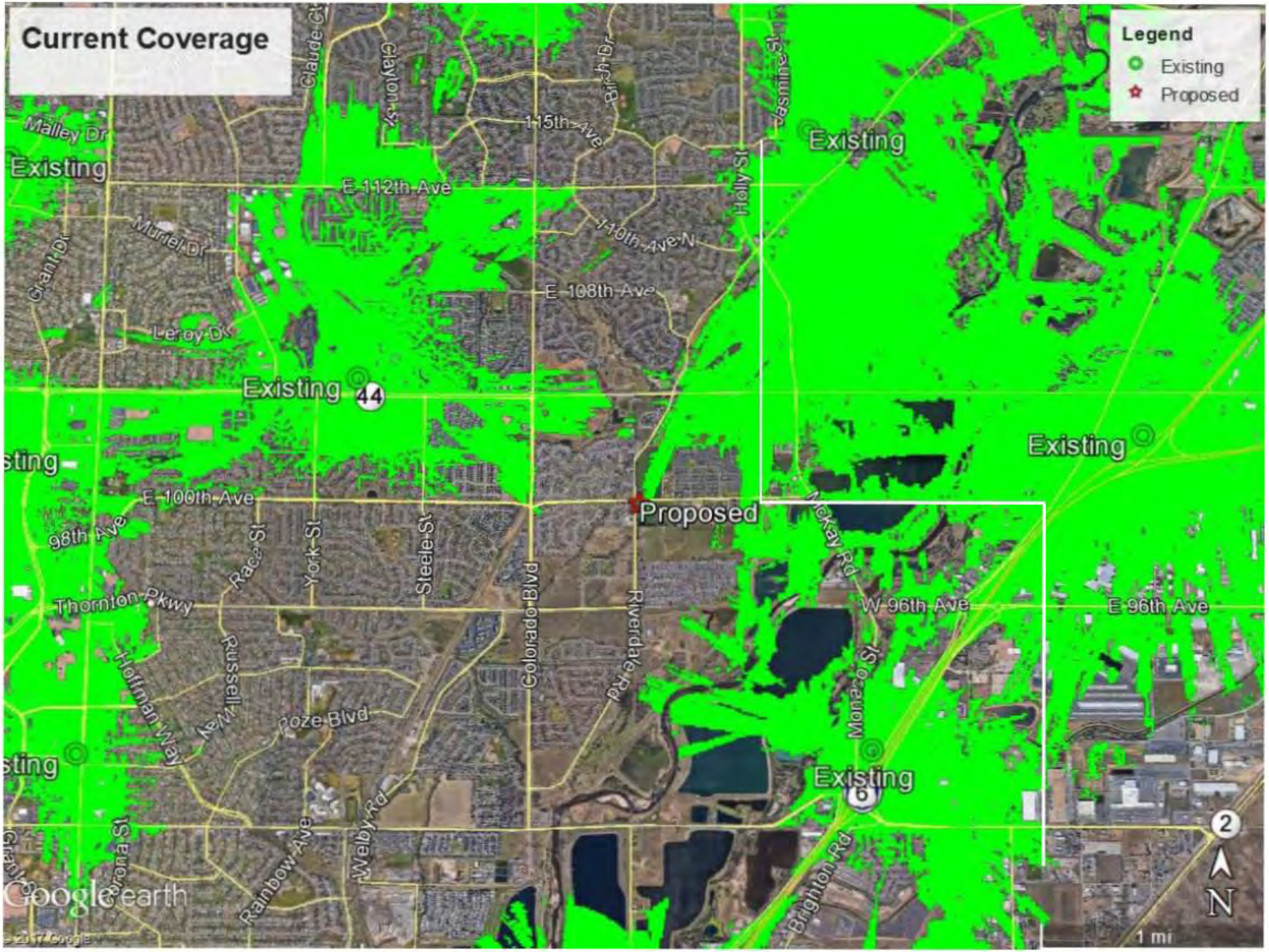
- 35’ max. height
- 70’ allowance for ag structures

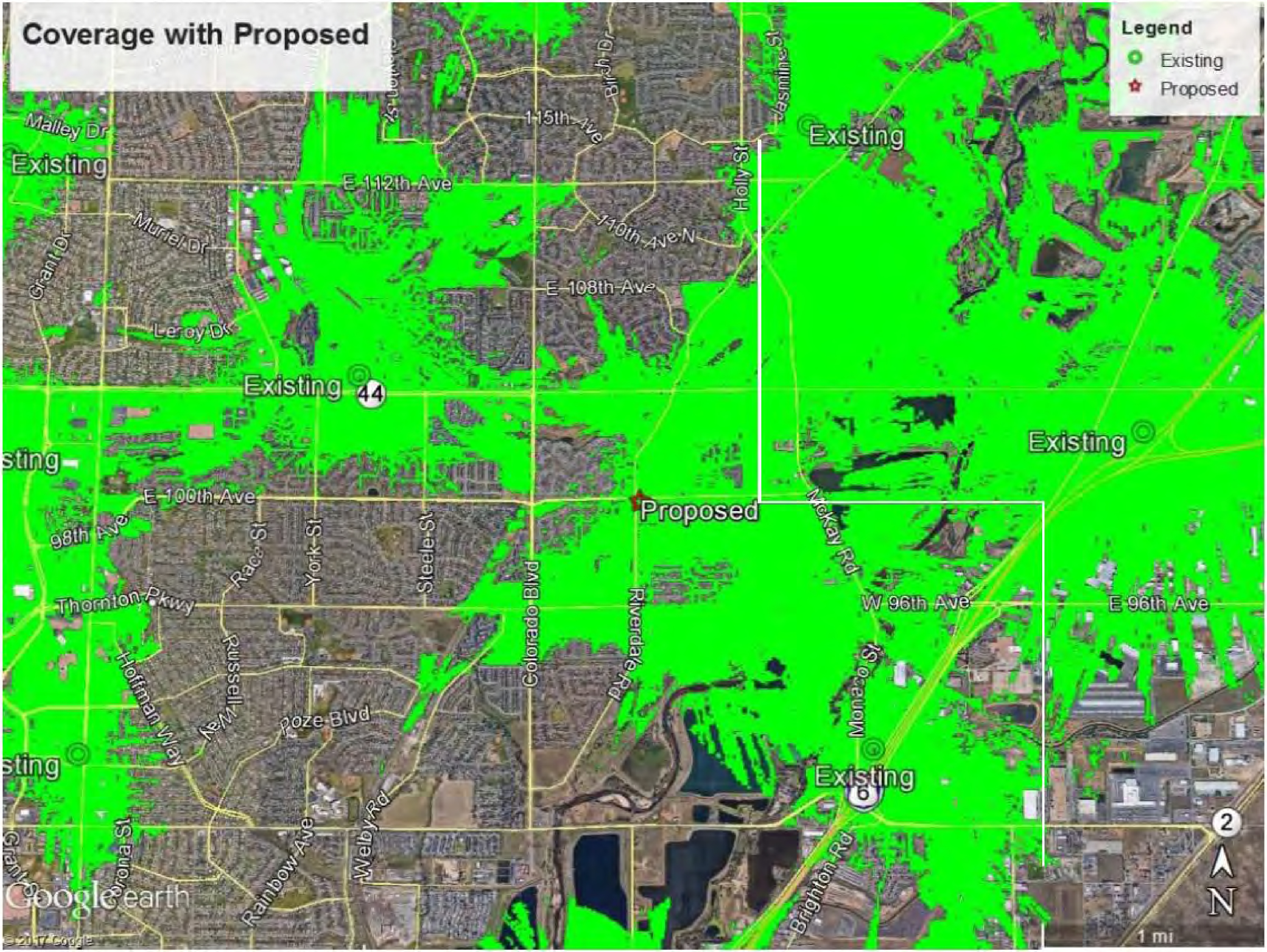


70’ HEIGHT

6’ WOODEN FENCE

SILO ELEVATION


Current Coverage
Legend
Existing
Proposed
Existing
Existing
Existing
Existing
Existing
Proposed
Malley Dr
E 112th Ave
Muriel Dr
Grant Dr
Leroy Dr
E 108th Ave
110th Ave N
115th Ave
Claude Ct
Clayton St
Birch Dr
Holly St
Jasmine St
E 100th Ave
98th Ave
Race St
York St
Steele St
Colorado Blvd
Riverdale Rd
Mckay Rd
Thornton Pkwy
W 96th Ave
E 96th Ave
Monaco St
Hoffman Way
Russell Way
Poze Blvd
Welby Rd
Rainbow Ave
Brighton Rd
44
6
2
N
1 mi
Google earth


Coverage with Proposed
Legend
Existing
Proposed
Existing
Existing
Existing
Existing
Existing
Proposed
sting
sting
Malley Dr
E 112th Ave
115th Ave
110th Ave N
E 108th Ave
Muriel Dr
Grant Dr
Leroy Dr
Birch Dr
Holly St
Jasmine St
E 100th Ave
98th Ave
Race St
York St
Steele St
Colorado Blvd
Riverdale Rd
McKay Rd
Thornton Pkwy
W 96th Ave
E 96th Ave
Russell Way
Hoffman Way
Poze Blvd
Monaco St
Rainbow Ave
Welby Rd
Brighton Rd
Corona St
44
6
2
N
1 mi
Google earth


PUBLIC NOTICE

Referral Period

Notices sent*	# of Comments Received
923	0

* Property owners within 750 feet were notified

No Concerns:

CDOT
CDPHE
CGS
Thornton
Thornton Fire
Tri-County Health
Xcel

Staff Analysis

- Consistent with regulations
- Comply with performance standards
- Harmonious & compatible
- Addressed all off-site impacts

Planning Commission Update

RCU2017-00042 – Verizon Hailstorm

Heard on the June 28, 2018 Planning Commission agenda.

Topics: Drainage, Landscaping

Approval of conditional use permit *(RCU2017-00042 Verizon Hailstorm)* with:

8 Findings-of-Fact,

1 Condition Precedent,

6 Conditions, and

1 Note.

Recommended Conditions Precedent:

1. The applicant shall submit a performance bond in the amount of $30,000 for removal. The bond documents shall be submitted, and approved by the Director of Community and Economic Development prior to approval of any associated building permit.

Recommended Conditions:

1. The applicant shall obtain a building permit for the telecommunications tower.
2. The conditional use permit shall expire on July 17, 2028.
3. The height of the freestanding telecommunications tower shall not exceed 70 feet.
4. The tower shall provide for co-location opportunities for other carriers.
5. Any telecommunications facility, that ceases to be in operation for a consecutive period of six months or more, shall be removed from the site within 90 days of the end of such period of non-use. The County shall have the right to enter the property to remove the tower should it cease to operate or abandoned.
6. An access permit shall be obtained for the proposed driveway along East 100th Avenue.