Board of County Commissioners
Eva J. Henry - District #1
Charles "Chaz" Tedesco - District #2
Emma Pinter - District #3
Steve O'Dorisio - District #4
Lynn Baca - 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
October 11, 2022
9:30 AM

1. **ROLL CALL**

2. **PLEDGE OF ALLEGIANCE**

3. **MOTION TO APPROVE AGENDA**

4. **AWARDS AND PRESENTATIONS**

   A. Proclamation of October 2022 as Domestic Violence Awareness Month

   B. Proclamation of October 2022 as Global Diversity Awareness Month

   C. Proclamation of October 2022 as National Disability Employment Awareness Month

5. **PUBLIC COMMENT**

   A. Citizen Communication

During this portion of the meeting, the board will hear public comment. The Chair will determine how much time is reserved for public comment and how much time is permitted for each speaker.

B. Elected Officials' Communication

6. CONSENT CALENDAR

A. List of Expenditures Under the Dates of September 13-23, 2022

B. Minutes of the Commissioners' Proceedings from September 27, 2022

C. Resolution Approving Right-of-Way Agreement between Adams County and Center Land Company for Property Necessary for the ADA Transition Area III – Steele Street Improvements Project in the Amount of $55,095.00

D. Resolution Approving the Amendment to the Flexible Benefits Plan

E. Resolution Approving Right-of-Way Agreement between Adams County and KLZ Radio Inc. for Property Necessary for the York Street Roadway and Drainage Improvements Project from East 78th Avenue to East 88th Avenue

F. Resolution Adopting Amendments to Adam County's Group Agreements with Kaiser Permanente

G. Resolution Adopting Amendments to Adams County's Contracts with UnitedHealthcare Services

H. Resolution Approving a Memorandum of Understanding Between Adams County and Colorado Coalition For The Homeless

I. Resolution Appointing Erika Manuel to the Workforce Development Board as a Business Sector/Healthcare Representative

J. Resolution Approving Amendment Three to the Agreement between Adams County and GMCO Corporation, in the Amount of $5,892.19, for Fugitive Dust Chloride Abatement

K. Resolution Approving Change Order One (Amendment One) to the Agreement between Adams County and A-1 Chipseal Company in the Amount of $19,594.40, for the 2022 Seal Program

L. Resolution Approving Amendment Two to the Agreement between Adams County and Growing Home in the Amount of $1,194,839.65, for Housing and Homeless Prevention Services

7. NEW BUSINESS

A. COUNTY MANAGER

1. County Manager's Recommended 2023 Adams County Budget

2. Resolution Authorizing the Creation of a Public Health Department Fund to Account for Revenues and Expenditures for the Adams County Health Department

3. Resolution Approving an Agreement between Adams County and Shiloh Home Inc., in the Amount Not to Exceed $652, 323.00, for Guaranteed Beds

4. Resolution Approving Amendment Two to an Agreement Adams County and the Brendle Group, Inc., in the Amount of $220,000.00, for Sustainability Planning Services

5. Resolution Approving an Agreement between Adams County and Epic Aviation, LLC in the Amount of $4,992,761.80, to Provide Aviation Fuel (Jet A) And Avgas (100LL)

B. COUNTY ATTORNEY

8. EXECUTIVE SESSION

A. Motion to Adjourn into Executive Session Pursuant to C.R.S. 24-6-402(4)(b) and (e) for the Purpose of Receiving Legal Advice and Instructing Negotiators Regarding Olguin Case

B. Motion to Adjourn into Executive Session Pursuant to C.R.S. 24-6-402(4)(e) for the Purpose of Instructing Negotiators Regarding Economic Development Opportunity

9. LAND USE HEARINGS

A. Cases to be Heard

1. PRC2021-00006 Ascent Drive Resort – Continued

10. ADJOURNMENT

AND SUCH OTHER MATTERS OF PUBLIC BUSINESS WHICH MAY ARISE

Proclamation

"Domestic Violence Awareness Month"
October 2022

Whereas, one in three women will experience domestic violence during her lifetime; one in every four women will experience sexual assault in her lifetime; and one in seven men have been the victim of severe physical violence by an intimate partner in their lifetime; and,

Whereas, approximately 15.5 million children are exposed to domestic violence every year; and 7 million children live in families in which severe intimate partner violence occurred; and,

Whereas, domestic violence incidents increased by 8.1% nationwide during the COVID pandemic; and,

Whereas, domestic violence is a serious crime that affects people of all races, ages, gender, and income levels; and,

Whereas, the crimes of domestic and sexual violence violate an individual's privacy, dignity, security, and humanity due to the systematic use of physical, emotional, sexual, psychological, and economic control and/or abuse; and,

Whereas, victims of violence should have access to medical and legal services, counseling, emergency and transitional housing, and other supportive services so that they can safely escape the cycle of abuse especially during this current public health crisis; and,

Whereas, we encourage domestic and sexual violence victims and their families to seek assistance from appropriate victims' services organizations such as the dedicated systems and non-profit based victim advocates in Adams County; and,

Whereas, the 17th Judicial District Domestic Violence High Risk Team, state coalitions, national organizations, and other agencies nationwide are committed to increasing public awareness of domestic and sexual violence and its prevalence, and to eliminating it through prevention and education; and,

Whereas, important partnerships have been formed among criminal and juvenile justice agencies, healthcare providers, allied professionals, and victim services to assist victims of domestic and sexual violence and their families; and,

Whereas, Adams County, Colorado, has a moral obligation to work to prevent domestic violence, address its brutal and destructive effects and make ending domestic violence a local priority.

Now, Therefore, Be It Resolved, that the Board of Commissioners, of the County of Adams, State of Colorado, proclaims October 2022 as

"Domestic Violence Awareness Month"

and urges all residents to actively support first responders, victim of crime and their service providers in our community, to work towards the elimination of domestic violence and sexual assault.

In witness whereof, we have set our hands and caused the seal of the county to be affixed October 11, 2022.

Proclamation

"Global Diversity Awareness Month"

October 2022

Whereas, each year, the United States observes Global Diversity Awareness Month in October by celebrating and acknowledging the value of each human being, regardless of their nationality, color, race, sex, gender, country of origin, language, or otherwise; and,

Whereas, Global Diversity Awareness Month serves as a reminder of the positive impact a diverse culture of people can have on society as a whole; and,

Whereas, the population of Adams County is composed of many different races and cultural backgrounds, based on the most recent census estimates; and,

Whereas, after the Second World War, the Universal Declaration of Human Rights was adopted by the United Nations General Assembly at the Palais de Chaillot in Paris. The Declaration represents the first global expression of rights to which all human beings are inherently entitled; and,

Whereas, Global Diversity refers to the range of differences that describes the composition of a group of two or more people, in a cross-cultural and multi-national context. Many individuals and organizations, including Adams County, believe positively viewing and appreciating global diversity will allow us to adopt more inclusive practices around the world; and,

Whereas, Adams County's A-Proud affinity groups embrace our diverse culture by providing employee-led groups, sharing a common experience, interest, or goal. These affinity groups provide support, enhance career development, and contribute to an overall positive work environment; and,

Whereas, there are many different ways to celebrate Global Diversity Awareness Month, which include hosting a multicultural movie night with foreign films, attending a cultural art exhibit, enjoying music from different parts of the world, supporting minority owned business or creating a celebration of your own.

Now, Therefore, Be it Resolved, that the Board of Commissioners, of the County of Adams, State of Colorado, proclaims October 2022 as

"Global Diversity Awareness Month"

and encourages all residents to honor the rich diversity of different cultures found within the county.

In witness whereof, we have set our hands and caused the seal of the county to be affixed October 11, 2022.

Proclamation

"National Disability Employment Awareness Month"

October 2022

Whereas, in October, Americans observe National Disability Employment Awareness Month by recognizing the accomplishments of the women and men with disabilities whose work helps keep the nation's economy strong and by reaffirming the commitment to ensure equal opportunity for all citizens; and,

Whereas, it is estimated approximately 5% of the United States total workforce live with at least one disability; and,

Whereas, this effort to educate the public about issues related to disability and employment began in 1945, when Congress enacted Public Law 176, declaring the first week of October each year as National Employ the Physically Handicapped Week; and,

Whereas, in 1962, the word "physically" was removed to acknowledge the employment needs and contributions of those with all types of disabilities. Twenty-five years later, Congress then expanded the week recognition to a month and changed the name to what we know it as today; and,

Whereas, this year's theme, "Disability: Part of the Equity Equation," invites us to recognize that this awareness month is more than a celebration, it's a call to action. It's a time to recommit to the hard work of advocating for better employment opportunities and outcomes for workers with disabilities; and,

Whereas, Adams County's employee-led A-Proud affinity group, Positivity Disability, provides a safe, and welcoming environment to foster support, awareness, education, and advocacy in and around the Disability Community.

Now, Therefore, Be It Resolved, that the Board of Commissioners, of the County of Adams, State of Colorado, proclaims October 2022 as

"National Disability Employment Awareness Month"

and encourages all residents to honor the multitudes of skills and talents of people with disabilities and the important impact that they have on our society.

In witness whereof, we have set our hands and caused the seal of the county to be affixed October 11, 2022.

County of Adams

Net Warrant by Fund Summary

Fund Number	Fund Description	Amount
1	General Fund	2,942,932.03
4	Capital Facilities Fund	70,494.25
5	Golf Course Enterprise Fund	125,496.07
6	Equipment Service Fund	254,671.76
7	Stormwater Utility Fund	1,509.30
13	Road & Bridge Fund	182,172.48
19	Insurance Fund	200,915.00
25	Waste Management Fund	5,402.48
28	Open Space Sales Tax Fund	350,159.56
30	Community Dev Block Grant Fund	36,483.00
31	Head Start Fund	19,300.67
34	Comm Services Blk Grant Fund	952.72
35	Workforce & Business Center	15,985.66
49	Public Health Department Fund	11,950.00
50	FLATROCK Facility Fund	2,108.89
		4,220,533.87

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00009661	1056644	ADAMS COUNTY FIRE PROTECTION D	9/20/2022	230,000.00
00009662	1186369	ADAMS COUNTY REGIONAL ECONOMIC	9/20/2022	150,000.00
00009663	378404	CARUSO JAMES LOUIS	9/20/2022	3,075.00
00009664	191633	CIVICPLUS llc	9/20/2022	100.00
00009665	227044	SOUTHWESTERN PAINTING	9/20/2022	13,214.00
00009669	145355	SANITY SOLUTIONS INC	9/21/2022	4,306.32
00009670	2284	SENIOR HUB THE	9/21/2022	96,112.19
00009671	1289924	ULTIMATE BEAUTY HAIRCARE & SUP	9/21/2022	5,000.00
00009672	1293537	VIDA CONSEJERIA INDIVIDUAL & F	9/21/2022	30,000.00
00009673	383698	ALLIED UNIVERSAL SECURITY SERV	9/22/2022	21,517.20
00009676	227044	SOUTHWESTERN PAINTING	9/22/2022	11,243.00
00774424	116716	FIVE STAR EDUCATION FOUNDATIO	9/22/2022	804,082.78
00774425	72554	AAA PEST PROS	9/22/2022	2,370.00
00774428	13884	ADAMS COUNTY SHERIFF	9/22/2022	1,907.39
00774429	903062	ADELANTE COMMUNITY DEVELOPMENT	9/22/2022	620,887.50
00774431	42507	AIRBOUND	9/22/2022	12,915.00
00774433	5166	ALLIANCE FOR INNOVATION INC	9/22/2022	3,825.00
00774434	12012	ALSCO AMERICAN INDUSTRIAL	9/22/2022	232.20
00774436	786384	ALTITUDE COMMUNITY LAW	9/22/2022	19.00
00774437	42415	AMERICAN INCOME LIFE INS CO	9/22/2022	40.00
00774438	419483	ANDERSON, CASSANDRA M	9/22/2022	284.00
00774439	498573	ARBORFORCE LLC	9/22/2022	933.14
00774440	1286688	ARTIST BETH WARMATH LLC	9/22/2022	3,750.00
00774443	83180	BACKFLOW TECH INC	9/22/2022	265.00
00774444	993099	BAYAUD ENTERPRISES INC	9/22/2022	39,119.43
00774447	429551	BISCUITS AND BERRIES CATERING	9/22/2022	25,955.59
00774448	414193	BMC SOFTWARE INC	9/22/2022	8,214.80
00774449	34850	BOULDER COUNTY 4-H	9/22/2022	350.00
00774450	13160	BRIGHTON CITY OF (WATER)	9/22/2022	807.60
00774451	13160	BRIGHTON CITY OF (WATER)	9/22/2022	5,168.05
00774452	13160	BRIGHTON CITY OF (WATER)	9/22/2022	16,782.19
00774453	13160	BRIGHTON CITY OF (WATER)	9/22/2022	28,983.60
00774454	13160	BRIGHTON CITY OF (WATER)	9/22/2022	150.20
00774455	1293517	BRILLIANT BEAUTY AESTHETIC & L	9/22/2022	19.00
00774460	28303	CENTURA HEALTH	9/22/2022	600.00
00774463	661015	CHP METRO NORTH LLC	9/22/2022	1,050.00

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00774464	1226046	CHRISTENSEN MELANIE	9/22/2022	975.75
00774466	434713	COAL CREEK ADULT EDUCATION CEN	9/22/2022	15,000.00
00774467	2157	COLO OCCUPATIONAL MEDICINE PHY	9/22/2022	2,200.00
00774470	1029850	COLORADO HOSPITALITY SERVICES	9/22/2022	50.00
00774471	414144	COLORADO MOISTURE CONTROL INC	9/22/2022	7,144.00
00774473	13648	COMPLETE DOOR SYSTEMS INC	9/22/2022	5,699.00
00774474	255001	COPYCO QUALITY PRINTING INC	9/22/2022	340.00
00774475	42984	CORECIVIC INC	9/22/2022	15,140.20
00774476	810159	CORHIO	9/22/2022	1,170.00
00774479	4071	DEER TRAIL / EAST ADAMS	9/22/2022	9,500.00
00774480	1285280	DELGADO ANTHONY	9/22/2022	50.00
00774481	1267726	EAGLE ROCK DISTRIBUTING COMP O	9/22/2022	325.44
00774482	35867	ELDORADO ARTESIAN SPRINGS INC	9/22/2022	57.26
00774485	47723	FEDEX	9/22/2022	600.12
00774487	197938	FIRST CALL OF COLO	9/22/2022	4,495.00
00774488	339325	FLEXENTIAL PROFESSIONAL SERVIC	9/22/2022	1,850.01
00774489	1024961	FOOD FOR HOPE	9/22/2022	60,158.33
00774490	1293524	FRIAS ADRIANA MARIA	9/22/2022	19.00
00774493	1004844	GPS SERVERS LLC	9/22/2022	19.00
00774494	1293523	HERNANDEZ JULIO	9/22/2022	19.00
00774496	115496	INNOVEST PORTFOLIO SOLUTIONS L	9/22/2022	9,500.00
00774497	32276	INSIGHT PUBLIC SECTOR	9/22/2022	21,485.89
00774498	44965	INTERVENTION COMMUNITY CORRECT	9/22/2022	230,388.93
00774499	516864	INVENTING ROOM	9/22/2022	3,143.75
00774500	746356	J. BROWER PSYCHOLOGICAL SERVIC	9/22/2022	4,600.00
00774501	13593	KAISER PERMANENTE	9/22/2022	34,850.00
00774503	536256	KIMMEL KENZIE NICOLE	9/22/2022	157.97
00774504	44695	KNS COMMUNICATIONS CONSULTANTS	9/22/2022	6,313.07
00774507	1020086	LABORATORY CORPORATION OF AMER	9/22/2022	1,886.62
00774509	48078	LARIMER COUNTY COMMUNITY CORRE	9/22/2022	2,118.54
00774510	1293525	LEGAL SERVICES OF SOUTHERN MIS	9/22/2022	19.00
00774511	36861	LEXIS NEXIS MATTHEW BENDER	9/22/2022	190.36
00774513	266471	MAZE AMANDA	9/22/2022	75.00
00774514	1039410	MECSTAT LABORATORIES	9/22/2022	390.00
00774515	8801432	MESA COUNTY	9/22/2022	2,097.77
00774516	1271727	MIDLAND CREDIT MANAGEMENT INC	9/22/2022	38.00

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00774518	374475	MOORE LAW GROUP APC	9/22/2022	19.00
00774519	1291132	MOUNTAIN PEAK LAW GROUP PC	9/22/2022	19.00
00774520	986500	MW GOLDEN CONSTRUCTORS	9/22/2022	5,000.00
00774521	16428	NICOLETTI-FLATER ASSOCIATES	9/22/2022	240.00
00774522	124449	NMS LABS	9/22/2022	17,551.00
00774523	13778	NORTH WASHINGTON ST WATER & SA	9/22/2022	29,418.70
00774524	470643	ONENECK IT SOLUTIONS LLC	9/22/2022	93,240.00
00774525	282112	ORACLE AMERICA INC	9/22/2022	55,047.05
00774526	473343	PALEO DNA	9/22/2022	1,717.20
00774527	516994	PARK 12 HUNDRED OWNERS ASSOCIA	9/22/2022	16,737.00
00774529	100332	PERKINELMER GENETICS	9/22/2022	105.00
00774530	192059	POINT SPORTS/ERGOMED	9/22/2022	180.00
00774533	1293518	PROOF TECHNOLOGY INC	9/22/2022	19.00
00774534	837076	PSYCHOLOGICAL DIMENSIONS	9/22/2022	4,125.00
00774535	1275960	PURCHASE POWER	9/22/2022	113.33
00774536	44703	QUICKSILVER EXPRESS COURIER	9/22/2022	126.26
00774537	762299	RED FLAG REPORTING	9/22/2022	3,325.00
00774539	1293521	RIQUELME LESLIE	9/22/2022	19.00
00774540	1149013	ROCKY MOUNTAIN PARTNERSHIP	9/22/2022	8,134.33
00774542	1270454	ROMERO LILIANA	9/22/2022	60.00
00774544	1029870	SANTIAGOS MEXICAN RESTURANT	9/22/2022	25.00
00774545	1293519	SEPULVEDA CASTILLA ITSA	9/22/2022	19.00
00774546	255505	SHERMAN & HOWARD LLC	9/22/2022	1,593.75
00774547	10449	SIR SPEEDY	9/22/2022	59.47
00774548	10449	SIR SPEEDY	9/22/2022	74.12
00774549	13932	SOUTH ADAMS WATER & SANITATION	9/22/2022	439.75
00774550	13932	SOUTH ADAMS WATER & SANITATION	9/22/2022	49.61
00774551	13932	SOUTH ADAMS WATER & SANITATION	9/22/2022	49.61
00774552	13932	SOUTH ADAMS WATER & SANITATION	9/22/2022	4,168.04
00774553	51001	SOUTHLAND MEDICAL LLC	9/22/2022	650.21
00774554	25335	STANLEY CONVERGENT SECURITY S	9/22/2022	695.00
00774555	42818	STATE OF COLORADO	9/22/2022	35,196.10
00774556	4056	STEELOCK GENERAL FENCE CONTRAC	9/22/2022	2,600.00
00774557	357775	STEIN LAW PC	9/22/2022	19.00
00774558	1293522	STONE DAMIAN	9/22/2022	66.00
00774559	599714	SUMMIT FOOD SERVICE LLC	9/22/2022	9,370.80

1 General Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00774560	293662	SUMMIT LABORATORIES INC	9/22/2022	519.00
00774561	102754	SUMMIT PATHOLOGY	9/22/2022	3,091.35
00774562	426037	SWIRE COCA-COLA USA	9/22/2022	21,640.08
00774563	517546	THOMPSON DARWIN	9/22/2022	66.00
00774564	22538	THOMSON REUTERS - WEST	9/22/2022	560.07
00774566	1094	TRI COUNTY HEALTH DEPT	9/22/2022	445.74
00774567	1094	TRI COUNTY HEALTH DEPT	9/22/2022	10,185.51
00774568	666214	TYGRETT DEBRA R	9/22/2022	250.00
00774578	20730	UNITED STATES POSTAL SERVICE	9/22/2022	197.80
00774579	46792	UNITEDHEALTHCARE INSURANCE COM	9/22/2022	9,550.00
00774582	1293822	VELASQUEZ BRITTANY	9/22/2022	200.00
00774583	28566	VERIZON WIRELESS	9/22/2022	145.71
00774584	1052623	VICTORY SUPPLY LLC	9/22/2022	299.18
00774585	7162	WAGNER GEORGIA C	9/22/2022	101.25
00774586	962191	WEIN JEFFREY MARC	9/22/2022	5,400.00
00774588	544338	WESTAR REAL PROPERTY SERVICES	9/22/2022	14,662.82
			Fund Total	**2,942,932.03**

4 Capital Facilities Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00774432	725672	ALL PRO CEMENT INC	9/22/2022	175.00
00774483	1281050	Essenza Architecture	9/22/2022	70,319.25
			Fund Total	**70,494.25**

5 Golf Course Enterprise Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00009674	6177	PROFESSIONAL RECREATION MGMT I	9/22/2022	75,896.37
00009675	6177	PROFESSIONAL RECREATION MGMT I	9/22/2022	7,242.28
00774426	72554	AAA PEST PROS	9/22/2022	45.00
00774435	12012	ALSCO AMERICAN INDUSTRIAL	9/22/2022	177.60
00774456	9822	BUCKEYE WELDING SUPPLY CO INC	9/22/2022	30.60
00774457	13206	C P S DISTRIBUTORS INC	9/22/2022	1,515.15
00774459	25288	CEM LAKE MGMT	9/22/2022	494.00
00774465	574439	CMI MECHANICAL	9/22/2022	437.77
00774477	44959	CRACKERJACK MUDJACKING INC	9/22/2022	2,020.00
00774478	105402	CULLIGAN	9/22/2022	251.77
00774492	160270	GOLF & SPORT SOLUTIONS	9/22/2022	5,130.71
00774505	11496	L L JOHNSON DIST	9/22/2022	2,620.48
00774506	525704	LABOR SOLUTIONS INC	9/22/2022	8,000.00
00774531	152295	POTESTIO BROTHER EQUIPMENT	9/22/2022	2,415.82
00774538	430098	REPUBLIC SERVICES #535	9/22/2022	1,085.97
00774541	433906	ROCKY MTN PUMP & CONTROLS LLC	9/22/2022	2,380.00
00774565	47140	TORO NSN	9/22/2022	233.00
00774569	76466	UNDERWATER RECOVERY SPECIALIST	9/22/2022	1,170.00
00774571	1007	UNITED POWER (UNION REA)	9/22/2022	27.28
00774572	1007	UNITED POWER (UNION REA)	9/22/2022	3,364.26
00774573	1007	UNITED POWER (UNION REA)	9/22/2022	4,062.59
00774574	1007	UNITED POWER (UNION REA)	9/22/2022	4,652.42
00774575	1007	UNITED POWER (UNION REA)	9/22/2022	1,147.04
00774576	1007	UNITED POWER (UNION REA)	9/22/2022	30.64
00774577	1007	UNITED POWER (UNION REA)	9/22/2022	169.82
00774591	13822	XCEL ENERGY	9/22/2022	895.50
			Fund Total	**125,496.07**

6 **Equipment Service Fund**

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00774532	324769	PRECISE MRM LLC	9/22/2022	6,096.00
00774543	16237	SAM HILL OIL INC	9/22/2022	248,575.76
			Fund Total	**254,671.76**

7 **Stormwater Utility Fund**

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00774581	158184	UTILITY NOTIFICATION CENTER OF	9/22/2022	1,509.30
			Fund Total	**1,509.30**

13 Road & Bridge Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00009668	816237	SALTWORX INC	9/21/2022	100,848.23
00774495	1141016	HILLEN HOLDINGS LLC	9/22/2022	5,750.00
00774512	9379	MARTIN MARTIN CONSULTING ENGIN	9/22/2022	75,574.25
			Fund Total	**182,172.48**

19 Insurance Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00774458	419839	CAREHERE LLC	9/22/2022	95,926.46
00774469	13297	COLO STATE TREASURER	9/22/2022	15.48
00774486	947425	FIRST AMERICAN ADMINISTRATORS	9/22/2022	182.31
00774502	13593	KAISER PERMANENTE	9/22/2022	61,112.71
00774517	98413	MINES & ASSOCIATES PC	9/22/2022	300.00
00774570	37507	UNITED HEALTHCARE	9/22/2022	2,747.52
00774580	46792	UNITEDHEALTHCARE INSURANCE COM	9/22/2022	40,630.52
			Fund Total	**200,915.00**

25 Waste Management Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00009666	535096	B & B ENVIRONMENTAL SAFETY INC	9/21/2022	5,402.48
			Fund Total	**5,402.48**

28 **Open Space Sales Tax Fund**

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00009667	1019666	BENNETT TOWN OF	9/21/2022	350,159.56
			Fund Total	**350,159.56**

30 **Community Dev Block Grant Fund**

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00774430	497263	AFFORDABLE REMODELING SOLUTION	9/22/2022	36,483.00
			Fund Total	**36,483.00**

31 Head Start Fund

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00774461	37266	CENTURY LINK	9/22/2022	148.02
00774462	37266	CENTURY LINK	9/22/2022	206.00
00774468	2157	COLO OCCUPATIONAL MEDICINE PHY	9/22/2022	90.00
00774472	248029	COMMUNITY REACH CENTER FOUNDAT	9/22/2022	6,515.84
00774491	834853	GETHSEMANE LUTHERAN CHURCH	9/22/2022	6,600.25
00774508	40843	LANGUAGE LINE SERVICES	9/22/2022	37.72
00774589	31360	WESTMINSTER PRESBYTERIAN CHURC	9/22/2022	2,890.84
00774590	59983	WESTMINSTER PUBLIC SCHOOLS	9/22/2022	2,812.00
			Fund Total	**19,300.67**

34 **Comm Services Blk Grant Fund**

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00774484	8818069	FAMILY TREE INC	9/22/2022	952.72
			Fund Total	**952.72**

35 Workforce & Business Center

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00774441	1017093	ASPEN FLYING CLUB	9/22/2022	11,580.00
00774442	140646	AZTEC SOFTWARE LLC	9/22/2022	1,250.00
00774587	248558	WELLS FARGO HOME MORTGAGE	9/22/2022	3,155.66
			Fund Total	**15,985.66**

49 **Public Health Department Fund**

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00774445	1279402	BERRY DUNN MCNEIL & PARKER LLC	9/22/2022	11,950.00
			Fund Total	**11,950.00**

50 **FLATROCK Facility Fund**

Warrant	Supplier No	Supplier Name	Warrant Date	Amount
00774427	72554	AAA PEST PROS	9/22/2022	60.00
00774446	178439	BEST CLEANER DISPOSAL INC	9/22/2022	377.75
00774528	612089	PBC COMMERCIAL CLEANING SYSTEM	9/22/2022	1,671.14
			Fund Total	**2,108.89**

Grand Total	**4,220,533.87**

2051	ANS - Admin & Customer Care	Fund	Voucher	Batch No	GL Date	Amount
	Animal Control/Shelter					
	VELASQUEZ BRITTANY	00001	1027491	427464	9/21/2022	200.00
					Account Total	200.00
					Department Total	200.00

1011	Board of County Commissioners	Fund	Voucher	Batch No	GL Date	Amount
	Printing External					
	SIR SPEEDY	00001	1027412	427427	9/21/2022	74.12
					Account Total	74.12
	Special Events					
	ROCKY MOUNTAIN PARTNERSHIP	00001	1027202	427031	9/15/2022	1,000.00
					Account Total	1,000.00
					Department Total	1,074.12

4	Capital Facilities Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	ALL PRO CEMENT INC	00004	1027700	427546	9/22/2022	175.00
	Essenza Architecture	00004	1027688	427546	9/22/2022	7,813.25
	Essenza Architecture	00004	1027689	427546	9/22/2022	62,506.00
					Account Total	70,494.25
					Department Total	70,494.25

941018	CDBG 2018/2019	Fund	Voucher	Batch No	GL Date	Amount
	Grants to Other Institutions					
	AFFORDABLE REMODELING SOLUTION	00030	1027507	427474	9/21/2022	6,490.00
	AFFORDABLE REMODELING SOLUTION	00030	1027508	427476	9/21/2022	5,950.00
	AFFORDABLE REMODELING SOLUTION	00030	1027509	427477	9/21/2022	15,348.00
	AFFORDABLE REMODELING SOLUTION	00030	1027510	427478	9/21/2022	8,695.00
					Account Total	36,483.00
					Department Total	36,483.00

1023	CLK Motor Vehicle	Fund	Voucher	Batch No	GL Date	Amount
	Printing External					
	COPYCO QUALITY PRINTING INC	00001	1027449	427450	9/21/2022	340.00
					Account Total	340.00
					Department Total	340.00

3060	Code Compliance	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	ARBORFORCE LLC	00001	1027339	427318	9/20/2022	933.14
					Account Total	933.14
					Department Total	933.14

9264	Community Recovery	Fund	Voucher	Batch No	GL Date	Amount
	Grants to Other Instit					
	FIVE STAR EDUCATION FOUNDATIO	00001	1027235	427083	9/16/2022	350,782.78
	FIVE STAR EDUCATION FOUNDATIO	00001	1027236	427084	9/16/2022	453,300.00
	ADAMS COUNTY FIRE PROTECTION D	00001	1027103	427011	9/15/2022	230,000.00
	ADELANTE COMMUNITY DEVELOPMENT	00001	1027383	427348	9/20/2022	620,887.50
	COAL CREEK ADULT EDUCATION CEN	00001	1027237	427085	9/16/2022	15,000.00
	FOOD FOR HOPE	00001	1027382	427347	9/20/2022	60,158.33
	ULTIMATE BEAUTY HAIRCARE & SUP	00001	1027340	427321	9/20/2022	5,000.00
	VIDA CONSEJERIA INDIVIDUAL & F	00001	1027380	427345	9/20/2022	30,000.00
					Account Total	1,765,128.61
					Department Total	1,765,128.61

2031	County Coroner	Fund	Voucher	Batch No	GL Date	Amount
	Medical Services					
	CARUSO JAMES LOUIS	00001	1027258	427111	9/16/2022	3,075.00
					Account Total	3,075.00
	Operating Supplies					
	ELDORADO ARTESIAN SPRINGS INC	00001	1027266	427112	9/16/2022	.31
	ELDORADO ARTESIAN SPRINGS INC	00001	1027267	427112	9/16/2022	41.95
	ELDORADO ARTESIAN SPRINGS INC	00001	1027268	427112	9/16/2022	11.00
	ELDORADO ARTESIAN SPRINGS INC	00001	1027269	427112	9/16/2022	4.00
	SOUTHLAND MEDICAL LLC	00001	1027272	427112	9/16/2022	650.21
					Account Total	707.47
	Other Professional Serv					
	FEDEX	00001	1027273	427112	9/16/2022	170.75
	FEDEX	00001	1027274	427112	9/16/2022	113.35
	FEDEX	00001	1027275	427112	9/16/2022	81.00
	FEDEX	00001	1027276	427112	9/16/2022	199.15
	FEDEX	00001	1027277	427112	9/16/2022	35.87
	FIRST CALL OF COLO	00001	1027265	427112	9/16/2022	4,495.00
	LABORATORY CORPORATION OF AMER	00001	1027278	427112	9/16/2022	1,886.62
	LEXIS NEXIS MATTHEW BENDER	00001	1027271	427112	9/16/2022	190.36
	MECSTAT LABORATORIES	00001	1027262	427112	9/15/2022	195.00
	MECSTAT LABORATORIES	00001	1027263	427112	9/16/2022	195.00
	NICOLETTI-FLATER ASSOCIATES	00001	1027281	427112	9/16/2022	240.00
	NMS LABS	00001	1027270	427112	9/16/2022	17,551.00
	PALEO DNA	00001	1027259	427112	9/15/2022	378.00
	PALEO DNA	00001	1027260	427112	9/15/2022	1,339.20
	PERKINELMER GENETICS	00001	1027264	427112	9/16/2022	105.00
	SUMMIT PATHOLOGY	00001	1027279	427112	9/16/2022	3,091.35
	THOMSON REUTERS - WEST	00001	1027280	427112	9/16/2022	560.07
					Account Total	30,826.72
	Postage & Freight					
	PURCHASE POWER	00001	1027261	427112	9/15/2022	113.33
					Account Total	113.33
	Subscrip/Publications					
	CORHIO	00001	1027282	427112	9/16/2022	1,170.00

2031	County Coroner	Fund	Voucher	Batch No	GL Date	Amount
					Account Total	1,170.00
					Department Total	35,892.52

951016	CSBG	Fund	Voucher	Batch No	GL Date	Amount
	Education & Training					
	FAMILY TREE INC	00034	1027101	427008	9/15/2022	310.00
					Account Total	310.00
	Travel & Transportation					
	FAMILY TREE INC	00034	1027101	427008	9/15/2022	642.72
					Account Total	642.72
					Department Total	952.72

9248	Culture Services	Fund	Voucher	Batch No	GL Date	Amount
	Employee Development					
	SIR SPEEDY	00001	1027358	427327	9/20/2022	59.47
					Account Total	59.47
					Department Total	59.47

1051	District Attorney	Fund	Voucher	Batch No	GL Date	Amount
	Court Reporting Transcripts					
	MAZE AMANDA	00001	1027396	427421	9/21/2022	75.00
	WAGNER GEORGIA C	00001	1027398	427421	9/21/2022	101.25
					Account Total	176.25
					Department Total	176.25

7041	Economic Development Center	Fund	Voucher	Batch No	GL Date	Amount
	Grants to Other Instit					
	ADAMS COUNTY REGIONAL ECONOMIC	00001	1026943	426798	9/13/2022	25,000.00
	ADAMS COUNTY REGIONAL ECONOMIC	00001	1026944	426798	9/13/2022	50,000.00
	ADAMS COUNTY REGIONAL ECONOMIC	00001	1026946	426798	9/13/2022	50,000.00
	ADAMS COUNTY REGIONAL ECONOMIC	00001	1026947	426798	9/13/2022	25,000.00
					Account Total	150,000.00
					Department Total	150,000.00

6	Equipment Service Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	PRECISE MRM LLC	00006	1027490	427447	9/21/2022	6,096.00
	SAM HILL OIL INC	00006	1027472	427447	9/21/2022	23,740.62
	SAM HILL OIL INC	00006	1027473	427447	9/21/2022	21,608.40
	SAM HILL OIL INC	00006	1027474	427447	9/21/2022	25,261.51
	SAM HILL OIL INC	00006	1027475	427447	9/21/2022	26,121.34
	SAM HILL OIL INC	00006	1027476	427447	9/21/2022	27,379.41
	SAM HILL OIL INC	00006	1027477	427447	9/21/2022	33,646.29
	SAM HILL OIL INC	00006	1027478	427447	9/21/2022	19,504.71
	SAM HILL OIL INC	00006	1027479	427447	9/21/2022	905.18
	SAM HILL OIL INC	00006	1027480	427447	9/21/2022	6,638.12
	SAM HILL OIL INC	00006	1027481	427447	9/21/2022	3,299.66
	SAM HILL OIL INC	00006	1027482	427447	9/21/2022	11,734.88
	SAM HILL OIL INC	00006	1027483	427447	9/21/2022	38,689.65
	SAM HILL OIL INC	00006	1027484	427447	9/21/2022	3,288.55
	SAM HILL OIL INC	00006	1027485	427447	9/21/2022	5,588.14
	SAM HILL OIL INC	00006	1027486	427447	9/21/2022	1,169.30
					Account Total	254,671.76
					Department Total	254,671.76

98802	ESF Supplemental PY20	Fund	Voucher	Batch No	GL Date	Amount
	Software and Licensing					
	AZTEC SOFTWARE LLC	00035	1027296	426892	9/19/2022	1,250.00
					Account Total	1,250.00
					Department Total	1,250.00

9240	Extension - Horticulture	Fund	Voucher	Batch No	GL Date	Amount
	Travel & Transportation					
	46675	00001	1027319	427295	9/20/2022	69.00
	46675	00001	1027319	427295	9/20/2022	69.00
	46675	00001	1027319	427295	9/20/2022	5.00
	46675	00001	1027319	427295	9/20/2022	36.00
	46675	00001	1027319	427295	9/20/2022	36.00
	46675	00001	1027319	427295	9/20/2022	69.00
					Account Total	284.00
					Department Total	284.00

9244	Extension- 4-H/Youth	Fund	Voucher	Batch No	GL Date	Amount
	Mileage Reimbursements					
	46392	00001	1027316	427295	9/20/2022	19.89
	46394	00001	1027317	427295	9/20/2022	28.08
	46395	00001	1027318	427295	9/20/2022	110.00
					Account Total	157.97
	Operating Supplies					
	AMERICAN INCOME LIFE INS CO	00001	1027284	427118	9/16/2022	25.00
	AMERICAN INCOME LIFE INS CO	00001	1027159	427026	9/15/2022	15.00
	BOULDER COUNTY 4-H	00001	1027283	427118	9/16/2022	350.00
					Account Total	390.00
					Department Total	547.97

6031	Extension- Soil Conservation	Fund	Voucher	Batch No	GL Date	Amount
	Operating Supplies					
	DEER TRAIL / EAST ADAMS	00001	1027099	427004	9/8/2022	9,500.00
					Account Total	9,500.00
					Department Total	9,500.00

50	FLATROCK Facility Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	AAA PEST PROS	00050	1027694	427546	9/22/2022	60.00
	BEST CLEANER DISPOSAL INC	00050	1027465	427447	9/21/2022	377.75
	PBC COMMERCIAL CLEANING SYSTEM	00050	1027728	427546	9/22/2022	1,671.14
					Account Total	2,108.89
					Department Total	2,108.89

1076	FO - Adams County Svc Center	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=13306	00001	1027289	427202	9/13/2022	4,168.04
					Account Total	4,168.04
					Department Total	4,168.04

5025	FO - Club House Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Building Repair & Maint					
	CMI MECHANICAL	00005	1027424	427435	9/21/2022	437.77
					Account Total	437.77
					Department Total	437.77

1060	FO - Community Corrections	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=13302	00001	1027285	427202	9/13/2022	439.75
					Account Total	439.75
					Department Total	439.75

1112	FO - Coroner's Office	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=13298	00001	1027290	427202	9/9/2022	807.60
	Energy Cap Bill ID=13300	00001	1027291	427202	9/9/2022	5,168.05
					Account Total	5,975.65
					Department Total	5,975.65

2009	FO - Detention Center	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=13297	00001	1027292	427202	9/9/2022	16,782.19
	Energy Cap Bill ID=13301	00001	1027293	427202	9/9/2022	28,983.60
	Energy Cap Bill ID=13303	00001	1027294	427202	9/9/2022	150.20
					Account Total	45,915.99
					Department Total	45,915.99

1070	FO - Fleet Building	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	Energy Cap Bill ID=13299	00001	1027286	427202	9/13/2022	49.61
	Energy Cap Bill ID=13305	00001	1027287	427202	9/13/2022	49.61
					Account Total	99.22
					Department Total	99.22

1077	FO - Government Center	Fund	Voucher	Batch No	GL Date	Amount
	Building Repair & Maint					
	COLORADO MOISTURE CONTROL INC	00001	1027431	427435	9/21/2022	7,144.00
	STANLEY CONVERGENT SECURITY S	00001	1027426	427435	9/21/2022	695.00
	SUMMIT LABORATORIES INC	00001	1027427	427435	9/21/2022	519.00
					Account Total	8,358.00
					Department Total	8,358.00

1079	FO - Human Services Center	Fund	Voucher	Batch No	GL Date	Amount
	Other Repair & Maint					
	PARK 12 HUNDRED OWNERS ASSOCIA	00001	1027429	427435	9/21/2022	16,737.00
					Account Total	16,737.00
					Department Total	16,737.00

1019	FO - Mailroom & Dock	Fund	Voucher	Batch No	GL Date	Amount
	Postage & Freight					
	UNITED STATES POSTAL SERVICE	00001	1027442	427449	9/21/2022	197.80
					Account Total	197.80
					Department Total	197.80

1106	FO - Westminster MV	Fund	Voucher	Batch No	GL Date	Amount
	Building Rental					
	WESTAR REAL PROPERTY SERVICES	00001	1027428	427435	9/21/2022	14,662.82
					Account Total	14,662.82
					Department Total	14,662.82

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	Diversion Restitution Payable					
	COLORADO HOSPITALITY SERVICES	00001	1027392	427421	9/21/2022	50.00
	DELGADO ANTHONY	00001	1027391	427421	9/21/2022	50.00
	ROMERO LILIANA	00001	1027394	427421	9/21/2022	60.00
	SANTIAGOS MEXICAN RESTURANT	00001	1027395	427421	9/21/2022	25.00
					Account Total	185.00
	Received not Vouchered Clrg					
	AAA PEST PROS	00001	1027724	427546	9/22/2022	60.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	125.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	40.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	40.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	30.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	35.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	120.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	100.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	45.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	40.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	85.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	65.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	150.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	40.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	40.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	40.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	40.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	310.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	55.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	55.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	215.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	60.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	325.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	140.00
	AAA PEST PROS	00001	1027724	427546	9/22/2022	115.00
	AIRBOUND	00001	1027696	427546	9/22/2022	12,915.00
	ALLIANCE FOR INNOVATION INC	00001	1027701	427546	9/22/2022	3,825.00
	ALLIED UNIVERSAL SECURITY SERV	00001	1027719	427554	9/22/2022	5,433.48

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	ALLIED UNIVERSAL SECURITY SERV	00001	1027720	427554	9/22/2022	5,309.64
	ALLIED UNIVERSAL SECURITY SERV	00001	1027721	427554	9/22/2022	5,294.16
	ALLIED UNIVERSAL SECURITY SERV	00001	1027722	427554	9/22/2022	5,479.92
	ALSCO AMERICAN INDUSTRIAL	00001	1027705	427546	9/22/2022	232.20
	ARTIST BETH WARMATH LLC	00001	1027699	427546	9/22/2022	3,750.00
	BACKFLOW TECH INC	00001	1027686	427546	9/22/2022	265.00
	BAYAUD ENTERPRISES INC	00001	1027455	427447	9/21/2022	39,119.43
	BISCUITS AND BERRIES CATERING	00001	1027744	427567	9/22/2022	25,955.59
	BMC SOFTWARE INC	00001	1027697	427546	9/22/2022	8,214.80
	CHP METRO NORTH LLC	00001	1027445	427447	9/21/2022	1,050.00
	COMPLETE DOOR SYSTEMS INC	00001	1027496	427447	9/21/2022	5,699.00
	CORECIVIC INC	00001	1027452	427447	9/21/2022	8,721.95
	CORECIVIC INC	00001	1027453	427447	9/21/2022	6,133.05
	CORECIVIC INC	00001	1027454	427447	9/21/2022	285.20
	EAGLE ROCK DISTRIBUTING COMP O	00001	1027488	427447	9/21/2022	136.44
	EAGLE ROCK DISTRIBUTING COMP O	00001	1027489	427447	9/21/2022	189.00
	FLEXENTIAL PROFESSIONAL SERVIC	00001	1027487	427447	9/21/2022	1,850.01
	INNOVEST PORTFOLIO SOLUTIONS L	00001	1027703	427546	9/22/2022	9,500.00
	INSIGHT PUBLIC SECTOR	00001	1027691	427546	9/22/2022	989.89
	INSIGHT PUBLIC SECTOR	00001	1027692	427546	9/22/2022	20,496.00
	INTERVENTION COMMUNITY CORRECT	00001	1027456	427447	9/21/2022	569.25
	INTERVENTION COMMUNITY CORRECT	00001	1027457	427447	9/21/2022	1,161.78
	INTERVENTION COMMUNITY CORRECT	00001	1027458	427447	9/21/2022	9,899.00
	INTERVENTION COMMUNITY CORRECT	00001	1027459	427447	9/21/2022	202,900.50
	INTERVENTION COMMUNITY CORRECT	00001	1027460	427447	9/21/2022	15,858.40
	INVENTING ROOM	00001	1027443	427447	9/21/2022	3,143.75
	J. BROWER PSYCHOLOGICAL SERVIC	00001	1027706	427546	9/22/2022	2,600.00
	J. BROWER PSYCHOLOGICAL SERVIC	00001	1027707	427546	9/22/2022	2,000.00
	KNS COMMUNICATIONS CONSULTANTS	00001	1027693	427546	9/22/2022	6,313.07
	LARIMER COUNTY COMMUNITY CORRE	00001	1027448	427447	9/21/2022	2,118.54
	MESA COUNTY	00001	1027495	427447	9/21/2022	2,097.77
	MW GOLDEN CONSTRUCTORS	00001	1027500	427447	9/21/2022	1,500.00
	MW GOLDEN CONSTRUCTORS	00001	1027500	427447	9/21/2022	2,000.00
	MW GOLDEN CONSTRUCTORS	00001	1027501	427447	9/21/2022	1,500.00
	ONENECK IT SOLUTIONS LLC	00001	1027698	427546	9/22/2022	93,240.00
	ORACLE AMERICA INC	00001	1027494	427447	9/21/2022	3,664.37

1	General Fund	Fund	Voucher	Batch No	GL Date	Amount
	ORACLE AMERICA INC	00001	1027466	427447	9/21/2022	51,382.68
	QUICKSILVER EXPRESS COURIER	00001	1027446	427447	9/21/2022	126.26
	RED FLAG REPORTING	00001	1027462	427447	9/21/2022	3,325.00
	ROCKY MOUNTAIN PARTNERSHIP	00001	1027687	427546	9/22/2022	7,134.33
	SANITY SOLUTIONS INC	00001	1027437	427442	9/21/2022	1,076.58
	SANITY SOLUTIONS INC	00001	1027438	427442	9/21/2022	3,229.74
	SENIOR HUB THE	00001	1027439	427442	9/21/2022	96,112.19
	SHERMAN & HOWARD LLC	00001	1027444	427447	9/21/2022	1,593.75
	SOUTHWESTERN PAINTING	00001	1027718	427554	9/22/2022	11,243.00
	STATE OF COLORADO	00001	1027704	427546	9/22/2022	35,196.10
	STEELOCK GENERAL FENCE CONTRAC	00001	1027726	427546	9/22/2022	2,600.00
	SUMMIT FOOD SERVICE LLC	00001	1027708	427546	9/22/2022	9,370.80
	SWIRE COCA-COLA USA	00001	1027493	427447	9/21/2022	7,456.66
	SWIRE COCA-COLA USA	00001	1027493	427447	9/21/2022	14,183.42
	TYGRETT DEBRA R	00001	1027725	427546	9/22/2022	250.00
	VICTORY SUPPLY LLC	00001	1027709	427546	9/22/2022	299.18
	WEIN JEFFREY MARC	00001	1027690	427546	9/22/2022	5,400.00
					Account Total	773,760.88
					Department Total	773,945.88

5	Golf Course Enterprise Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	AAA PEST PROS	00005	1027695	427546	9/22/2022	45.00
					Account Total	45.00
					Department Total	45.00

5026	Golf Course- Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	Contract Employment					
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	481.62
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	25,454.33
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	2,960.78
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	13,699.58
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	1,717.70
					Account Total	44,314.01
	Equipment Rental					
	BUCKEYE WELDING SUPPLY CO INC	00005	1027115	427018	9/15/2022	30.60
					Account Total	30.60
	Gas & Electricity					
	UNITED POWER (UNION REA)	00005	1027135	427018	9/15/2022	4,062.59
	UNITED POWER (UNION REA)	00005	1027136	427018	9/15/2022	4,652.42
	UNITED POWER (UNION REA)	00005	1027137	427018	9/15/2022	1,147.04
	UNITED POWER (UNION REA)	00005	1027138	427018	9/15/2022	30.64
	UNITED POWER (UNION REA)	00005	1027139	427018	9/15/2022	169.82
	XCEL ENERGY	00005	1027140	427018	9/15/2022	122.83
					Account Total	10,185.34
	Grounds Maintenance					
	C P S DISTRIBUTORS INC	00005	1027116	427018	9/15/2022	688.99
	C P S DISTRIBUTORS INC	00005	1027117	427018	9/15/2022	826.16
	CEM LAKE MGMT	00005	1027415	427434	9/21/2022	494.00
	GOLF & SPORT SOLUTIONS	00005	1027120	427018	9/15/2022	667.12
	GOLF & SPORT SOLUTIONS	00005	1027121	427018	9/15/2022	2,111.43
	GOLF & SPORT SOLUTIONS	00005	1027122	427018	9/15/2022	2,352.16
	L L JOHNSON DIST	00005	1027126	427018	9/15/2022	772.90
	L L JOHNSON DIST	00005	1027419	427434	9/21/2022	203.03
	ROCKY MTN PUMP & CONTROLS LLC	00005	1027422	427434	9/21/2022	1,990.00
	ROCKY MTN PUMP & CONTROLS LLC	00005	1027131	427018	9/15/2022	390.00
	TORO NSN	00005	1027423	427434	9/21/2022	233.00
					Account Total	10,728.79
	Other Repair & Maint					
	CRACKERJACK MUDJACKING INC	00005	1027118	427018	9/15/2022	2,020.00
	LABOR SOLUTIONS INC	00005	1027416	427434	9/21/2022	8,000.00

5026	Golf Course- Maintenance	Fund	Voucher	Batch No	GL Date	Amount
	UNDERWATER RECOVERY SPECIALIST	00005	1027132	427018	9/15/2022	1,170.00
					Account Total	11,190.00
	Repair & Maint Supplies					
	ALSCO AMERICAN INDUSTRIAL	00005	1027112	427018	9/15/2022	60.72
	ALSCO AMERICAN INDUSTRIAL	00005	1027113	427018	9/15/2022	58.44
	ALSCO AMERICAN INDUSTRIAL	00005	1027114	427018	9/15/2022	58.44
	CULLIGAN	00005	1027119	427018	9/15/2022	251.77
					Account Total	429.37
	Telephone					
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	242.21
					Account Total	242.21
	Vehicle Parts & Supplies					
	L L JOHNSON DIST	00005	1027123	427018	9/15/2022	213.13
	L L JOHNSON DIST	00005	1027124	427018	9/15/2022	438.42
	L L JOHNSON DIST	00005	1027125	427018	9/15/2022	263.88
	L L JOHNSON DIST	00005	1027417	427434	9/21/2022	323.00
	L L JOHNSON DIST	00005	1027418	427434	9/21/2022	406.12
	POTESTIO BROTHER EQUIPMENT	00005	1027420	427434	9/21/2022	841.55
	POTESTIO BROTHER EQUIPMENT	00005	1027421	427434	9/21/2022	1,041.24
	POTESTIO BROTHER EQUIPMENT	00005	1027127	427018	9/15/2022	141.52
	POTESTIO BROTHER EQUIPMENT	00005	1027129	427018	9/15/2022	1,178.61
	POTESTIO BROTHER EQUIPMENT	00005	1027128	427018	9/15/2022	787.10-
					Account Total	4,060.37
					Department Total	81,180.69

5021	Golf Course- Pro Shop	Fund	Voucher	Batch No	GL Date	Amount
	Contract Employment					
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	19,724.86
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	2,331.67
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	165.48
					Account Total	22,222.01
	Gas & Electricity					
	UNITED POWER (UNION REA)	00005	1027133	427018	9/15/2022	27.28
	UNITED POWER (UNION REA)	00005	1027134	427018	9/15/2022	3,364.26
	XCEL ENERGY	00005	1027140	427018	9/15/2022	772.67
					Account Total	4,164.21
	Golf Merchandise					
	PROFESSIONAL RECREATION MGMT I	00005	1027714	427551	9/22/2022	1,423.87
	PROFESSIONAL RECREATION MGMT I	00005	1027714	427551	9/22/2022	681.39
	PROFESSIONAL RECREATION MGMT I	00005	1027714	427551	9/22/2022	296.11
	PROFESSIONAL RECREATION MGMT I	00005	1027714	427551	9/22/2022	459.39
	PROFESSIONAL RECREATION MGMT I	00005	1027714	427551	9/22/2022	4,381.52
					Account Total	7,242.28
	Insurance Premiums					
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	597.48
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	6,586.69
					Account Total	7,184.17
	Security Service					
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	441.00
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	1,343.57
					Account Total	1,784.57
	Telephone					
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	82.48
	PROFESSIONAL RECREATION MGMT I	00005	1027463	427452	9/21/2022	66.92
					Account Total	149.40
	Water/Sewer/Sanitation					
	REPUBLIC SERVICES #535	00005	1027130	427018	9/15/2022	1,085.97
					Account Total	1,085.97
					Department Total	43,832.61

935122	HHS Grant	Fund	Voucher	Batch No	GL Date	Amount
	Building Rental					
	COMMUNITY REACH CENTER FOUNDAT	00031	1027027	426898	9/14/2022	6,515.84
	GETHSEMANE LUTHERAN CHURCH	00031	1027030	426898	9/14/2022	6,600.25
	WESTMINSTER PRESBYTERIAN CHURC	00031	1027032	426898	9/14/2022	2,890.84
	WESTMINSTER PUBLIC SCHOOLS	00031	1027033	426898	9/14/2022	2,812.00
					Account Total	18,818.93
	Interpreting Services					
	LANGUAGE LINE SERVICES	00031	1027031	426898	9/14/2022	37.72
					Account Total	37.72
	Medical Services					
	COLO OCCUPATIONAL MEDICINE PHY	00031	1027028	426898	9/14/2022	90.00
					Account Total	90.00
	Telephone					
	CENTURY LINK	00031	1027024	426898	9/14/2022	148.02
	CENTURY LINK	00031	1027025	426898	9/14/2022	206.00
					Account Total	354.02
					Department Total	19,300.67

8622	Insurance -Benefits & Wellness	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	MINES & ASSOCIATES PC	00019	1027355	427327	9/20/2022	300.00
					Account Total	300.00
					Department Total	300.00

19	Insurance Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	CAREHERE LLC	00019	1027450	427447	9/21/2022	46,073.89
	CAREHERE LLC	00019	1027451	427447	9/21/2022	10,293.57
	CAREHERE LLC	00019	1027447	427447	9/21/2022	39,559.00
	COLO STATE TREASURER	00019	1027505	427447	9/21/2022	15.25
	COLO STATE TREASURER	00019	1027506	427447	9/21/2022	.23
					Account Total	95,941.94
	Retiree Med - Kaiser					
	KAISER PERMANENTE	00019	1027503	427470	9/21/2022	61,112.71
					Account Total	61,112.71
	Retiree Med - Pacificare					
	UNITEDHEALTHCARE INSURANCE COM	00019	1027497	427468	9/21/2022	40,630.52
					Account Total	40,630.52
					Department Total	197,685.17

1061	IT Administration	Fund	Voucher	Batch No	GL Date	Amount
	Consultant Services					
	CHRISTENSEN MELANIE	00001	1027088	426928	9/14/2022	415.20
	CHRISTENSEN MELANIE	00001	1027089	426928	9/14/2022	560.55
					Account Total	975.75
					Department Total	975.75

6202	Open Space Tax- Grants	Fund	Voucher	Batch No	GL Date	Amount
	Grants to Other Instit					
	BENNETT TOWN OF	00028	1026400	426325	9/7/2022	350,159.56
					Account Total	350,159.56
					Department Total	350,159.56

1015	People Services	Fund	Voucher	Batch No	GL Date	Amount
	Insurance Premiums					
	KAISER PERMANENTE	00001	1027504	427470	9/21/2022	34,850.00
	UNITEDHEALTHCARE INSURANCE COM	00001	1027498	427468	9/21/2022	9,550.00
					Account Total	44,400.00
					Department Total	44,400.00

2061	PKS - Weed & Pest	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	VERIZON WIRELESS	00001	1027393	427420	9/21/2022	80.02
					Account Total	80.02
					Department Total	80.02

5012	PKS- Regional Complex	Fund	Voucher	Batch No	GL Date	Amount
	Improv Other Than Bldgs					
	SOUTHWESTERN PAINTING	00001	1027332	427308	9/20/2022	13,214.00
					Account Total	13,214.00
	Other Professional Serv					
	VERIZON WIRELESS	00001	1027390	427420	9/21/2022	65.69
					Account Total	65.69
					Department Total	13,279.69

5016	PKS- Trail Ranger Patrol	Fund	Voucher	Batch No	GL Date	Amount
	Water/Sewer/Sanitation					
	NORTH WASHINGTON ST WATER & SA	00001	1027388	427420	9/21/2022	25,595.15
	NORTH WASHINGTON ST WATER & SA	00001	1027389	427420	9/21/2022	3,823.55
					Account Total	29,418.70
					Department Total	29,418.70

1082	PLN- Development Review	Fund	Voucher	Batch No	GL Date	Amount
	Software and Licensing					
	CIVICPLUS llc	00001	1026906	426781	9/13/2022	100.00
					Account Total	100.00
					Department Total	100.00

49	Public Health Department Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	BERRY DUNN MCNEIL & PARKER LLC	00049	1027702	427546	9/22/2022	11,950.00
					Account Total	11,950.00
					Department Total	11,950.00

3056	PW - Capital Improvement Plan	Fund	Voucher	Batch No	GL Date	Amount
	Road & Streets					
	HILLEN HOLDINGS LLC	00013	1027330	427306	9/20/2022	5,750.00
					Account Total	5,750.00
					Department Total	5,750.00

8615	Retiree Pre65 UHC	Fund	Voucher	Batch No	GL Date	Amount
	Administration Fee					
	UNITED HEALTHCARE	00019	1027499	427468	9/21/2022	601.86
	UNITED HEALTHCARE	00019	1027499	427468	9/21/2022	85.98
					Account Total	687.84
	Insurance Premiums					
	UNITED HEALTHCARE	00019	1027499	427468	9/21/2022	1,802.22
	UNITED HEALTHCARE	00019	1027499	427468	9/21/2022	257.46
					Account Total	2,059.68
					Department Total	2,747.52

8624	Retiree Vision	Fund	Voucher	Batch No	GL Date	Amount
	Ins. Premium-Vision					
	FIRST AMERICAN ADMINISTRATORS	00019	1027502	427470	9/21/2022	182.31
					Account Total	182.31
					Department Total	182.31

13	Road & Bridge Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	MARTIN MARTIN CONSULTING ENGIN	00013	1027467	427447	9/21/2022	3,037.50
	MARTIN MARTIN CONSULTING ENGIN	00013	1027468	427447	9/21/2022	72,536.75
	SALTWORX INC	00013	1027435	427442	9/21/2022	100,050.00
	SALTWORX INC	00013	1027435	427442	9/21/2022	798.23
					Account Total	176,422.48
					Department Total	176,422.48

2011	SHF- Admin Services Division	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	COLO OCCUPATIONAL MEDICINE PHY	00001	1027334	427312	9/20/2022	600.00
	POINT SPORTS/ERGOMED	00001	1027336	427312	9/20/2022	180.00
	PSYCHOLOGICAL DIMENSIONS	00001	1027337	427312	9/20/2022	900.00
					Account Total	1,680.00
					Department Total	1,680.00

2015	SHF- Civil Section	Fund	Voucher	Batch No	GL Date	Amount
	Sheriff's Fees					
	ALTITUDE COMMUNITY LAW	00001	1027302	427203	9/19/2022	19.00
	BRILLIANT BEAUTY AESTHETIC & L	00001	1027304	427203	9/19/2022	19.00
	FRIAS ADRIANA MARIA	00001	1027310	427203	9/19/2022	19.00
	GPS SERVERS LLC	00001	1027303	427203	9/19/2022	19.00
	HERNANDEZ JULIO	00001	1027309	427203	9/19/2022	19.00
	LEGAL SERVICES OF SOUTHERN MIS	00001	1027311	427203	9/19/2022	19.00
	MIDLAND CREDIT MANAGEMENT INC	00001	1027300	427203	9/19/2022	19.00
	MIDLAND CREDIT MANAGEMENT INC	00001	1027301	427203	9/19/2022	19.00
	MOORE LAW GROUP APC	00001	1027313	427203	9/19/2022	19.00
	MOUNTAIN PEAK LAW GROUP PC	00001	1027298	427203	9/19/2022	19.00
	PROOF TECHNOLOGY INC	00001	1027305	427203	9/19/2022	19.00
	RIQUELME LESLIE	00001	1027307	427203	9/19/2022	19.00
	SEPULVEDA CASTILLA ITSA	00001	1027306	427203	9/19/2022	19.00
	STEIN LAW PC	00001	1027299	427203	9/19/2022	19.00
	STONE DAMIAN	00001	1027308	427203	9/19/2022	66.00
	THOMPSON DARWIN	00001	1027314	427203	9/19/2022	66.00
					Account Total	398.00
					Department Total	398.00

2071	SHF- Detention Facility	Fund	Voucher	Batch No	GL Date	Amount
	Medical Services					
	CENTURA HEALTH	00001	1027335	427312	9/20/2022	600.00
					Account Total	600.00
	Other Professional Serv					
	COLO OCCUPATIONAL MEDICINE PHY	00001	1027334	427312	9/20/2022	1,600.00
	PSYCHOLOGICAL DIMENSIONS	00001	1027337	427312	9/20/2022	1,125.00
	PSYCHOLOGICAL DIMENSIONS	00001	1027337	427312	9/20/2022	2,100.00
					Account Total	4,825.00
					Department Total	5,425.00

2018	SHF- Records/Warrants Section	Fund	Voucher	Batch No	GL Date	Amount
	Extraditions					
	ADAMS COUNTY SHERIFF	00001	1027333	427312	9/20/2022	1,907.39
					Account Total	1,907.39
					Department Total	1,907.39

3701	Stormwater Administration	Fund	Voucher	Batch No	GL Date	Amount
	Other Professional Serv					
	UTILITY NOTIFICATION CENTER OF	00007	1027384	427415	9/21/2022	1,509.30
					Account Total	1,509.30
					Department Total	1,509.30

4011	Tri County Health	Fund	Voucher	Batch No	GL Date	Amount
	Grants to Other Instit					
	TRI COUNTY HEALTH DEPT	00001	1027413	427431	9/21/2022	445.74
	TRI COUNTY HEALTH DEPT	00001	1027414	427431	9/21/2022	10,185.51
					Account Total	10,631.25
					Department Total	10,631.25

25	Waste Management Fund	Fund	Voucher	Batch No	GL Date	Amount
	Received not Vouchered Clrg					
	B & B ENVIRONMENTAL SAFETY INC	00025	1027434	427442	9/21/2022	5,402.48
					Account Total	5,402.48
					Department Total	5,402.48

97200	WIOA ADULT PROGRAM	Fund	Voucher	Batch No	GL Date	Amount
	Clnt Trng-Tuition					
	ASPEN FLYING CLUB	00035	1027315	427293	9/20/2022	1,580.00
					Account Total	1,580.00
	Supp Svcs-Housing Expenses					
	WELLS FARGO HOME MORTGAGE	00035	1027295	426892	9/19/2022	3,155.66
					Account Total	3,155.66
					Department Total	4,735.66

97700	WIOA DLW PROGRAM	Fund	Voucher	Batch No	GL Date	Amount
	Clnt Trng-Tuition					
	ASPEN FLYING CLUB	00035	1027315	427293	9/20/2022	10,000.00
					Account Total	10,000.00
					Department Total	10,000.00

Grand Total	**4,220,533.87**

Board of County Commissioners
Minutes of Commissioners' Proceedings

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

Tuesday
September 27, 2022
9:30 AM

1. ROLL CALL

Rollcall

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

2. PLEDGE OF ALLEGIANCE

3. MOTION TO APPROVE AGENDA

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

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

4. AWARDS AND PRESENTATIONS

A. Proclamation of September 28, 2022 as Good Neighbor Day

5. PUBLIC COMMENT

A. Citizen Communication

During this portion of the meeting, the board will hear public comment. The Chair will determine how much time is reserved for public comment and how much time is permitted for each speaker.

B. Elected Officials' Communication

6. CONSENT CALENDAR

A motion was made by Commissioner O'Dorisio, seconded by Commissioner Tedesco, that this Consent Calendar be approved. The motion carried by the following vote:

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

A. List of Expenditures Under the Dates of September 5-9, 2022

B. Minutes of the Commissioners' Proceedings from September 20, 2022

C. Resolution Proclaiming September 28, 2022, as Adams County Employee Recognition Day

D. Resolution Approving an Agreement for Possession and Use with Norberto G. Cabanas and Rio Javier Vargas for Property Necessary for the York Street Improvements Project – East 78th Avenue to East 88th Avenue

E. Resolution Approving the Intergovernmental Agreement between Adams County and 27J School District Regarding Colorado Preschool Special Education Program for 2022-2023

F. Resolution Approving Abatement Petitions and Authorizing the Refund of Taxes for Account Numbers P0036666, R0203025, R0173562, R0207373, R0208101, R0171823, P0037624, R0203074, R0050158, and P0037364

G. Resolution Approving the First Amendment to the Subrecipient Agreement between Adams County and Maiker Housing Partners for the Disbursement of Emergency Rental Assistance Funds

H. Resolution for Final Acceptance of the Public Improvements Constructed at the Rago Office Building, 1551 Cargill Drive, (Case No.'s PRC2018-00007, EGR2018-00045, SUB2020-00003, SIA2019-00021, UTL2020-00566)

I. Resolution for Final Acceptance of the Public Improvements Constructed at the Pecos Logistics Park Filing Number 1, 56th Ave and Pecos Street, (Case No.'s PLN2019-00005, PLT2019-00013, PLT2020-00005, RCU2019-00004, PRC2019-00016, PRC2020-00002, CSI2019-00009, CSI2020,00005, EGR2019-00017, INF2020-00006, SUB2020-00010, SIA2020,00004, SIA2021-00005, ILD2020-00066)

J. Resolution Approving Right-of-Way Agreement between Adams County and The United Water Company for Property Necessary for the 62nd Avenue Roadway and Drainage Improvements Project from Pecos Street to Washington Street

7. NEW BUSINESS

A. COUNTY MANAGER

1. Resolution Approving an Agreement between Adams County and MW Golden Constructors in the Amount of $5,000.00, for Pre-Construction Costs for Construction Manager/General Contractor Services for the Adams County Justice Center Alternative Dispute Resolution Room Conversion to Court Rooms

A motion was made by Commissioner Henry, seconded by Commissioner Tedesco, that this Resolution be approved. The motion carried by the following vote:

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

2. Resolution Approving Amendment Four to the Agreement between Adams County JK Transport, Inc., in the Amount of $175,000.00, for 2022 Truck Hauling Services

A motion was made by Commissioner O'Dorisio, seconded by Commissioner Henry, that this New Business be approved. The motion carried by the following vote:

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

B. COUNTY ATTORNEY

8. LAND USE HEARINGS

A. Cases to be Heard

1. PLN2022-00003 Thornton Water Project

A motion was made by Commissioner Henry, seconded by Commissioner O'Dorisio, that this Land Use Hearing be approved. The motion carried by the following vote:

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

2. PLN2022-00007 Advancing Adams Comprehensive Plan

A motion was made by Commissioner Henry, seconded by Commissioner Pinter, that this Land Use Hearing be approved. The motion carried by the following vote:

Aye: 4 - Commissioner Henry, Commissioner Pinter, Commissioner O'Dorisio, and Commissioner Baca

Nay: 1 - Commissioner Tedesco

Resolution Approving the 2022 Update to the Transportation Master Plan (a.k.a Advancing Adams)

A motion was made by Commissioner O'Dorisio, seconded by Commissioner Pinter, that this Resolution be approved. The motion carried by the following vote:

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

Resolution Approving the 2022 Parks, Open Space, & Trails Master Plan

A motion was made by Commissioner Baca, seconded by Commissioner Tedesco, that this Resolution be approved. The motion carried by the following vote:

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

9. ADJOURNMENT

AND SUCH OTHER MATTERS OF PUBLIC BUSINESS WHICH MAY ARISE

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Approving Right-of-Way Agreement between Adams County and Center Land Company for Property Necessary for the ADA Transition Area III – Steele Street Improvements Project in the Amount of $55,095.00
FROM: Brian Staley
AGENCY/DEPARTMENT: Public Works
HEARD AT STUDY SESSION ON:
RECOMMENDED ACTION: That the Board of County Commissioners approves the right-of-way agreement for acquisition of property interests needed for the ADA Transition Area III – Steele Street Improvements Project.

BACKGROUND:
Adams County is in the process of acquiring property interests along the Steele Street corridor from East Niver Creek to East 88th Avenue for the ADA Transition Area III – Steele Street Improvements Project. The intention of this Project is to identify and improve the overall mobility and accessibility of maturing neighborhoods with ADA accessibility connectivity including ADA-compliant sidewalks and the addition of ADA pedestrian ramps ("Improvements") where absent. Attached is a copy of the right-of-way agreement between Adams County and Center Land Company, for acquisition of the property interests in the amount of $55,095.00. The attached resolution allows the County to acquire ownership of the property interests needed for the use of the public and provide the necessary documents to close on the property.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
Adams County Public Works, Office of the County Attorney and Adams County Board of County Commissioners.

ATTACHED DOCUMENTS:
Resolution Right-of-Way Agreement

FISCAL IMPACT:
Yes

Fund:	13			
Cost Center:	3056			
		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:		9135	30562201	$15,000,000
Add'l Capital Expenditure not included in Current Budget:				
Total Expenditures:				$15,000.000

New FTEs requested: **No**

Future Amendment Needed: **No**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING RIGHT-OF-WAY AGREEMENT BETWEEN ADAMS COUNTY AND CENTER LAND COMPANY FOR PROPERTY NECESSARY FOR THE ADA TRANSITION AREA III – STEELE STREET IMPROVEMENTS PROJECT IN THE AMOUNT OF $55,095.00

WHEREAS, Adams County is in the process of acquiring right-of-way and easements along ADA Transition Area III – Steele Street Improvements Project ("Project"); and,

WHEREAS, the intention of this Project is to identify and improve the overall mobility and accessibility of maturing neighborhoods with ADA accessibility connectivity including ADA-compliant sidewalks and the addition of ADA pedestrian ramps ("Improvements") where absent; and,

WHEREAS, this right-of-way acquisition is a portion of 8240 Steele Street located in the Southeast Quarter of Section 25, Township 2 South, Range 68 West of the 6th Principal Meridian, County of Adams, State of Colorado, and owned by Center Land Company, ("Parcel 3"); and,

WHEREAS, Adams County requires ownership of Parcel 3 for construction of the street improvements; and,

WHEREAS, Center Land Company, is willing to sell Parcel 3 to Adams County under the terms and conditions of the attached Right-of-Way Agreement.

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, State of Colorado, that the attached Right-of-Way Agreement between Adams County and Center Land Company, a copy of which is attached hereto and incorporated herein by this reference, be and hereby is approved.

BE IT FURTHER RESOLVED that the Chair of the Board of County Commissioners is hereby authorized to execute said Right-of-Way Agreement on behalf of Adams County.

Right-of-Way Agreement

This Agreement is made and entered into by and between **Center Land Company** whose address is **1480 East 73rd Ave., Denver, Colorado 80229** ("Owner"), and the County of Adams, State of Colorado, a body politic, who address is 4430 South Adams County Parkway, Brighton, Colorado, 80601 ("County") for the conveyance in rights-of-way of the property described on Exhibit A attached hereto and incorporated herein by this reference (the "Property") for the ADA III Steele Street project (the "Project").

The County shall pay the Owner **FIFTY-FIVE THOUSAND AND NINETY-FIVE AND NO/100 DOLLARS ($55,095.00)** ("Purchase Price") for the Property, subject to the terms and conditions of this Agreement, the sufficiency of which is hereby acknowledged. The parties further agree that the consideration shall consist of $39,495.00 for the conveyance of road right-of-way and $15,600.00 for driveway, trees & shrubs. The Purchase Price has been agreed upon and between the parties as the total just compensation due to the Owner for the Property, including all costs and expenses, and the consideration shall be given and accepted in full satisfaction of this Agreement.

In consideration of the above premises and the mutual promise and covenants below, the Owner and the County agree to the following:

1. The Owner hereby warrants that the Owner is the sole Owner of the Property, that the Owner owns the Property in fee simple subject only to matters of record and that the Owner has the authority to enter into this Agreement and convey the Property.

2. The Owner agrees to execute and deliver to the County the attached deed upon tender by the County of a warrant (check) for the Purchase Price as soon as possible following the mutual execution of this Agreement.

3. The Owner hereby irrevocably grants to the County possession and use of the Property upon execution of this Agreement by the Owner and the County. The County and its contractors, agents, directors, employees, and all others acting by or on behalf of it, or with its permission, shall have the undisputed right to possession of the Property, and the County may use and enjoy the Property against the Owner and its respective successors and assigns and all persons claiming any right, title, or interest to the Property by and through the Owner. This grant of possession shall remain in effect with respect to the Property until such time as the County obtains from the Owner a duly executed and acknowledged deed conveying the Property.

4. The Owner agrees to pay all taxes that are due but not yet payable for the current tax year on the Property pro-rated through the date the Property is conveyed to the County, and any and all past due taxes and assessments.

5. The County through its contractor shall assure that reasonable access shall be always maintained to the Owner's property for ingress and egress. If necessary, any full closure of access shall be coordinated between the contractor and the Owner and/or its agent.

6. The County will remove a portion of the driveway, relocate the chain link or other type fence, remove the portion of the sprinkler system out of the right of way, and remove trees and shrubs identified in the right-of-way. The County has agreed to reimburse the owner the expense of these items as noted herein and made part of this Agreement. The Owner has

entered into this Agreement acknowledging that the County has the power of eminent domain and is acquiring the Property for a public purpose.

7. If the Owner fails to consummate this Agreement for any reason, except the County's default, the County may at its option, enforce this Agreement by bringing an action against the Owner for specific performance.

8. This Agreement contains all agreements, understandings and promises between the Owner and the County, relating to the Property and the Project and shall be deemed a contract binding upon the Owner and the County and their successors, heirs and assigns.

9. The Owner shall be responsible for reporting proceeds of the sale to taxing authorities, including the submittal of Form 1099-S with the Internal Revenue Service, if applicable.

10. This Agreement has been entered into in the State of Colorado and shall be governed according to the laws thereof.

11. Each party shall pay its own attorney fees. The County shall pay all closing costs.

Owner:
Center Land Company

Name: Paul Yantorno

Title: President

Signature: Paul Yantorno

Date: 8/8/22

Approved:

BOARD OF COUNTY COMMISSIONERS-COUNTY OF ADAMS, STATE OF COLORADO

Chair _____ Date _____

Approved as to Form:

County Attorney

EXHIBIT "A"

PROJECT NUMBER: 18930
PARCEL NUMBER: RW-3
DATE: SEPTEMBER 22, 2021

DESCRIPTION

A tract or parcel of land No. RW-3 of the Adams County Public Works Department, State of Colorado Project No. 18930, containing 3,038 sq. ft. (0.070 acres), more or less, lying in the Southeast 1/4 of Section 25, Township 2 South, Range 68 West of the 6th Principal Meridian, Adams County, State of Colorado, being a portion of property as described at Reception No. 363530 in the Adams County Clerk and Recorder's Office, said tract or parcel of land being more particularly described as follows:

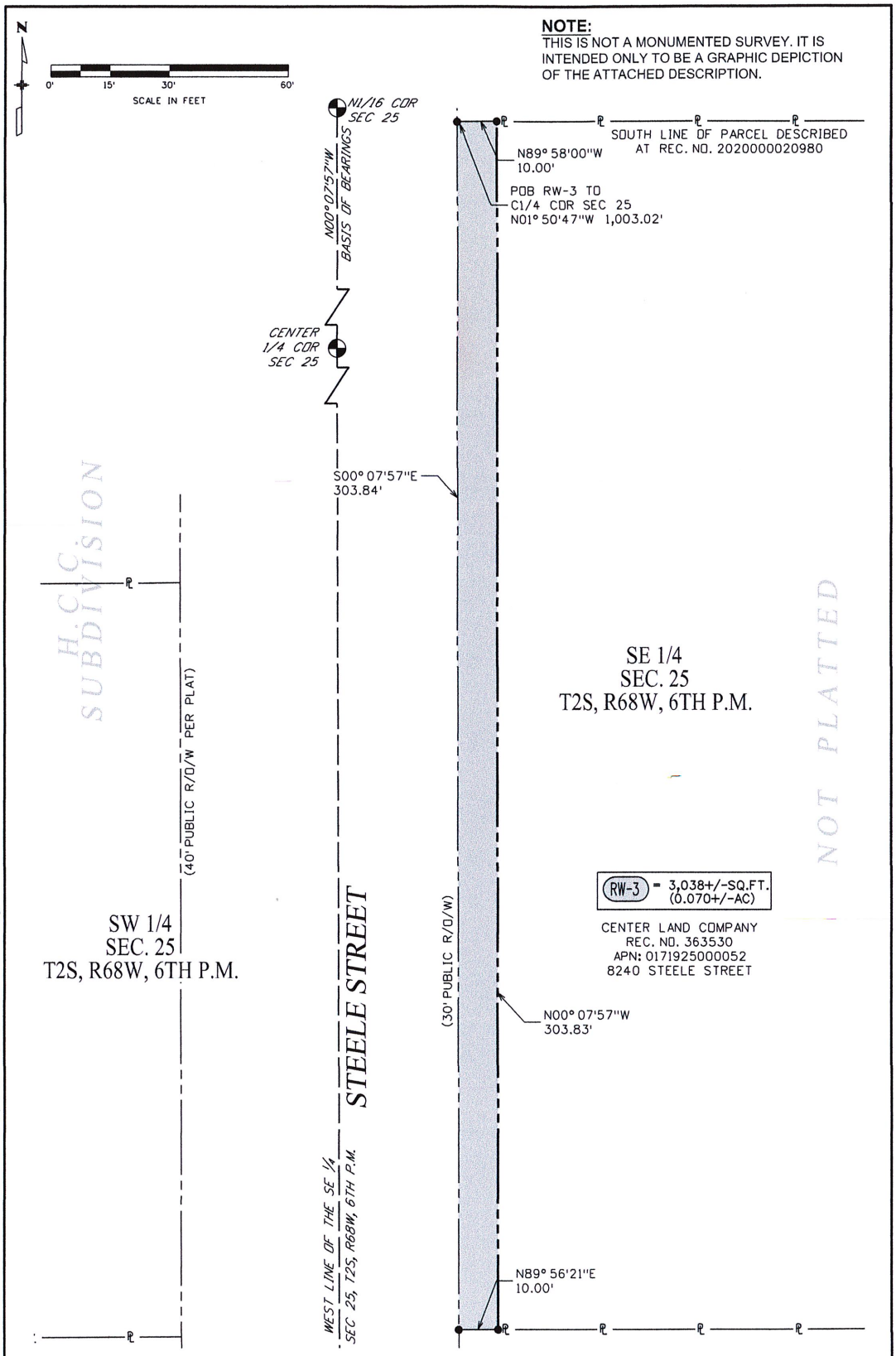
BEGINNING at a the northwest corner of said property, also being on the east right-of-way line of Steele Street, whence the Center 1/4 corner of said Section 25, being a 3-1/4" aluminum cap on a 3/4" x 30" rebar stamped "American West LS 38046 2016", bears North 01°50'47" West, 1,003.02 feet, said point being the TRUE POINT OF BEGINNING;

1. Thence along the west line of said property and east right-of-way line of Steele Street, South 00°07'57" East, a distance of 303.84 feet, to the southwest corner of said property;
2. Thence along the south line of said property, North 89°56'21" East, a distance of 10.00 feet;
3. Thence North 00°07'57" West, a distance of 303.83 feet to the north line said property;
4. Thence along said north line, North 89°58'00" West, a distance of 10.00 feet, more or less, to the TRUE POINT OF BEGINNING,

The above described tract or parcel of land contains 3,038 sq. ft. (0.070 acres), more or less.

Basis of Bearings: Bearings are based on a grid bearing of North 00°07'57" West from the Center 1/4 corner of Section 25, Township 2 South, Range 68 West of the 6th Principal Meridian, being a 3-1/4" aluminum cap on a 3/4" x 30" rebar stamped "American West LS 38046 2016", to the North 1/16 corner of said Section 25, being a 3-1/4" aluminum cap in range box stamped "City of Thornton PLS 20155 1988".

Prepared for and on behalf of
Adams County Public Works Department
Jeffry P. Eickelman, PLS #29034
Farnsworth Group, Inc.
5613 DTC Parkway, Suite 1100
Greenwood Village, CO 80111



10/25/2021 jfinley 1:51:26 PM J:\2021\021135.00 - Steele St ROW Plans\Survey\07_Drawings\18930RDW_Exhibit-RW-3.dgn

ADAMS COUNTY, COLORADO
4430 S. Adams County Parkway
1st Floor, Suite W5700
Brighton, CO 80601
Phone: 720-523-6875

ENGINEERS ARCHITECTS SURVEYORS SCIENTISTS
Farnsworth GROUP
5613 DTC Parkway, Suite 1100
GREENWOOD VILLAGE, CO 80111
(303) 682-8838 / (303) 692-0470 Fax
www.f-w.com

EXHIBIT "B"
ADAMS COUNTY ADA AREA III - STEELE STREET

PARCEL NUMBER RW-3
SE1/4 SEC 25, T-2-S R-68-W, 6TH PM
ADAMS COUNTY, COLORADO

Project No: 18930
Date: October 19, 2021
Sheet Number: 1 of 1

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Approving the Amendment to the Flexible Benefits Plan
FROM: Cindy Bero
AGENCY/DEPARTMENT: People & Culture Services
HEARD AT STUDY SESSION ON:
RECOMMENDED ACTION: That the Board of County Commissioners approves the amendment to the Flexible Spending Account that allows employees an extended grace period of 12 months for both 2020 and 2021.

BACKGROUND:
The Adams County Board of County Commissioners had previously approved the establishment of Health Care and Dependent Care Flexible Spending Accounts (FSA) for the benefit of eligible Adams County employees as a way to save money on applicable out-of-pocket expenses. During the uncertainty of the Covid-19 pandemic, the option was given to FSA plan sponsors to extend the grace period in which to incur and submit claims. By amending the plans to temporarily allow a 12-month grace period, this will help ensure employees don't lose money in their FSA plans due to changing circumstances. The plan was previously amended to allow for a temporary 12-month grace period for 2020. This amendment is to continue the temporary 12-month grace period for 2021 (and 2020).

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
People and Culture Services County Attorney's Office

ATTACHED DOCUMENTS:
Resolution FSA Amendment 2020 and 2021

FISCAL IMPACT:
No

6.D

Additional Note:

BOARD OF COUNTY COMMISSIONERS
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING THE AMENDMENT TO THE FLEXIBLE BENEFITS PLAN

WHEREAS, the Adams County Board of County Commissioners recognizes the importance of offering flexible spending account benefit plans to employees that help them save money on health and dependent care expenses; and,

WHEREAS, plan sponsors of flexible spending accounts have been given the option to temporarily extend the grace period of these plans to twelve months; and,

WHEREAS, the attached Amendment to the Health Care and Dependent Care Flexible Benefits Plan will temporarily amend the flexible spending accounts to temporarily allow a twelve-month grace period for plan years 2020 and 2021.

NOW, THEREFORE, BE IT RESOLVED, that the Board of County Commissioners, County of Adams, State of Colorado, hereby approves the attached Amendment to the Flex Benefits Plan.

AMENDMENT TO THE ADAMS COUNTY GOVERNMENT FLEXIBLE BENEFITS PLAN

This Amendment to the **Adams County Government** Flexible Benefits Plan (the "Plan") is adopted by **Adams County Government** (the "Employer"), effective as of the date set forth herein.
WHEREAS the Employer desires to amend the Adams County Government Flexible Benefits Plan's information as set forth herein.

NOW, THEREFORE, effective January 1, 2020, Adams County Government has amended its Plan to temporarily adopt the changes outlined below.

Extended Grace Period:
Extended Grace Period for twelve (12) months for Health FSAs and DCFSAs - A plan that includes a Health FSA or DCFSA may extend the grace period for a plan year ending in 2020 or 2021 to 12 months after the end of such plan year, with respect to unused benefits or contributions remaining in either arrangement. For example, a 2020 calendar year plan year with a grace period to March 15, 2021 may extend the grace period to December 31, 2021, effectively allowing participants until December 31, 2021 to incur claims against their 2020 plan year balances. Please note that health FSAs may not have both a grace period and a carryover.

Please select the Plan(s) that you would like to apply the extension:

Health FSA ☒ 2020 plan year ☒ 2021 plan year

DCFSA ☒ 2020 plan year ☒ 2021 plan year

Temporary Increase under the American Rescue Plan Act (ARPA) of Maximum Exclusion Amount for the Dependent Care Flexible Spending Arrangement (DCFSA) to $10,500

For taxable years beginning in 2021, the maximum amount of DCFSA benefits permitted for income exclusion is temporarily increased to $10,500 (or $5,250 for married taxpayers filing separately). Plans can be amended retroactively to incorporate this change provided the amendment is adopted no later than the end of the plan year in which the amendment is to be effective and the plan is operated consistently with the terms of the amendment as of the date the amendment is effective.

IN WITNESS WHEREOF, and as evidence of the adoption of the Amendment set forth herein, the undersigned officer of Adams County Government has executed this Amendment to the Plan, this _____ day of_____, 2022.

Adams County Government

By: _____
Title: _____

APPROVED AS TO FORM:

_____
Adams County Attorney's Office

ADAMS COUNTY GOVERNMENT FLEXIBLE BENEFITS PLAN
SUMMARY OF MATERIAL MODIFICATIONS TO YOUR SUMMARY PLAN DESCRIPTION

Adams County Government Flexible Benefits Plan

This document summarizes important changes to your Adams County Government Flexible Benefits Plan and should be kept with your Summary Plan Description (SPD) for future reference.

With respect to the current Plan Information in your SPD, effective January 1, 2020, Adams County Government amended its Plan to temporarily adopt the changes listed below:

Extended Grace Period:
Extended Grace Period for twelve (12) months for Health FSAs and DCFSAs - A plan that includes a Health FSA or DCFSA may extend the grace period for a plan year ending in 2020 or 2021 to 12 months after the end of such plan year, with respect to unused benefits or contributions remaining in either arrangement. For example, a 2020 calendar year plan year with a grace period to March 15, 2021 may extend the grace period to December 31, 2021, effectively allowing participants until December 31, 2021 to incur claims against their 2020 plan year balances. Please note that health FSAs may not have both a grace period and a carryover.

Please select the Plan(s) that you would like to apply the extension:

Health FSA ☒ 2020 plan year ☒ 2021 plan year

DCFSA ☒ 2020 plan year ☒ 2021 plan year

Temporary Increase under the American Rescue Plan Act (ARPA) of Maximum Exclusion Amount for the Dependent Care Flexible Spending Arrangement (DCFSA) to $10,500

For taxable years beginning in 2021, the maximum amount of DCFSA benefits permitted for income exclusion is temporarily increased to $10,500 (or $5,250 for married taxpayers filing separately). Plans can be amended retroactively to incorporate this change provided the amendment is adopted no later than the end of the plan year in which the amendment is to be effective and the plan is operated consistently with the terms of the amendment as of the date the amendment is effective.

[Sample Certificate of Adopting Resolution][1]

ACTIONS TAKEN AND RESOLUTIONS ADOPTED BY CONSENT OF AUTHORIZED REPRESENTATIVE

Adams County Government

The undersigned, being an authorized representative of Adams County Government (the "Employer") hereby adopt the following Resolution by unanimous consent and direct that this Consent Resolution be entered in the minute books of the Corporation.

RESOLVED, that the Amendment to the Adams County Government Flexible Benefits Plan (the Amendment) is hereby approved and adopted, and that an authorized representative of the Employer is hereby authorized and directed to execute and deliver to the Administrator of the Plan one or more counterparts of the Amendment.

The undersigned further certifies that attached hereto is a copy of the Amendment approved and adopted in the foregoing resolution.

Date: _____

Signed: _____

_____

(print name/title)

[1] WARNING: The legal requirements for a valid Certificate of Adopting Resolution vary from state to state. The language herein is suggested resolution language. Each employer should consult with their own legal counsel to ensure compliance.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Approving Right-of-Way Agreement between Adams County and KLZ Radio Inc. for Property Necessary for the York Street Roadway and Drainage Improvements Project from East 78th Avenue to East 88th Avenue
FROM: Brian Staley
AGENCY/DEPARTMENT: Public Works
HEARD AT STUDY SESSION ON:
RECOMMENDED ACTION: That the Board of County Commissioners approves the right-of-way agreement for acquisition of property interests needed for the York Street Improvements Project.

BACKGROUND:
Adams County is in the process of acquiring property interests along the York Street corridor from East 78th Avenue to East 88th Avenue for the York Street Roadway Improvement Project. The intention of this Project is to identify and improve the overall roadway and drainage of York Street. Attached is a copy of the right-of-way agreement between Adams County and KLZ Radio Inc. for acquisition of property interests in the amount of $5,420.00. The attached resolution allows the County to acquire ownership of the property interests needed for the use of the public and provide the necessary documents to close on the property

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
Adams County Public Works, Office of the County Attorney and Adams County Board of County Commissioners.

ATTACHED DOCUMENTS:
Resolution Right-of-Way Agreement

FISCAL IMPACT:
Yes

Fund:	13
Cost Center:	3056

	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:	9135	30562301	$15,000,000
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			$15,000,000

New FTEs requested: **No**

Future Amendment Needed: **No**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING RIGHT-OF-WAY AGREEMENT BETWEEN ADAMS COUNTY AND KLZ RADIO INC. FOR PROPERTY NECESSARY FOR THE YORK STREET ROADWAY AND DRAINAGE IMPROVEMENTS PROJECT FROM EAST 78TH AVENUE TO EAST 88TH AVENUE

WHEREAS, Adams County is in the process of acquiring right-of-way and easements along York Street corridor from East 78th Avenue to East 88th Avenue for the York Street Roadway and Drainage Improvements Project ("Project"); and,

WHEREAS, the intention of this Project is to identify and improve the overall roadway and drainage ("Improvements"); and,

WHEREAS, this right-of-way acquisition is of property located in the Southwest Quarter of Section 25, Township 2 South, Range 68 West of the 6th Principal Meridian, County of Adams, State of Colorado, and owned by KLZ Radio Inc. ("Parcel FEE-215A"); and,

WHEREAS, Adams County requires ownership of Parcel FEE-215A, for construction of the Improvements; and,

WHEREAS, KLZ Radio Inc. is willing to sell Parcel FEE-215A to Adams County under the terms and conditions of the attached Right-of-Way Agreement.

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners, County of Adams, State of Colorado, that the attached Right-of-Way Agreement between Adams County and KLZ Radio Inc., a copy of which is attached hereto and incorporated herein by this reference, be and hereby is approved.

BE IT FURTHER RESOLVED that the Chair of the Board of County Commissioners is hereby authorized to execute said Right-of-Way Agreement on behalf of Adams County.

Right-of-Way Agreement

This Agreement is made and entered into by and between **KLZ Radio Inc.** whose address is PO Box 3003, Bluebell, PA 19422-0735 ("Owner"), and the County of Adams, State of Colorado, a body politic, who address is 4430 South Adams County Parkway, Brighton, Colorado, 80601 ("County") for the conveyance of rights-of-way on property located at 8170 York Street hereinafter (the "Property") for the York Street Improvements Project – East 78th Avenue to East 88th Avenue (the "Project"). The legal description and conveyance documents for the interests on said Property are set forth in Exhibit "A" attached hereto and incorporated herein by this reference.

The compensation agreed to by the Owner and the County for the acquisition of the Property interests described herein is **FIVE THOUSAND FOUR HUNDRED TWENTY NO/100 DOLLARS ($5,420.00),** including the performance of the terms of this Agreement, the sufficiency of which is hereby acknowledged. The parties further agree that the consideration shall consist of $5,420.00 for the conveyance of a fee parcel of land for a water quality storm drainage pond. This consideration has been agreed upon and between the parties as the total just compensation due to the Owner and the consideration shall be given and accepted in full satisfaction of this Agreement.

In consideration of the above premises and the mutual promise and covenants below, the Owner and the County agree to the following:

1. The Owner hereby warrants that the Owner is the sole Owner of the Property, that the Owner owns the Property in fee simple subject only to matters of record and that the Owner has the authority to enter into this Agreement and convey the Property.

2. The Owner agrees to execute and deliver to the County the attached deed upon tender by the County of a warrant (check) for the Purchase Price as soon as possible following the mutual execution of this Agreement.

3. The Owner hereby irrevocably grants to the County possession and use of the Property upon execution of this Agreement by the Owner and the County. The County and its contractors, agents, directors, employees, and all others acting by or on behalf of it, or with its permission, shall have the undisputed right to possession of the Property, and the County may use and enjoy the Property against the Owner and its respective successors and assigns and all persons claiming any right, title, or interest to the Property by and through the Owner. This grant of possession shall remain in effect with respect to the Property until such time as the County obtains from the Owner a duly executed and acknowledged deed conveying the Property.

4. The County through its contractor shall assure that reasonable access shall be always maintained to the Owner's property for ingress and egress. If necessary, any full closure of access shall be coordinated between the contractor and the Owner and/or its agent.

5. The Owner has entered into this Agreement acknowledging that the County has the power of eminent domain and is acquiring the Property for a public purpose.

6. If the Owner fails to consummate this Agreement for any reason, except the County's default, the County may at its option, enforce this Agreement by bringing an action against the Owner for specific performance.

7. This Agreement contains all agreements, understandings and promises between the Owner and the County, relating to the Property and the Project and shall be deemed a contract binding upon the Owner and the County and their successors, heirs and assigns.

8. The Owner shall be responsible for reporting proceeds of the sale to taxing authorities, including the submittal of Form 1099-S with the Internal Revenue Service, if applicable.

9. This Agreement has been entered into in the State of Colorado and shall be governed according to the laws thereof.

10. Each party shall pay its own attorney fees. The County shall pay all closing costs.

Owner:
KLZ Radio Inc.

Name: Donald B Crawford

Title: President

Signature: _____

Date: 8/17/2022

Approved:

BOARD OF COUNTY COMMISSIONERS-COUNTY OF ADAMS, STATE OF COLORADO

_____ _____
Chair Date

Approved as to Form:

_____
County Attorney

EXHIBIT "A"

RIGHT-OF-WAY NUMBER: FEE-215A

PROJECT NUMBER: IMP-3056-1603

SECTION 25, TOWNSHIP 2 SOUTH, RANGE 68 WEST

SIXTH PRINCIPAL MERIDIAN

ADAMS COUNTY

DESCRIPTION

A tract of parcel of land No. FEE-215A of Adams County Project Number IMP-3056-1603, containing 902 square feet, more or less, being a portion of the tract described in the Warranty Deed recorded on August 31, 1992 in Book 3947, Page 572 of the records of the Adams County Clerk and Recorder's Office, situated in the Southwest Quarter of Section 25, Township 2 South, Range 68 West of the 6th Principal Meridian, County of Adams, State of Colorado, being more particularly described as follows:

COMMENCING at the Southwest corner of Section 25, whence the West line of the Southwest Quarter of said Section 25 bears N00°04'09"E, a distance of 2628.81 feet; thence N18°58'15"E, a distance of 572.96 feet to a point on the Northwesterly boundary of said tract and the **POINT OF BEGINNING PARCEL FEE-215A:**

Thence departing said boundary, S61°17'41"E, a distance of 8.94 feet;

Thence S33°47'02"W, a distance of 83.75 feet;

Thence S47°42'23"W, a distance of 36.99 feet to said northwesterly boundary;

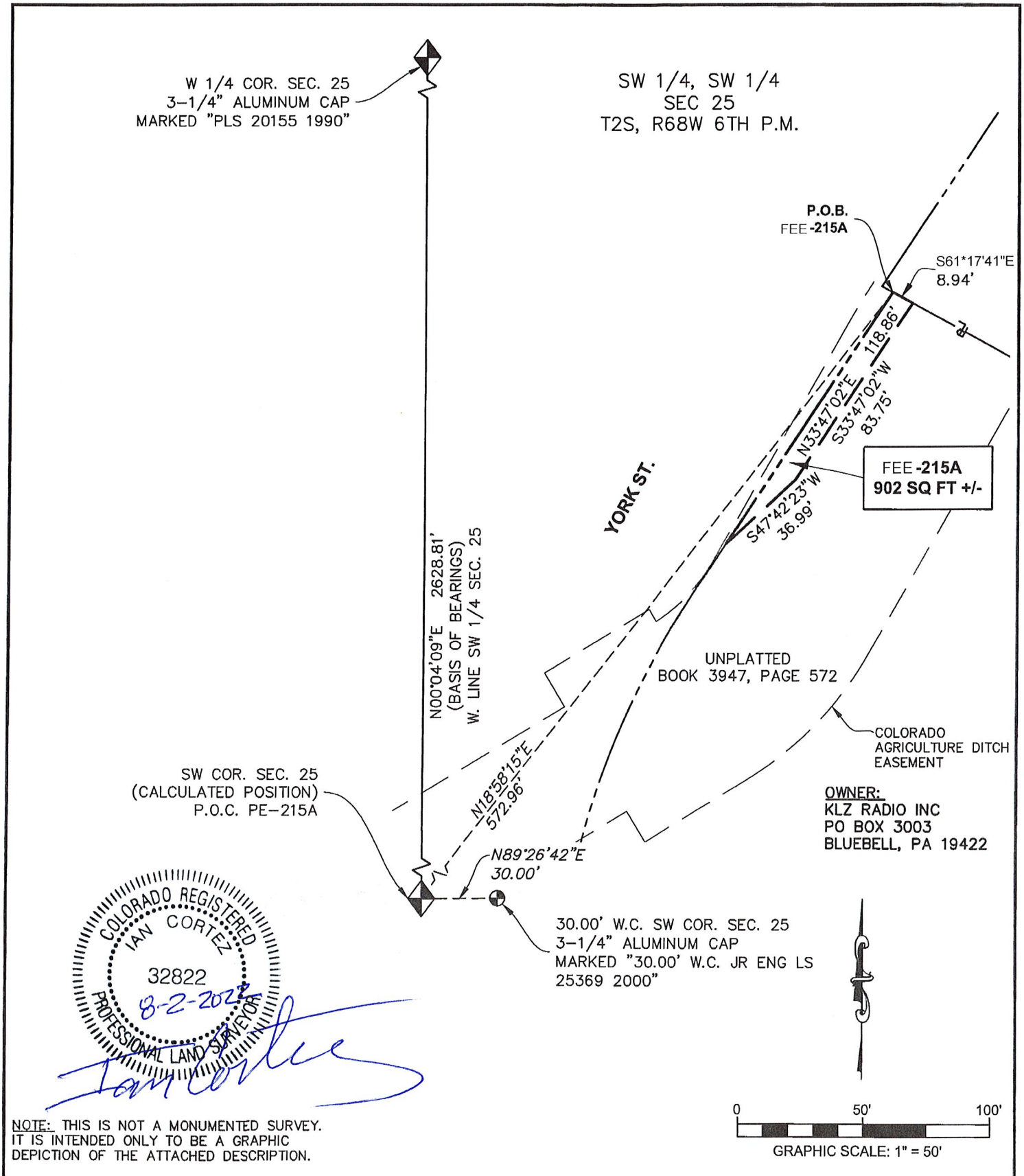
Thence along said Northwesterly boundary N33°47'02"E, a distance of 118.86 feet to the **POINT OF BEGINNING PARCEL FEE-215A.**

Containing 902 square feet, +/-

Legal description prepared by:

Ian Cortez, PLS
Colorado Professional
Land Surveyor No. 32822
For and on behalf of:
Adams County, Colorado

Exhibit "B" attached and hereby made a part thereof.



COLORADO REGISTERED
IAN CORTEZ
32822
8-2-2022
PROFESSIONAL LAND SURVEYOR

NOTE: THIS IS NOT A MONUMENTED SURVEY.
IT IS INTENDED ONLY TO BE A GRAPHIC
DEPICTION OF THE ATTACHED DESCRIPTION.

ADAMS COUNTY
COLORADO

ASCENT
GEOMATICS SOLUTIONS

Ascent Geomatics Solutions
8620 Wolff Court
Westminster, CO 80031
(303) 928-7128

EXHIBIT "B"
YORK ST – 78TH AVE TO 88TH AVE

RockSol
Consulting Group, Inc

12076 Grant Street
Thornton, CO 80241
Ph: (303) 962-9300
Fax: (303) 962-9350

FEE-215A
KLZ RADIO INC

File Name: IMP-3056-1603_FEE-215A
Project No. IMP-3056-1603
Print Date: 8/02/2022 | Sheet: 2 of 2

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Adopting Amendments to Adams County's Group Agreements with Kaiser Permanente
FROM: Cindy Bero
AGENCY/DEPARTMENT: People & Culture Services
HEARD AT STUDY SESSION ON: September 21, 2021
RECOMMENDED ACTION: That the Board of County Commissioners Approve the 2022 Group Agreement and amendments 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 2022, thereby providing additional health plan choices. The attached Group Agreement, Amendments, Letter of Understanding, Rate Sheet and Evidences of Coverage outline the current benefits with Kaiser Permanente as approved through Study Session.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
People and Culture Services County Attorney's Office

ATTACHED DOCUMENTS:
2022 Evidences of Coverage (active employees/COBRA/pre65 retirees and Senior Advantage)
2022 Large Group Agreement
2022 Rate Sheet
2022 Summary of Benefit Changes
2022 Performance Guarantee Agreement

FISCAL IMPACT:
No

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION ADOPTING AMENDMENTS TO ADAMS COUNTY'S GROUP AGREEMENTS WITH KAISER PERMANENTE

WHEREAS, the Adams County Board of County Commissioners recognize 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, 2022:

1. 2022 Evidences of Coverage (Active Employees/COBRA/Pre65 Retirees and Medicare)
2. 2022 Large Group Agreement
3. 2022 Medical Plan Rate Sheet
4. 2022 Summary of Benefit Changes
5. 2022 Performance Guarantee Agreement

NOW, THEREFORE, BE IT RESOLVED, that the Board of County Commissioners, County of Adams, State of Colorado, hereby adopts the attached Amendments to Adams County's Group Agreements with Kaiser Permanente.

BE IT FURTHER RESOLVED, that the Chair of the Board of County Commissioners is hereby authorized to execute said Amendments on behalf of Adams County.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of Colorado

A Colorado Nonprofit Corporation

2022

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 Premiums 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, of the following year (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 any Medicare Part D coverage level thresholds. 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 Premiums 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 Premiums, 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 Premiums, for the period prior to the termination date.

Termination Due to Non-Acceptance of Amendments

All amendments are deemed accepted by Group unless Health Plan receives Group's written notice of non-acceptance at least 30 days before the effective date of the amendment, in which case this *Agreement* will terminate on the following date, as applicable:

- In the case of amendments described in the "Amendment of *Agreement*" section under "Amendments Related to Government Approval" and "Amendments Due to Medicare Changes," and amendments described under "Other Amendments" that do not require 60 days notice by Health Plan, if Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice of non-acceptance, the termination date will be first of the month following 30 days after Health Plan receives notice of non-acceptance.
- In all other cases, the termination date will be the day before the effective date of the amendment.

Termination for Nonpayment

When Group fails to pay Premiums on or before the Due Date, Group shall have a period of at least thirty-one (31) days to pay all Premiums owed ("Grace Period"). The Grace Period shall begin the day after the Due Date and shall apply to all payments except the first payment. This *Agreement* will remain in full force and effect throughout the Grace Period and Group will remain responsible for payment of Premiums during the Grace Period (and any additional period prior to termination, if that occurs). If Health Plan receives full of payment of Premiums on or before the last day of the Grace Period, this *Agreement* will remain in effect according to its term and conditions.

If Group fails to pay all Premiums owed (including those owed for the Grace Period), then Health Plan may, at its option and in lieu of any other remedy, terminate this *Agreement* without further extension or consideration. Health Plan will notify Group of the past-due amount and the effective date of termination. Such notice shall be sent at least thirty (30) days prior to the effective date of termination. If Premiums are paid after the Grace Period ends, Health Plan may charge interest on the overdue Premiums. Interest shall not accrue during the Grace Period, and the (simple) interest rate shall be six (6) percent per year or the maximum amount permitted by applicable law, whichever is less.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members in order to comply with CMS termination notice requirements.

Termination for Fraud or for Intentionally Furnishing Incorrect or Incomplete Information

If Group commits fraud or intentionally furnishes incorrect or incomplete material information to Health Plan, Health Plan may terminate this *Agreement* by giving advance notice to Group, and Group is liable for all unpaid Premiums 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 Premiums 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.

Premiums

Group will pay to Health Plan, for each Member, the amount(s) specified on the Rate Sheet for each month on or before the date on the monthly invoice or, if Group is self-pay, then the date indicated on the Rate Sheet to which Health Plan and Group agree in writing, but in no event later than the last day of the month preceding the month of coverage (the "Due Date"). Only Members for whom Health Plan has received the appropriate Premiums payment listed on the Rate Sheet are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan has received appropriate payment.

When this *Agreement* terminates, if Group does not have another agreement with Health Plan, then the due date for all Premiums amounts will be the earlier of: (1) the last Due Date, or (2) the termination date of this *Agreement*. If group does not prepay Full Premiums by the last day of the month preceding the coverage month, the Premiums may include an additional administrative charge upon renewal. "Full Premiums" means 100 percent of monthly Premiums for each enrolled Member, as set forth in this "Premiums" section.

Premium Rebates

If state or federal law requires Health Plan to rebate Premiums from this or any earlier contract year and Health Plan rebates Premiums 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

Premiums 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, Premiums 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;
- 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; or
- Through the date that the Member covered under the policy is no longer eligible or covered if the policyholder notifies the Health Plan within ten (10) business days after the date that the Member is no longer eligible or covered because the Member left employment without notice to the Group or the Member is an employee whose employment was terminated for gross misconduct.

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 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 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 Premiums 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 Premiums 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.
  - 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 Premiums.

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.

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.

Grandfathered Health Plan Coverage

For any coverage identified in an EOC as a "grandfathered health plan" under the Patient Protection and Affordable Care Act (a/k/a the ACA), Group must immediately inform Health Plan if this coverage does not meet (or no longer meets) the requirements for grandfathered status including but not limited to any change in its contribution rate to the cost of any grandfathered health plan(s) during the plan year. Group represents that, for any coverage identified as a "grandfathered health plan" in the applicable EOC, Group has not decreased its contribution rate more than five percent (5%) for any rate tier for such grandfathered health plan when compared to the contribution rate in effect on March 23, 2010 for the same plan. Health Plan will rely on Group's representation in issuing and/or continuing any and all grandfathered health plan coverage.

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: 1/1/2022

GROUP: COUNTY OF ADAMS 385

BY: _____
Authorized Group Officer Signature

_____
Please Print Your Name and Title

_____
Date Signed

KAISER FOUNDATION HEALTH PLAN OF COLORADO – A NONPROFIT CORPORATION

BY:
Authorized Representative Signature

Mike Ramseier, President – Colorado Region
Please Print Your Name and Title

10/15/2021
Date Signed

APPROVED AS TO FORM
COUNTY ATTORNEY

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado (Health Plan) and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "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 2022 contract year.

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Surprise Billing — Know your rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing." This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles, and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network."

Out-of-network hospitals, facilities, or providers often bill you the difference between what Kaiser Permanente decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Kaiser Permanente will pay out-of-network providers and facilities directly. Again, you are responsible only for paying your in-network cost-sharing for covered services.
- Kaiser Permanente will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of your reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital, or facility in any OTHER situation, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance-billed.

If you do receive a bill for amounts other than your copayments, deductibles, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at **303-894-7490** or **1-800-930-3745 (TTY 711)**.

Ambulance Information: You may be balance-billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by Kaiser Permanente, you may receive a balance bill.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-632-9700** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 South Havana, Aurora, CO 80014, or by phone at Member Services: 1-800-632-9700.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY: **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY: **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY: **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY: **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY: **711**).

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the identical heading in the "Benefits/Coverage (What Is Covered)" section and to the "Limitations/Exclusions (What Is Not Covered)" section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and Advanced Imaging Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits; Emergency Services; urgent care; and outpatient surgery.

Here is some important information to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service must be Medically Necessary (refer to the "Definitions" section in this EOC); ***and***
   b. The Service must be provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service must be described in this EOC as covered. Refer to the "Benefits/Coverage (What is Covered)" section.
2. The Charges for your Services are not always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. 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.
8. 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.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.
11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

There is no medical Deductible. If your Group has purchased a supplemental prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply *only* to the pharmacy Deductible.

The pharmacy Deductible represents the full amount you must pay for prescription drugs before any Copayment or Coinsurance applies. Prescription drugs may or may not be subject to the pharmacy Deductible. It depends on the plan your Group has purchased.

A. For prescription drugs that **ARE** subject to the pharmacy Deductible:

1. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.
2. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements").
3. Your applicable Copayment, Coinsurance, and pharmacy Deductible may not apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

B. For prescription drugs that **ARE NOT** subject to the pharmacy Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance", "Drugs, Supplies, and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts you pay over eligible 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 provide 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** or go to **kp.org**.

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 their own OPM. •If you reach your individual OPM before the family OPM is met, you 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 *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
Specialty care visits *(Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
Consultations with clinical pharmacists *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
Allergy evaluation and testing	
• Primary care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit
• Specialty care visits *(Applies to Out-of-Pocket Maximum)*	Visit: $25 Copayment each visit
Allergy injections *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit An additional charge may apply for allergy serum
Gynecology care visits *(Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
Routine prenatal and postpartum visits *(Applies to Out-of-Pocket Maximum)*	No Charge
Office-administered drugs *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance with $250 maximum
• Travel immunizations *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Virtual Care Services	
• Email	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• E-visits	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Chat with a provider 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 visits	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
• Video visits	
o Primary care visits *(Applies to Out-of-Pocket Maximum)*	No Charge
o Specialty care visits *(Applies to Out-of-Pocket Maximum)*	No Charge

6.F

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)*	Ambulatory surgical center: $150 Copayment each surgery Outpatient hospital: $300 Copayment each surgery
Outpatient hospital Services, including direct admission to observation care *(Applies to Out-of-Pocket Maximum)*	No Charge

Hospital Inpatient Care	You Pay
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.) *(Applies to Out-of-Pocket Maximum)*	$500 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
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Chiropractic care	
• Evaluation and/or manipulation *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or X-rays required for chiropractic care *(See "X-ray, Laboratory, and Advanced Imaging Procedures" for Out-of-Pocket Maximum information.)*	See "X-ray, Laboratory, and Advanced Imaging 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
(Applies to Out-of-Pocket Maximum)	30% Coinsurance

Dental Services following Accidental Injury	You Pay
(Does not apply to Out-of-Pocket Maximum)	Not Covered

Dialysis Care	You Pay
(Applies to Out-of-Pocket Maximum)	$25 Copayment each visit

6.F

Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
Durable Medical Equipment *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
• Breast pumps *(Applies to Out-of-Pocket Maximum)*	No Charge
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 *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• All other prosthetic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Orthotic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Oxygen *(Applies 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 Out-of-Plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Applies to Out-of-Pocket Maximum)*	$250 Copayment each visit Excludes advanced imaging 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 advanced imaging procedures are excluded, see "X-ray, Laboratory, and Advanced Imaging Procedures" for applicable Copayment or Coinsurance.
Plan and Out-of-Plan emergency room observation care *(Applies to Out-of-Pocket Maximum)*	$250 Copayment each visit Emergency room Copayment is waived if you receive emergency care and then are transferred to observation care. If the above amount is a Coinsurance, the Coinsurance is applied to both the emergency room care and the observation care. If you are directly admitted to observation care, see "Outpatient hospital Services" for applicable Copayment or Coinsurance.

6.F

Urgent Care	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan and Out-of-Plan urgent care *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit

Family Planning and Sterilization Services	You Pay
Family planning counseling *(See "Office Services" for Out-of-Pocket Maximum information.)*	See "Office Services" for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures *(See "Outpatient Hospital and Surgical Services" for Out-of-Pocket Maximum information).*	See "Office Services" or "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 *(Applies 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 *(Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
Hearing aids for Members up to age 18 *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
• Fitting and recheck visits *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
Hearing aids for Members age 18 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Fitting and recheck visits *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Provider *(Applies 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 *(Applies to Out-of-Pocket Maximum)*	No Charge
Hospice care for terminally ill patients *(Applies to Out-of-Pocket Maximum)*	No Charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Applies to Out-of-Pocket Maximum)*	$500 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 or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit $15 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment

Out-of-Area Benefit	**You Pay**
The following Services are limited to Dependents up to the age of 26 outside the Service Area	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and substance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)* *Visit: (Applies to Out-of-Pocket Maximum)* *Other Services:* (*Do not apply to Out-of-Pocket Maximum)* *Preventive immunizations:* (*Applies to Out-of-Pocket Maximum)*	Visit limit: Limited to 5 visits per Accumulation Period Visit: $15 Copayment Other Services received during an office visit: Not Covered Preventive immunizations: No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	Diagnostic X-ray limit: Limited to 5 diagnostic X-rays per Accumulation Period 20% Coinsurance
Outpatient physical, occupational, and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	Therapy visit limit: Limited to 5 therapy visits (any combination) per Accumulation Period Visit: $15 Copayment
Outpatient prescription drugs	Prescription drug fills: Limited to 5 prescription drug fills (any combination) per Accumulation Period
• Copayment/Coinsurance (except as listed below) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty
• Prescribed diabetic supplies *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Preventive drugs o Contraceptive drugs *(Applies to Out-of-Pocket Maximum)*	No Charge
o Over the counter (OTC) items *(Federally mandated over the counter items)* *(Applies to Out-of-Pocket Maximum)*	No Charge
o Tobacco cessation drugs *(Applies to Out-of-Pocket Maximum)*	No Charge

Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Inpatient treatment 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	
• Habilitative Services	
o In-person visits (*Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
o Video visits (*Applies to Out-of-Pocket Maximum*)	No Charge Visit limits are combined between in-person vists and video visits.
• Rehabilitative Services	
o In-person visits *(Applies to Out-of-Pocket Maximum*)	$15 Copayment each visit Limited to 20 visits per therapy per Accumulation Period
o Video visits (*Applies to Out-of-Pocket Maximum)*	No Charge Visit limits are combined between in-person vists and video visits.
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
Outpatient physical, occupational, and speech therapy video visits to treat Autism Spectrum Disorder *(Applies to Out-of-Pocket Maximum)*	No Charge
Applied Behavioral Services	
• Applied Behavior Analysis (ABA) to treat Autism Spectrum Disorder (*Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
• Applied Behavior Analysis (ABA) video visits to treat Autism Spectrum Disorder (Applies to Out-of-Pocket Maximum)	No Charge
Pulmonary rehabilitation *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit

6.F

Prescription Drugs, Supplies, and Supplements	You Pay
See Additional Provisions if your Group has purchased coverage for outpatient prescription drugs.	
Outpatient prescription drugs *(Applies to Out-of-Pocket Maximum)*	
• Pharmacy Deductible	Not Applicable
• Copayment/Coinsurance (except as listed below):	$15 Generic/$30 Brand name/$50 Non-preferred Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Infertility drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply of all prescription insulin drugs.
o Diabetic supplies *(When obtained from sources designated by Kaiser Permanente)* *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Preventive drugs	
o Over the counter (OTC) items: *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)*	No Charge
o Prescription contraceptives *(Supply limit according to applicable law)* *(Applies to Out-of-Pocket Maximum)*	No Charge
o Tobacco cessation drugs *(Not subject to pharmacy Deductible)*	No Charge
• Preventive maintenance drugs *(Applies to Out-of-Pocket Maximum)*	See applicable Outpatient prescription drug Copayment/Coinsurance
• Sexual dysfunction drugs *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty drugs *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance up to $250 per drug dispensed
Supply Limit	
• Day supply limit	30 days
• Mail-order supply limit	$30 Generic/$60 Brand/$100 Non-preferred Up to 90 days See Additional Provisions

Preventive Care Services	You Pay
Preventive care visits *(Applies to Out-of-Pocket Maximum)* • Adult preventive care exams and screenings • Behavioral health screening • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings (*Applies to Out-of-Pocket Maximum)*	
• Colonoscopies	No Charge
• Flexible sigmoidoscopies	No Charge
Preventive Virtual Care Services *(Applies to Out-of-Pocket Maximum))* • Email • Chat with a provider online • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam	See "Office Services" or "Laboratory Services" for applicable Copayment or Coinsurance

Reconstructive Surgery	You Pay
(See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)	See "Outpatient Hospital and Surgical Services" or "Hospital Inpatient Care" for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility (including lab and X-ray) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
Intrauterine insemination (IUI) *(Applies to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
In Vitro Fertilization (IVF) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Gamete Intrafallopian Transfer (GIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Zygote Intrafallopian Transfer (ZIFT) *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

Skilled Nursing Facility Care	You Pay
(Applies to Out-of-Pocket Maximum)	$500 Copayment per admission Limited to 100 days per Accumulation Period

Substance Use Disorder Services	You Pay
Inpatient medical detoxification *(Applies to Out-of-Pocket Maximum)*	$500 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 or intensive outpatient therapy *(Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit $15 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment
Residential rehabilitation *(Applies to Out-of-Pocket Maximum)*	$500 Copayment per inpatient admission

Transplant Services	**You Pay**
(See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for Out-of-Pocket Maximum information.)	See "Office Services", "Outpatient Hospital and Surgical Services", or "Hospital Inpatient Care" for applicable Copayment or Coinsurance

Vision Services and Optical	**You Pay**
Eye exams for treatment of injuries and/or diseases	See "Office Services" for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist	
• Up to the end of the calendar year the Member turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit Test: $15 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit Test: $15 Copayment each visit
Routine eye exam when performed by an Ophthalmologist	
• Up to the end of the calendar year the Member turns age 19 *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $25 Copayment each visit Test: $25 Copayment each visit
• Members age 19 and over *Visit: (Applies to Out-of-Pocket Maximum)* *Refraction test: (Applies to Out-of-Pocket Maximum)*	Visit: $25 Copayment each visit Test: $25 Copayment each visit
Optical hardware	
• Up to the end of the calendar year the Member 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

6.F

X-ray, Laboratory, and Advanced Imaging Procedures	You Pay
Diagnostic laboratory Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Therapeutic X-ray Services *(Applies to Out-of-Pocket Maximum)*	$25 Copayment each visit
Advanced imaging procedures including but not limited to CT, PET, MRI, nuclear medicine *(Applies 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 an advanced imaging procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, e-visits, online chat, telephone visits, and video visits. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, e-visits, online chat, telephone visits, and video visits. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives. *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Prescription Drug fill maximum per Accumulation Period	Not Applicable
• Outpatient prescription drugs filled at an Out-of-Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

6.F

Eligibility Amendments

- 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 the Member 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.
- Domestic Partner
  Your Group coverage includes health benefits for both same- and opposite-sex domestic partners and their Dependents. To be covered they must meet:
  1. the eligibility requirements as described in the "Eligibility" section of this EOC; and
  2. the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.
  You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.
- Grandchildren
  Under your Group contract, a grandchild of you or your Spouse cannot be enrolled as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed legal guardian of the grandchild. This includes an adopted or foster grandchild.

Group-Specific coverage

- Eligible Organization
  This plan covers federally mandated over-the-counter non-prescription female contraceptive drugs and devices.

Additional Provisions

Please see “Additional Provisions” for any supplemental information that applies to your coverage.

6.F

CONTACT US

Advice Nurses (Medical Advice) – Available 24 hours a day, 7 days a week	
CALL	**303-338-4545** 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.

Clinical Contact Center (to schedule an appointment)	
CALL	**303-338-4545** 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	**303-471-7700** or toll-free **1-866-359-8299** For members seeking Behavioral Health services in southern Colorado, please call **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	**303-338-3800** or toll-free **1-800-632-9700**
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**

Patient Financial Services	
CALL	**303-743-5900** or toll-free **1-800-632-9700**
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**

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	**303-338-3600** or toll-free **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Kaiser Permanente** **National Claims Administration - 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**

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.

TABLE OF CONTENTS

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. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

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 the "Eligibility Amendments" section of the "Schedule of Benefits (Who Pays What)" and/or the "Additional Provisions."

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date:

1. New Employees and their Dependents
   If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage
   If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents
   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

   The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:
   a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.

For existing Subscribers:

i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.

ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.

For existing Subscribers:

i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.

ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment."

4. Special Enrollment

You or your Dependent may experience a triggering event that allows a change in your enrollment. Examples of triggering events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The triggering event results in a special enrollment period that usually (but not always) starts on the date of the triggering event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's triggering event. To learn more about triggering events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, contact your Group. If your Group coverage is ending, call **Member Services** or go to kp.org/specialenrollment.

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 our Service Area, except as described under the following headings:

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Urgent Care" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

In some circumstances, you might receive emergency or non-emergency Services from an Out-of-Plan Provider or Out-of-Plan Facility. **Non-emergency Services from Out-of-Plan Providers are not covered unless they are authorized by us.** If Services from an Out-of-Plan Provider or Out-of-Plan Facility are authorized, the Deductible, Copayment, and/or Coinsurance for these authorized Services are the same as for covered Services received from a Plan Provider or Plan Facility. You have the right and responsibility to request a Plan Provider to provide Services.

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 their own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. **You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.** You may also receive a second medical opinion from a Plan Provider upon request. Please refer to the "Second Opinions" section.

   You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign into your account online, or call the **Clinical Contact Center** for help choosing a PCP.

2. Changing Your Primary Care Provider

   Please call the **Clinical Contact Center** to change your PCP. You may also change your PCP online or when visiting a Kaiser Permanente Medical Office Building. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

   If your Plan Provider decides that you need covered Services not available from us, they will request a referral for you to see an Out-of-Plan Provider. If your Plan Provider decides you need specialty care that is not eligible for a self-referral, they will request a referral for you to see a specialty-care Plan Provider. (See the "Specialty Referrals" section below.)

   These referral requests 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.

   An Authorization is required for Services provided by Out-of-Plan Providers or Out-of-Plan Facilities. If your provider refers you to an Out-of-Plan Provider or Out-of-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 in advance by Health Plan. 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 Referrals

   Generally, you will need a referral and prior Authorization for Services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

   For additional information on which Services require prior Authorization, please call **Member Services**. You will find specialty-care Plan Providers in the Kaiser Permanente Provider Directory. 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**.

   Authorization from Health Plan is required for: (i) Services in addition to those provided as part of the routine office visit, such as procedures or surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) Out-of-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.

3. Second Opinions
Upon request and subject to payment of any applicable Copayments or Coinsurance, you may get a second opinion from a Plan Provider about any proposed covered Services.

If the recommendations of the first and second providers differ regarding the need for Services, a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

Authorization of a second or third opinion is limited to a consultation only and does not include any additional Services. Authorization of a second or third opinion may be limited to providers in Kaiser Permanente Medical Office Buildings.

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**

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.

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. There may be instances when you need to receive urgent care outside our Service Area. The Copayment or Coinsurance for urgent care 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.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. 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.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization; Deductible; Copayment; Coinsurance; limitations and exclusions, as further described in the Visiting Member Brochure available online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. 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, non-Member claims for Emergency or non-emergency care Services will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership.

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.

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 noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)"; and "Urgent Care" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care" in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- Your provider has received prior Authorization for your Services, as appropriate; and
- You have met any Deductible requirements described in the "Schedule of Benefits (Who Pays What)."

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

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.
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. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.
11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or Coinsurance shown in the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.
    - Drugs (including Biologics and Biosimilars) 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 Utilization Management Program Criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram; sleep study; stress test; pulmonary function test; any treatment room; or direct admission to any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program 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 Area:
   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 childbirth 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 Provider 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 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 Utilization Management Program 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 and Other Transportation

1. Coverage
   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide. Kaiser Permanente applies Medicare guidelines for ambulance Services in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

   Note: Health Plan will cover certain non-emergent, non-ambulance transportation when there is prior Authorization by Health Plan.

E. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**
   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown in the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.
   b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. 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 Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and
3. The facility is certified by Medicare and is a Plan Facility; and

4. A Plan Provider provides a written referral for care at the facility.

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Provider as described below; when prescribed by a Plan Provider 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, insulin pump supplies, and continuous glucose monitors 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.
      v. Home ultraviolet light therapy equipment for certain skin conditions.

   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 or stolen 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, theft, or loss, when prescribed by a Plan Provider 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. 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 Provider 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 Provider, 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 Provider 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."

H. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are not subject to any Copayments or Coinsurance, or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

I. 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 or mental health emergency, 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 Out-of-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them inside our Service Area. For information about emergency benefits away from home, please call **Member Services**.

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Services are provided by a Plan Provider or an Out-of-Plan Provider.

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 Out-of-Plan Providers (out-of-Plan Emergency Services)
   "Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities 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 Out-of-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 Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed. 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 a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the emergency.

ii. Emergency Services Limitation for Out-of-Plan Providers
If you are admitted to an Out-of-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. If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. 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. If you choose to remain at an Out-of-Plan Facility for post-Stabilization care, non-Emergency Services are not covered after we have made arrangements to transfer you to a Plan Facility for care. You will be responsible for payment for any post-Stabilization treatment received at the Out-of-Plan Facility.

b. Emergency Services Exclusions and Limitations
Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. 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.

The exclusions and limitations of your plan will still apply if non-covered Services are provided by an Out-of-Plan Provider or Out-of-Plan Facility.

c. Payment
Our payment is reduced by:
i. any applicable Copayment and/or Coinsurance for Emergency Services and advanced imaging procedures performed in the emergency room. The emergency room and advanced imaging procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
v. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: If you receive out-of-Plan Emergency Services, our payment is also reduced by any other payments you would have had to make if you received the same Services from our Plan Providers. The procedure for receiving reimbursement for out-of-Plan Emergency Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

2. Urgent Care
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, you may be able to receive care in your home. There may be instances when you need to receive urgent care outside our Service Area. 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.

Note: The procedure for receiving reimbursement for out-of-Plan urgent care Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

J. Family Planning and Sterilization Services

1. Coverage
   a. Family planning counseling. This includes counseling and information on birth control.
   b. Tubal ligations.
   c. Vasectomies.

   Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and Advanced Imaging Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced sterilization.
   b. Acupuncture for the treatment of infertility.
   c. Donor semen or eggs.
   d. Any and all Services, supplies, office administered drugs and prescription drugs related to the procurement and/or storage of semen and/or eggs.
   e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to intrauterine insemination or conception by artificial means. This includes, but is not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer, and zygote intra fallopian transfer.

   Note: See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

K. Gender Affirming Health Services

We cover gender affirming health Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet Utilization Management Program Criteria to be eligible for coverage.

1. Coverage

   Non-surgical Services:
   a. Office visits and mental health visits.
   b. Laboratory Services and X-ray Services.
   c. Hormone therapy visits and administration.
   d. Facial hair removal (assigned male at birth).
   e. Outpatient prescription drugs, if covered by your plan.
   f. Inpatient and outpatient hospital care.
   g. Treatment for complications of surgery.

   Surgical Services:
   a. Pre-surgical and post-surgical consultations with surgeon.
   b. Gender affirmation surgeries including:
      i. **Assigned female at birth**: hysterectomy; oophorectomy; metoidioplasty; phalloplasty; vaginectomy; scrotoplasty; erectile prosthesis; urethral extension; bilateral mastectomy with chest reconstruction; breast reduction.
      ii. **Assigned male at birth**: penectomy; vaginoplasty; clitoroplasty; labiaplasty; orchiectomy; breast augmentation; tracheal shave.
   c. Inpatient and outpatient hospital care.
   d. Treatment for complications of surgery.

   You pay the applicable Copayment, Coinsurance, and/or Deductible shown in 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.

2. Gender Affirming Health Services Exclusions
   a. Abdominoplasty.
   b. Blepharoplasty.
   c. Calf implants.
   d. Collagen injections.
   e. Face lifts.
   f. Facial feminization/harmonization surgery.
   g. Permanent hair removal and implantation (nonfacial), with the exception of hair removal in preparation for lower body gender affirmation surgery.
   h. Lipoplasty of the waist.
   i. Liposuction.
   j. Pectoral implants.
   k. Rhinoplasty.
   l. Voice modification surgery.

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 Over

   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 infusion therapy, physical therapy, occupational therapy, speech therapy, home health aide Services, and medical social Services:

   a. only on an Intermittent Care basis (as described below); and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered by a Plan Provider. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

   Intermittent Care basis means skilled nursing, therapy, social work, and home health aide Services, that are not custodial, and require a skilled professional, and are provided less than 8 hours (combined) each day and 28 or fewer hours each week.

   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 advanced imaging procedures are not covered under this section. See "X-ray, Laboratory, and Advanced Imaging Procedures."

2. Home Health Care Exclusions

   a. Custodial care. Custodial care is care that helps with activities of daily living (like bathing, dressing, using the bathroom, and eating) or personal needs that could be done safely and reasonably without professional skills or training.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

O. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for Hospice Special Services. 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 Provider 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 Provider and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Health Plan:
a. Physician care.
b. Nursing care.
c. Physical, occupational, speech, and respiratory therapy.
d. Medical social Services.
e. Home health aide and homemaker Services.
f. Medical supplies, drugs, biologicals, and appliances.
g. Palliative drugs in accordance with our drug formulary guidelines.
h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
i. Counseling and bereavement Services.
j. Services of volunteers.

P. Mental Health Services

1. Coverage
We cover mental health Services as shown below. Mental health includes but is not limited to biologically based illnesses or disorders.

a. Outpatient Therapy
We cover individual visits, group visits, and intensive outpatient therapy.

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 Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider 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, 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.

We will not deny coverage for intentionally self-inflicted injuries, including attempted suicide.

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. Services which are custodial or residential in nature.

Q. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
The Out-of-Area Benefit is limited to certain office visits; diagnostic X-rays; physical, occupational, and speech therapy; and prescription drug fills as covered under this EOC:
a. Office visit exam limited to:
i. Primary care visit.
ii. Specialty care visit.
iii. Preventive care visit.
iv. Gynecology care visit.
v. Hearing exam.
vi. Mental health visit.

vii. Substance use disorder visit.
viii. The administration of allergy injections.
ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).

b. Diagnostic X-rays.

c. Physical, occupational, and speech therapy visits.

d. Prescription drug fills.

See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
The Out-of-Area Benefit does not include the following Services:
a. Other Services provided during a covered office visit such as, but not limited to: procedures; laboratory tests; and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
b. Services received outside the United States.
c. Transplant Services.
d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
e. Allergy evaluation; routine prenatal and postpartum visits; chiropractic care; acupuncture services; applied behavior analysis (ABA); hearing tests; hearing aids; home health visits; hospice services; and travel immunizations.
f. Breast cancer screening and/or imaging.
g. Ultrasounds.
h. Advanced imaging procedures, including but not limited to: CT; PET; MRI; nuclear medicine.
i. Any and all Services not listed in the "Coverage" section of this benefit.

R. Physical, Occupational, and Speech Therapy and Inpatient 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. Inpatient Rehabilitation Services
We will cover treatment while you are in a designated inpatient rehabilitation facility. See the "Schedule of Benefits (Who Pays What)."

d. Pulmonary Rehabilitation
We cover treatment in a pulmonary rehabilitation program if prescribed or recommended by a Plan Provider 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 Provider and Medically Necessary, we cover:

i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. 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 Inpatient Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

S. Prescription Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary includes the list of prescription drugs (including Biologics and Biosimilars) that have been approved by our formulary committee for our Members. Our committee is comprised of physicians, pharmacists, and a nurse practitioner. This committee selects prescription drugs for our drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a drug is included in our drug formulary, please call **Member Services**.

If your prescription drug has a Copayment shown in 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.

For outpatient prescription drugs and/or items that are covered under the "Prescription Drugs, Supplies, and Supplements" section and obtained at a pharmacy owned and operated by Health Plan, you may be able to use approved manufacturer coupons as payment for the Copayment, Coinsurance, and/or Deductible that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire Copayment, Coinsurance, and/or Deductible for your prescription. Certain health plan coverages are not eligible for coupons. You can get more information about the Kaiser Permanente coupon program rules and limitations at kp.org/rxcoupons.

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 Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown in 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: Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

   i. We cover:
      (a) prescription contraceptives intended to last:
         (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
         (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
      (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

      For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

b. Outpatient Prescription Drugs
Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

i. Prescriptions by Mail
If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers 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 and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. 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, such as self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown in 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. Diabetic Supplies and Accessories
Diabetic 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 a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
a. Drugs for which a prescription is not required by law.
b. Disposable supplies for home use such as: bandages; gauze; tape; antiseptics; dressings; 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. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
l. Unless approved by Health Plan, drugs not approved by the FDA.
m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
n. Prescription drugs necessary for Services excluded under this EOC.
o. Drugs administered during a medical office visit. See "Office Services."
p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics."

T. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

U. Reconstructive Surgery

1. Coverage
We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

V. Reproductive Support Services

Reproductive Support Services are not covered unless your Group has purchased additional supplemental coverage.

Note: To determine if your Group has the Reproductive Support Services benefit, see the "Schedule of Benefits (Who Pays What)."

W. Skilled Nursing Facility Care

1. Coverage
We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:
a. Room and board.
b. Nursing care.
c. Medical social Services.
d. Medical and biological supplies.
e. Blood, blood products, and their administration.

A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Health Plan.

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 (DME) and Prosthetics and Orthotics"; X-ray, laboratory, and advanced imaging procedures, see "X-ray, Laboratory, and Advanced Imaging Procedures."

2. Skilled Nursing Facility Care Exclusion
Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

X. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services
We cover Services for the medical management of withdrawal symptoms. 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 Provider.

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 Provider.

We cover substance use disorder Services, whether they are voluntary or are court-ordered, 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 treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

4. Substance Use Disorder Services Exclusion
Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Provider.

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 Utilization Management Program Criteria 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 Providers 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 Health Plan. We cover living organ donation Services in accordance with state law. (Colorado Revised Statutes, Section 10-16-104(24)) For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.
   b. Plan Providers must determine that the Member satisfies Utilization Management Program Criteria before the Member receives Services.
   c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Health Plan. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Health Plan selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.
   d. After referral, if a Plan Provider 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 Health Plan refers you to a 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 Provider 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 Kaiser Permanente Medical Office Buildings.

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. Miscellaneous Services and supplies, such as: eyeglass holders; eyeglass cases; repair kits; contact lens cases; contact lens cleaning and wetting solution; and lens protection plans.
   e. 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).
   f. Orthoptic (eye training) therapy or low vision therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and Advanced Imaging Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. Advanced imaging procedures such as: MRI; CT; PET; and nuclear medicine.
      Note: For advanced imaging 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 advanced imaging 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 under your hospital inpatient care benefit.

2. X-ray, Laboratory, and Advanced Imaging Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services.
   b. Naturopathy Services.
   c. Massage therapy.
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Cryopreservation.** Any and all Services related to cryopreservation, unless your Group has purchased additional coverage. This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

5. **Custodial or Residential Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting; and taking medicine.

6. **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 Provider, 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 Provider 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, or (c) Medically Necessary Services required for the direct treatment of a covered transplant procedure. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
   a. Bandages.
   b. Gauze.
   c. Tape.
   d. Antiseptics.
   e. Dressings.
   f. Ace-type bandages.
   g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;
   b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
   c. Teaching and support services to increase academic performance;
   d. Academic coaching or tutoring for skills such as grammar, math, and time management;
   e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of their license under Colorado law that is intended to address speech impediments;
   f. Teaching you how to read, whether or not you have dyslexia;
   g. Educational testing; testing for ability, aptitude, intelligence, or interest;
   h. Teaching (or any other items or services associated with) activities such as: art; dance; horse riding; music; swimming; or teaching you how to play.

10. **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.

11. **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. 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.

12. **Genetic Testing and Gene Therapy.** Genetic testing and gene therapy, unless determined to be: Medically Necessary; and you meet Utilization Management Program Criteria.

13. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased additional supplemental coverage.

14. **Intermediate Care.** Care in an intermediate care facility.

15. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.

16. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-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.

17. **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.

18. **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.

19. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
a. Employment;
b. Participation in employee programs;
c. Insurance;

d. Disability;
e. Licensing;
f. School events, sports, or camp;
g. Governmental agencies;
h. Court order, parole, or probation;
i. Travel.

20. **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 a Plan Provider refers you to an Out-of-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.

21. **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.

22. **Weight Management Facilities.** Services received in a weight management facility.

23. **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 Providers will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
    i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
    ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.
ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii., a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:

i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order-of-benefits is determined as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
   - The **Plan** covering the **Custodial parent**;
   - The **Plan** covering the spouse of the **Custodial parent**;
   - The **Plan** covering **the non-custodial parent**; and then
   - The **Plan** covering the spouse of the **non-custodial parent**.

C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the

order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties

You must ensure we receive the maximum reimbursement allowed by law for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes, but is not limited to, 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; or (f) any responsible party or entity.

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. The amount of reimbursement due the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

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 another 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 other 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 or from any other party, entity or insurer, regardless of whether the other party, entity or insurer admits

fault. Proceeds of such judgment, award 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 another party, entity or insurer, 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 or entity 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, legal representative, or conservator asserts a claim against another party, entity or insurer based on your injury or illness, your estate, parent, guardian, legal representative, or conservator and any settlement or judgment recovered by the estate, parent, guardian, legal representative, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim. 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 another party, entity or insurer. 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. Traditional or Gestational Surrogacy

In situations where you receive monetary compensation to act as either a traditional or gestational 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. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

Note: This "Traditional or Gestational Surrogacy" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receives
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian, LLC
Attn: Surrogacy Subrogation Operations
PO Box 36380
Louisville, KY 40233
Fax: 502-214-1291

Note: A baby born under a Surrogacy Arrangement does not have health coverage rights under the surrogate's health coverage. The intended parents of a child born under a Surrogacy Arrangement will need to arrange for health coverage for the newborn.

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, can be found in the "Schedule of Benefits (Who Pays What)." Payment responsibility information for Emergency Services and urgent care can be found 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 Out-of-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 Out-of-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.

You may file a claim (request for payment/reimbursement):

- by signing in to kp.org, completing an electronic form, and uploading supporting documentation;
- by mailing a paper form that can be obtained by visiting kp.org/formsandpubs or calling Member Services; or
- if you are unable to access the electronic form (or obtain the paper form), by mailing the minimum amount of information we need to process your claims:
  1. Member/patient name and Medical/Health Record Number
  2. The date you received the Services
  3. Where you received the Services
  4. Who provided the Services
  5. Why you think we should pay for the Services
  6. A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services.

  Mailing address to submit your claim:

  Kaiser Permanente
  National Claims Administration - Colorado
  P.O. Box 373150
  Denver, CO 80237-3150

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 Providers have telephone access to interpreters in over 150 languages.
3. Plan Providers 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 Out-of-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. Genetic Testing Information

In accordance with state law: (1) Information derived from genetic testing shall be confidential and privileged. Any release, for purposes other than diagnosis, treatment, or therapy, of genetic testing information that identifies the person tested with the test results released requires specific written consent by the person tested. (2) Any entity that receives information derived from genetic testing may not seek, use, or keep the information for any nontherapeutic purpose or for any underwriting purpose connected with the provision of group disability insurance or long-term care insurance coverage.

M. 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.

N. Group and Members are not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

O. 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.

P. 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.

Q. 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.

R. 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**.

S. 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.

T. Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You generally may access and receive copies of your PHI, update or amend your PHI, and ask us for an accounting of certain disclosures of your PHI. You also may request delivery of confidential communications to a location other than your usual address or by alternate means.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) 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* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Kaiser Permanente Medical Office Building or on our website, kp.org**.**

U. 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 you 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 may 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 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 Premiums.

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.

V. 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/Nonrenewal/Continuation" 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 Premiums, 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's 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 Provider 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 Premiums from your Group. If your Group fails to pay us the appropriate Premiums for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums 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 Premiums, 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 Premiums 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 Premiums, no later than 30 days after the date of termination of employment.

Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums 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 Outside of our Service Area

If you move to an area not within any Kaiser regional health plan service area, your membership may be terminated. We will provide you with thirty (30) days' notice of termination which will include the reason for termination.

I. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum limits 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, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (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; 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),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

   In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from a Colorado medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then our denial shall be considered an adverse benefit determination

3. An **appeal** is a request for us to review our initial adverse benefit determination.

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 unless we fail to follow the claims and appeals process described in this Section IX.

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 (including your provider (medical facility or health care professional)) 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, if you ask for one. 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) or a denial of an application for individual plan coverage.

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 the reviewer 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 Service may be the basis for our denial of your pre-service claim. 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 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 have a physical or mental disability, creates 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, 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, so long as 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 15 days of receiving your claim, 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 all of the information that you send us 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. Please let us know if you wish to have our decision sent 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 schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. 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 present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 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 have a physical or mental disability, creates 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 appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

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 or Services for a period of time or number of treatments or Services, when the course of treatment already being received will 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 decision (an adverse benefit determination), 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 have a physical or mental disability, 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. 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 (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time 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 days end and explain why 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 45 days that 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. Please let us know if you wish to have our decision sent to your provider.

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 or Services), 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 schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. 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 present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

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 have a physical or mental disability, 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. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

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 or urgent care Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill, your medical record(s) and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 15 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, 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 such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. 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 present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least 5 days prior to the meeting, unless any new material is developed after that 5 day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

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.

Voluntary Second Level of Appeal

Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

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.

Appeals of Denial of Individual Plan Application
Here is the procedure for filing an appeal of our denial of an individual plan application:

Within 180 days after you receive our adverse benefit determination regarding your individual plan application, you must tell us in writing that you want to appeal our denial of an individual plan application. Please include the following: (1) your name and application reference number, (2) all of the reasons why you disagree with our adverse benefit determination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 203004
Denver, CO 80220-9004

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.

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 provided, 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 a physical or mental 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 Facility, 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 Provider 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 Providers. 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 Premiums, 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 Provider: A licensed medical provider, other than a Preferred Provider, who is contracted to render covered Services to Members under this EOC. Affiliated Providers may change during the year. You may have a higher Copayment and/or Coinsurance if a covered Service is rendered by an Affiliated Provider rather than by a Preferred Provider.

Authorization: A referral request that has received approval from Health Plan.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

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 (Copay): The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

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.

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:
1. Serious jeopardy to the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition:
1. A medical screening examination 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, further medical examination and treatment as required to Stabilize the patient 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 individual from a facility.

Family Unit: A Subscriber and all of their Dependents.

Habilitative Services: Health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. 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: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

Kaiser Permanente Medical Office Building: An outpatient treatment facility operated and staffed by Health Plan and Medical Group. Please refer to your Provider Directory for additional information about each Medical Office Building.

Life or Limb Threatening Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

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 Provider or Out-of-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 over, 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 Premiums. This EOC sometimes refers to a Member as "you" or "your."

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

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 medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this EOC. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

Plan Optometrist: A 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 may change during the year.

Plan Provider: A Plan Provider may be a Preferred Provider or an Affiliated Provider. A Plan Provider does not include providers who contract only to provide referral Services. Plan Providers may change during the year.

Preferred Provider: A Preferred Provider is (i) a licensed medical provider (ii) who is contracted with us to render covered Services to Members under this EOC (iii) and with whom a Member may have a lower Copayment and/or Coinsurance. Preferred Providers include Medical Group doctors and Kaiser Permanente Medical Office Building providers, and any other Plan Provider we designate as a Preferred Provider. Preferred Providers may change during the year. You may have a higher Copayment and/or Coinsurance if a covered Service is not rendered by a Preferred Provider.

Premiums: Periodic membership charges paid by Group.

Service Area: Our Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Larimer, Las Animas, Lincoln, Morgan, Otero, Park, Pueblo, Teller, and Weld counties within the following zip codes: 69128, 69145, 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, 80106, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80118, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80132, 80133, 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, 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, 80436, 80437, 80439, 80444, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80511, 80512, 80513, 80514, 80515, 80516, 80517, 80520, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80530, 80532, 80533, 80534, 80535, 80536, 80537, 80538, 80539, 80540, 80541, 80542, 80543, 80544, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80601, 80602, 80603, 80610, 80611, 80612, 80614, 80615, 80620, 80621, 80622, 80623, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80640, 80642, 80643, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 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, 82063, 82070, 82082.

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 their 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).

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

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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.

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)

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)

CHIR0AA

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown in the "Schedule of Benefits (Who Pays What)" when provided by Plan Providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to Plan Providers.

   Note: The following are covered, but not under this section: Physical therapy, see "Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services"; X-ray and laboratory tests, see "X-ray, Laboratory, and Advanced Imaging 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. 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 (01-22)

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider 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, theft, 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 your 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 Provider, 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 or stolen 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. 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 Provider 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 Provider, 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.
      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 or stolen 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 accordance 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 Provider, unless you are 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 or stolen orthotic devices.
      vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

INFT0AA

REPRODUCTIVE SUPPORT SERVICES

1. Coverage
   We cover Services for diagnosis and treatment of involuntary infertility due to a medical condition and for Members who are unable to reproduce due to factors associated with their partner or lack of a partner. The following Services are covered as shown in the "Schedule of Benefits (Who Pays What)":

   a. Office visits, X-ray and laboratory tests.
   b. Intrauterine insemination (IUI).
   c. Office administered drugs supplied and used during an office visit for IUI.

   Note: Prescription drugs are not covered under this section. See "Prescription Drugs, Supplies, and Supplements" in the "Schedule of Benefits (Who Pays What)" to determine if you have coverage for prescription drugs received from a Plan Pharmacy for IUI.

2. Limitations
   a. IUI coverage is limited to a maximum of three (3) treatment cycles during the entire period you are enrolled in this plan.
   b. Services are covered only for the person who is the Member.

3. Exclusions
   These exclusions apply to fertile as well as infertile individuals or couples.
   a. Any and all Services to reverse voluntary, surgically induced infertility.
   b. Acupuncture for the treatment of infertility, unless your Group has purchased additional coverage for this service. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has the acupuncture benefit.
   c. Donor sperm, eggs, or embryos.
   d. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy related to the procurement, transfer, and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos, except as listed in the "Coverage" section of this benefit.
   e. Prescription drugs received from a pharmacy for infertility services, unless prescription drug coverage for infertility is purchased.
   f. Any and all Services, supplies, office administered drugs, and prescription drugs received from a pharmacy that are related to conception by artificial means, except as listed in the "Coverage" section of this benefit.

This rider amends the EOC to provide limited coverage for reproductive support Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

INFT0AA (01-22)

PREVENTIVE SERVICES RIDER

Preventive care Services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Provider. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Deductible, Copayment, or Coinsurance for these additional diagnostic Services.
- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Deductible, Copayment, or Coinsurance for these additional non-preventive Services.
- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Deductible, Copayment, or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources and Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive 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.

PV0AD (01-21)

RX0BL

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage
   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain

specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

Non-Formulary Drug Exception Process:
You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

Diabetic 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. Health Plan 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 not listed as generic in the 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 Provider and obtained at Plan Pharmacies; or
b. Provider to whom a Member has been referred by a Plan Provider 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.
b. Insulin. You are not responsible for more than $100 per thirty-day supply of all covered prescription insulin drugs.
c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.

Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. 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 Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs with some exceptions. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs.
      You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.

e. Any drugs listed as not covered in the “Schedule of Benefits (Who Pays What).”
f. Drugs to shorten the length of the common cold.
g. Drugs to enhance athletic performance.
h. Drugs available over the counter and by prescription for the same strength.
i. Certain 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 (01-22)

NOTES

NOTES

6.F

Kaiser Foundation Health Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

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COUNTY OF ADAMS

Important plan information

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Evidence of Coverage

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Kaiser Permanente Senior Advantage Group Plan (HMO)

This booklet gives you the details about your Medicare health care and prescription drug coverage during your group's 2022 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).

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, 2023, 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.

EG22001 MC/XX/2021
KPSA-GROUP-PART D (01-22)

KAISER PERMANENTE®

6.F

Medical Benefits Chart: Kaiser Permanente Group Senior Advantage (HMO)

COUNTY OF ADAMS
385 - 015

Services that are covered for you	What you must pay when you get these services
Annual Deductible	No Medical Deductible
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.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer. • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease). • Not associated with surgery. • Not associated with pregnancy. An additional eight sessions are covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	$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 services
Provider requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • A master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • A current, full, active, and unrestricted license to practice acupuncture in a state, territory, or commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by regulations at 42 CFR §§ 410.26 and 410.27.	
If purchased by your group, supplemental acupuncture services*	Not covered

†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 services
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 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. • †Nonemergency 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
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.

†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 services
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.
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.
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.

†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 services
Cardiac rehabilitation services Comprehensive programs for cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	
Individual therapy visits.	$15 Copayment each visit or $25 Copayment each visit Copayment dependent upon provider type
Group therapy visits.	Your primary care office visit copayment or $10, whichever is less.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
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 cost-sharing, coinsurance, copayment, or deductible for this cardiovascular disease testing that is covered once every five years.

†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 services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past three years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams
Chiropractic services Covered services include: We cover only manual manipulation of the spine to correct subluxation These Medicare-covered services are provided by a participating chiropractor. Please refer to your **Provider Directory** for participating chiropractors. If purchased by your group, supplemental chiropractic services. Laboratory Services or X-rays required for Chiropractic care	$15 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions See Outpatient diagnostic tests and therapeutic services and supplies

†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 services
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.
Dental services (from designated providers)*	Please see the Additional Provisions in the back of this booklet to see if your group has purchased coverage for dental services.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

†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 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.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and noninsulin 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 type.

†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 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
We also cover the following DME not covered by Medicare when medically necessary: • Phototherapy equipment for the following conditions: vitiligo, eczema, lichen planus, atopic dermatitis, idiopathic dermatitis, severe pruritus, morphea, scleroderma, and cutaneous lymphomas.	20% Coinsurance

†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 services
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 advanced imaging procedures. This copayment does not apply if you are immediately admitted directly to the hospital as an inpatient (it does apply if you are admitted to the hospital as an outpatient; for example, if you are admitted for observation). †**Note:**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 services
Fitness benefit (SilverSneakers Fitness Program*) A health and fitness benefit is provided through Tivity Health SilverSneakers® Fitness Program that includes the following: • A basic fitness membership with access to all participating fitness locations and their basic amenities. Facilities and amenities vary by location. • SilverSneakers® group fitness classes, taught by certified instructors that focus on cardiovascular health, muscle strengthening, flexibility, agility, balance, and coordination. Classes vary by location. • 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. • Virtual resources available through the SilverSneakers LIVE and SilverSneakers On-Demand programs, and the mobile app, SilverSneakers GO. • SilverSneakers FLEX® program, which provides options to get active outside of traditional gyms (like recreation centers, malls, and parks). • You can enroll in SilverSneakers® Steps, a self-directed fitness program for members and receive one home fitness kit per calendar year, which includes tools and resources to help you get fit at home or on the go.	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 services
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. SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers LIVE, SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2021 Tivity Health, Inc. All rights reserved.	
Health and wellness education programs Health and wellness programs include weight management, quitting tobacco, diabetes management, life care planning, prediabetes, and more. Registered dietitians, health coaches, certified diabetes educators, and other health professionals facilitate our classes. We offer in-person, online, and phone options to fit your learning style. Contact Member Services for more details. You can also view information online at **kp.org.**	No Charge

†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 services
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
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.

†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 services
Home infusion therapy† Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care. • Patient training and education not otherwise covered under the durable medical equipment benefit. • Remote monitoring. • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. We cover home infusion supplies and drugs if all of the following are true: • Your prescription drug is on our Medicare Part D formulary. • 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 for professional services, training, and monitoring. The components (such as, Medicare Part B drugs, DME, and medical supplies) needed to perform home infusion may be subject to the applicable cost-sharing listed elsewhere in this Medical Benefits Chart depending on the item. **Note:** If a covered home infusion supply or drug is not filled by a network home-infusion pharmacy, the supply or drug may be subject to the applicable cost-sharing listed elsewhere in this booklet depending on the service.

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Services that are covered for you	What you must pay when you get these 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.	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.
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Services that are covered for you	What you must pay when you get these 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 nonhospice care (care that is not related to your terminal prognosis), you should contact us to arrange the 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

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Services that are covered for you	What you must pay when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine. • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary. • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B. • COVID-19 vaccine • 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, Hepatitis B and COVID-19 vaccines.

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Services that are covered for you	What you must pay when you get these services
Inpatient hospital care† Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. There is no limit to the number of medically necessary hospital days or services that are generally and customarily provided by acute care general hospitals.Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive care or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical, occupational, and speech language therapy. • Inpatient substance abuse services for medical management of withdrawal symptoms associated with substance abuse (detoxification).	$250 Copayment per admission †If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. Note: If you are admitted to the hospital in 2021 and are not discharged until sometime in 2022, the 2021 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.

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***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 services
• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If we provide transplant services at a location outside the pattern of care for transplants in your community, and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. **Note:** Travel and lodging expenses must be authorized by us 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. 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	

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***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 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 at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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 rehabilitation.	$250 Copayment per inpatient admission
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

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Services that are covered for you	What you must pay when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a noncovered 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 mental health or SNF stay. However, in some cases, we will cover certain services you receive while you are in 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.	If your inpatient stay, inpatient mental health stay or SNF stay is no longer covered, we will continue to cover Medicare Part B services at the applicable cost-sharing listed elsewhere in this Medical Benefits Chart when provided by network providers.
• 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.	

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Services that are covered for you	What you must pay when you get these services
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered. by your doctor We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew his or her order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services are 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 services
Medicare Explorer by Kaiser Permanente If you travel outside any Kaiser Permanente service area, but inside the United States or its territories, we cover preventive, routine, follow-up, or continuing care office visits obtained from out-of-network Medicare providers. Contact the provider directly to schedule an appointment. Coverage services include: • Preventive care screenings and services that take place during an office visit. • Primary care office visits and services that take place during an office visit. • Specialty care office visits and services that take place during an office visit. • Medicare-covered chiropractic and acupuncture visits. • Medicare-covered hearing exams. • Medicare-covered and routine eye exams. • Outpatient diagnostic tests and therapeutic services and supplies, including blood, laboratory tests, electrocardiograms (EKGs), Holter Monitoring, and Electroencephalograms (EEGs). • X-rays and other basic imaging. Other outpatient diagnostic tests, including but not limited to, MRI, PET and CT scans are not covered. • Physical therapy, Speech therapy, Occupational therapy, pulmonary and cardiac rehabilitation services. • Mental health care outpatient visits, crisis intervention, and substance abuse treatment.	Not Covered

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Services that are covered for you	What you must pay when you get these 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 you take using durable medical equipment (such as nebulizers) that was authorized by the plan. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant. • Certain oral anti-cancer drugs and anti-nausea drugs. • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • 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. • 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. • Antigens. • 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).	No Charge 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.

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Services that are covered for you	What you must pay when you get these services
Note: We also cover some vaccines under our Part B and Part D prescription drug benefit Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in the Prescription Drug section of this chart.	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.
Opioid treatment program services† Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. Dispensing and administration of MAT medications (if applicable).	Office administered Medicare Part B treatment medications: See "Medicare Part B prescription drugs" Dispensing and administration: You will pay one Outpatient substance abuse services copayment per month See Specialty care visits under "Physician/practitioner services, including doctor's office visits"
• Substance use counseling • Individual and group therapy. • Toxicology testing. • Intake activities. • Periodic assessments.	See Specialty care visits under "Physician/practitioner services, including doctor's office visits"

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Services that are covered for you	What you must pay when you get these 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 — †Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET).	$100 Copayment per procedure
• †Radiation (radium and isotope) therapy, including technician, materials and supplies	$25 Copayment
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.	No Charge Note: There's no additional charge for outpatient observation stays when transferred for observation from an Emergency Department or outpatient surgery.

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Services that are covered for you	What you must pay when you get these services
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/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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 hospital services† Outpatient hospital services at designated facilities, including but not limited to: electroencephalogram, sleep study, stress test, pulmonary function test, any treatment room.	See "Outpatient surgery at Plan Facilities" for applicable Copayment or Coinsurance

†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 services
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/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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.	

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Services that are covered for you	What you must pay when you get these services
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.	
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 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

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Services that are covered for you	What you must pay when you get these services
Over-the-Counter (OTC) items We cover OTC items listed in our OTC catalog for free home delivery. You may order OTC items each quarter of the year (January, April, July, October) up to the quarterly benefit limit shown in the right column. The catalog lists the price of each item. Each order must be at least **$35.** Any unused portion of the quarterly benefit limit doesn't carry forward to the next quarter. To view our catalog and place an order online, please visit **kp.org/otc/co**. You may place an order over the phone or request a printed catalog be mailed to you by calling **1-833-238-6616** (TTY **711),** 7 a.m. to 6 p.m. CST, Monday through Friday.	Not Covered
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	$5 Generic/$15 Non-Preferred Generic/$40 Brand name/$60 Non-Preferred Brand name/$60 Specialty/No Charge injectable Part D vaccines Up to $4,430
Coverage Gap Stage • Outpatient prescription drugs and refills copayments/coinsurance (except as listed below) • Out-of-Pocket Costs	$5 Generic/$15 Non-Preferred Generic/$40 Brand name/$60 Non-Preferred Brand name/$60 Specialty/No Charge injectable Part D vaccines Up to $7,050
• Prescribed supplies and accessories.	No Charge
Infertility drugs.	Not Covered
Sexual dysfunction drugs.	Not Covered
	Supply Limit
Day supply limit.	30 days

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Services that are covered for you	What you must pay when you get these services
Mail-order supply limit.	90 days @ 2 Copayments
Physician/practitioner services, including doctor's office visits† "Providers" include, but are not limited to, physicians, physician assistants and nurse practitioners. 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. • Consultation, diagnosis, and treatment by a specialist. • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Second opinion by another network provider prior to surgery. • Nonroutine 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).	
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

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Services that are covered for you	What you must pay when you get these services
• Certain telehealth services, including those for: primary and specialty care, which includes cardiac rehabilitation, mental health care, substance abuse treatment, kidney disease education, dialysis services, diabetes self-management training, physical, speech and occupational therapies, preparation for surgery or a hospital stay, and follow up visits after a hospital stay, surgery or Emergency Department visit. Services will only be provided by telehealth when deemed clinically appropriate by the network provider rendering the service. You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. We offer the following means of telehealth: ♦ Interactive video visits for professional services when care can be provided in this format as determined by a network provider. ♦ Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a network provider. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home.	No Charge

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Services that are covered for you	What you must pay when you get these services
• Telehealth services to diagnose, evaluate or treat symptoms of stroke, regardless of your location. • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location. • Virtual check-ins (for example, by phone or video chat) with your doctor for 5 to 10 minutes if all of the following are true: you're not a new patient and the check-in isn't related to an office visit within the previous 7 days and the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours (except weekends and holidays) if all the following are true: you're not a new patient and the evaluation is not related to an office visit within the previous 7 days and the evaluation doesn't lead to an office visit within 24 hours or soonest available appointment. • Consultation your doctor has with other doctors by phone, internet, or electronic health record if you're not a new patient.	
	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

†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 services
†Allergy evaluation and testing. • Primary care visits • Specialty care visits	$15 Copayment each visit $25 Copayment each visit
• Group visits—Cooperative Health Care Clinic (CHCC), Drop in Group Medical Appointment (DIGMA) and group mental health and substance abuse treatments.	Your primary care office visit copayment or $10 copayment each visit, whichever is less.
Podiatry services† Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	See primary care office visit, specialty care office visit, and †Outpatient surgery cost-sharing above.
• We cover additional routine foot care not covered by Medicare, which includes assessment and treatment of corns or calluses, the trimming of nails (including mycotic nails), and other hygienic and preventive maintenance foot care. Please refer to your **Provider Directory** for contact information for routine foot care providers.	No Charge for up to 4 visits per calendar year
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.

†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 services
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, slings, splints, 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

†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 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.
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.	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.
***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 services
• For LDCT lung cancer screenings after the initial LDCT screening, the member 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.	
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.

†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 services
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. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.	$15 Copayment each visit or $25 Copayment each visit copayment dependent upon provider.
• †Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care).	Refer to the "Inpatient hospital care" section of this Medical Benefits Chart for the cost-sharing applicable to inpatient stays.
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply). Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section called "Medicare Part B prescription drugs".	No Charge

†Your provider must obtain prior authorization from our plan.
***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care† (For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") We cover up to 100 days per benefit period of skilled inpatient services in a skilled nursing facility in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body such as blood clotting factors.) • Blood – including storage and administration. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/practitioner services	No Charge Limited to 100 days per benefit period A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 calendar days in a row. Note: If a benefit period begins in 2021 for you and does not end until sometime in 2022 the 2021 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 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.	
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.
In addition to counseling services, we cover certain FDA-approved nicotine replacement therapies for over-the-counter use. The items must be ordered by a network provider and obtained from a network pharmacy. We will provide up to a 90-day supply twice during the calendar year.	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 services
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30–60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication. • Be conducted in a hospital outpatient setting or a physician's office. • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD. • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques. **Note:** SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time, if deemed medically necessary by a health care provider.	$30 Copayment each visit
Transportation benefit We cover one-way trips (limited to 50 miles one-way) to get you to and from a network provider when provided by our designated transportation provider (please see the **Provider Directory**).	Not Covered

†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 services
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. • **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.. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. **See Chapter 3, Section 3, for more information.**	$40 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 services
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. 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. • For people with diabetes, screening for and monitoring of diabetic retinopathy.	No charge, unless member receives the screening in conjunction with other services, such as a routine eye exam, then member will be charged the applicable copayment.

†Your provider must obtain prior authorization from our plan.
***Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.**

Services that are covered for you	What you must pay when you get these services
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. **Note:** 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. • 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 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.

Eligibility Amendments **Note:** Refer to Chapter 1 (Section 10) and Chapter 11 for information about coordination of benefits that applies to all covered services described in this Medical Benefits Chart.
Eligibility Amendments Your Group coverage includes health benefits for both same- and opposite-sex domestic partners and their Dependents. To be covered they must meet: 1. the eligibility requirements as described in the "Eligibility" section of this EOC; and 2. the conditions for domestic partnership as described in the Affidavit of Domestic Partnership. You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.
Eligibility Amendments Under your Group contract, a grandchild of you or your Spouse cannot be enrolled as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed legal guardian of the grandchild. This includes an adopted or foster grandchild.

†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.**

2022 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 Medicare 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.

Coverage under this plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at **https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

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 in, please call Member Services or your group’s benefit administrator.

This plan is offered by Kaiser Foundation Health Plan of Colorado (Health Plan) and it includes Medicare part D prescription drug coverage. When this **Evidence of Coverage** says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage (Senior Advantage).

The words "coverage" and "covered services" refer to the medical care and services and the prescription drugs available to you as a member of our plan.

It’s important for you to learn what our plan’s rules are and what services are available to you. We encourage you to set aside some time to look through this **Evidence of Coverage** booklet.

If you are confused or concerned or just have a question, please contact Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the Evidence of Coverage

It's part of our contract with you

This **Evidence of Coverage** is part of our contract with you about how we cover your care. Other parts of this contract include your enrollment form, our **2022 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, 2022, and December 31, 2022, unless amended.If your group's agreement renews at a later date in 2022, 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, 2022. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022. In addition, your group can make changes to the plans and benefits it offers at any time.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer our plan and Medicare renews its approval of our plan.

SECTION 2. What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as all the following are true:

- 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).
- You live in our geographic service area (Section 2.3 below describes our service area).
- You are a United States citizen or are lawfully present in the United States.

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, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) 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.

Our service area includes these counties in Colorado: **Denver-Boulder: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin and Jefferson. Northern Colorado: Larimer and Weld. Southern Colorado: El Paso and Pueblo**

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 2.6 When you can enroll in Senior Advantage 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 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 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:

Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Senior Advantage membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies.

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 and suppliers is available on our website at **kp.org/directory**.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers. See Chapter 3, "Using our plan's coverage for your medical services," for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the **Provider Directory**, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can view or download the **Provider Directory at kp.org/directory**. Both Member Services and our website can give you the most up-to-date information about our network providers.

Section 3.3 The Pharmacy Directory: Your guide to pharmacies in our network

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the **Pharmacy Directory** to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated **Pharmacy Directory** is located on our website at **kp.org/directory**. You may also call Member Services for updated provider information or to ask us to mail you a **Pharmacy Directory**. Please review the **2022 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 **2022 Comprehensive Formulary**. We call it the "Drug List" for short. It tells you which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by our plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved our Drug List. The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of our Drug List. To get the most complete and current information about which drugs are covered, you can visit our website **(kp.org)** or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 3.5 The Part D Explanation of Benefits (the "Part D EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the **Part D Explanation of Benefits** (or the **"Part D EOB"**).

The **Part D EOB** tells you the total amount you, others on your behalf,and we have spent on your Part D prescription drugs and the total amount paid for each of your Part D prescription drugs during each month the Part D benefits is used. The **Part D EOB** provides more information about the drugs you take, such as increases in price and other drugs with lower cost-sharing that may be available. You should consult with your prescriber about these lower cost options. 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.

The **Part D EOB** is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet). You can also choose to get your **Part D EOB** online instead of by mail. Please visit **kp.org/goinggreen** and sign on to learn more about choosing to view your **Part D EOB** securely online.

SECTION 4. Your monthly premium for our plan

Section 4.1 How much is your plan premium?

Plan premiums

Your group is responsible for paying premiums. If you are responsible for any contribution to the premiums, your group will tell you the amount and how to pay your group.

SECTION 5. Do you have to pay the Part D "late enrollment penalty"?

Section 5.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The cost of the late enrollment penalty depends upon how long you went without Part D or other 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 2022 this average premium amount is $33.06.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium, and then round it to the nearest 10 cents. In the example here, it would be 14% times $33.06, which equals $4.63. This rounds to $4.60. This amount would be added to the monthly premium for someone with a Part D late enrollment penalty.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, the penalty may change each year because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, you will continue to pay a penalty every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 5.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "creditable drug coverage." **Please note:**
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later.

- Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
- The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
- For additional information about creditable coverage, please look in your **Medicare & You** 2022 handbook or call **Medicare at 1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.

- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 5.4 What can you do if you disagree about your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review within 60 days from the date on the first letter you receive stating you have to pay a late enrollment penalty. If you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty. Call Member Services to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

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?

If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.

Section 6.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, visit **https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html.**

Section 6.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at **1-800-772-1213** (TTY **1-800-325-0778**).

Section 6.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required by law to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

SECTION 7. More information about your monthly premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 of this chapter, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. You must continue paying your Medicare premiums to remain a member of our plan.

If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

- 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 **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** 2022 gives you information about Medicare premiums in the section called "2022 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** 2022 from the Medicare website (**https://www.medicare.gov**) or you can order a printed copy by phone at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

Section 7.1 Paying your plan premium

Your group is responsible for paying premiums. If you are responsible for any contribution to the premiums, your group will tell you the amount and how to pay your group.

Section 7.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for our plan's monthly plan premium during your group's contract year.

However, in some cases, the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 8. Please keep your plan membership record up-to-date

Section 8.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage, including your primary care provider.

The doctors, hospitals, pharmacists, and other providers in our network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up-to-date.

Let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.

1-800-476-2167, 7 days a week, 8 a.m. to 8 p.m. (TTY 711)

- 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 1.3, 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.
WRITE	Kaiser Foundation Health Plan of Colorado 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. Monday to Friday, 8 a.m. to 8 p.m.
FAX	**1-866-466-4042**
WRITE	Kaiser Foundation Health Plan of Colorado 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 **www.medicare.gov/MedicareComplaintForm/home.aspx**.

How to contact us when you are asking for a coverage decision 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 for Part D prescription drugs – contact information
CALL	**1-888-791-7255** 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. Monday to Friday, 8 a.m. to 8 p.m.
FAX	**1-844-403-1028**
WRITE	OptumRx c/o Prior Authorization P.O. Box 25183 Santa Ana, CA 92799
WEBSITE	**kp.org**

How to contact us when you are making a complaint about your Part D prescription drugs

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 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	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	**1-866-466-4042**
WRITE	Kaiser Foundation Health Plan of Colorado 2500 South Havana Street Aurora, CO 80014-1622
WEBSITE	**kp.org**
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx.**

How to contact us when you are making an appeal about your medical care or Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information about making an appeal about your medical care or Part D prescription drugs, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."

Method	Appeals for medical care or Part D prescription drugs – contact information
CALL	**1-888-370-9858** Calls to this number are free. Monday through Friday, 8:30 a.m. to 5 p.m.
TTY	**711** Calls to this number are free. Monday through Friday, 8:30 a.m. to 5 p.m.
FAX	**1-866-466-4042**
WEBSITE	**kp.org**
WRITE	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.

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 Colorado Region 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** 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	**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 **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 to access SHIP and other resources:

- Visit www.medicare.gov.
- Click on "Forms, Help, and Resources" on far right of menu on top.
- In the drop down, click on "Phone Numbers & Websites."
- You now have several options:
  - Option 1: You can have a live chat.
  - Option 2: You can click on any of the "Topics" in the menu on bottom.
  - Option 3: You can select your state from the dropdown menu and click "Go." This will take you to a page with phone numbers and resources specific to your state.

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://doi.colorado.gov/insurance-products/health-insurance/senior-health-care-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	**1-888-317-0891** 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	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131
WEBSITE	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. 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** 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+).
- **Qualifying 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, 8 a.m. to 4:30 p.m.
TTY	**711**
WRITE	Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203
WEBSITE	**www.healthfirstcolorado.com**

SECTION 7. Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments.. This "Extra Help" also counts toward your out-of-pocket costs.

Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week;
- The Social Security Office at **1-800-772-1213**, between 7 a.m. to 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778** (applications); or
- Your state Medicaid office (applications) (see Section 6 in this chapter for contact information).

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you either to request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

If you aren't sure what evidence to provide us, please contact a network pharmacy or Member Services. The evidence is often a letter from either the state Medicaid or Social Security office that confirms you are qualified for "Extra Help." The evidence may also be state-issued documentation with your eligibility information associated with Home and Community-Based Services.

You or your appointed representative may need to provide the evidence to a network pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate cost-sharing amount until the Centers for Medicare & Medicaid Services (CMS) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to the pharmacy. Please provide your evidence in one of the following ways so we can forward it to CMS for updating:

- Write to Kaiser Permanente at:
  California Service Center
  Attn: Best Available Evidence
  P.O. Box 232407
  San Diego, CA 92193-2407
- Fax it to **1-877-528-8579**.
- Take it to a network pharmacy.

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs to Part D members who have reached the coverage gap and are not receiving "Extra Help." For brand-name drugs, the 70% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 25% of the negotiated price and a portion of the dispensing fee for brand-name drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your **Part D Explanation of Benefits (Part D EOB)** will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them, and move you through the coverage gap. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, we pay 75% of the price for generic drugs and you pay the remaining 25% of the price. For generic drugs, the amount paid by our plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

The Medicare Coverage Gap Discount Program is available nationwide. Because our plan offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 6, Section 6, for more information about your coverage during the Coverage Gap Stage.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand-name drugs. Also, the plan pays 5% of the costs of brand-name drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?

What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through **Bridging the Gap Colorado**. Note: To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/underinsured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Please call **Bridging the Gap Colorado at 303-692-2716.**

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call **Bridging the Gap Colorado at 303-692-2716.**

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help," you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand-name drug, you should review your next *Part D Explanation of Benefits (Part D EOB)* notice. If the discount doesn't appear on your *Part D EOB*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this chapter) or by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

In Colorado, the name of the State Pharmaceutical Assistance Program is Bridging the Gap Colorado.

Method	Bridging the Gap Colorado - contact information
CALL	**1-303-692-2716** Monday through Friday, 8 a.m. to 5 p.m.
WRITE	Bridging the Gap Colorado C/O CDPHE Care and Treatment Program ADAP-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. If you press "0," you may speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday If you press "1," you may access the automated RRB HelpLine and recorded information 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	**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, you must choose one of our available network providers to be your primary care provider. Your primary care provider is a physician who meets state requirements and is trained to give you primary medical care. Your PCP will usually practice general medicine (also called adult or internal medicine and family practice) and pediatrics. PCPs are identified in the **Provider Directory**.

Your PCP provides, prescribes, or authorizes medically necessary covered services. Your PCP will provide most of your routine or basic care and provide a referral as needed to see other network providers for other care you need. For example, to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). 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).

Your PCP will also coordinate your care. "Coordinating" your care includes checking or consulting with other network providers about your care and how it is going. In some cases, your PCP will need to get prior authorization (prior approval) from us (see Section 2.3 in this chapter for more information).

How do you choose your PCP?

As explained above, your PCP plays an important role in your health care. That's why we require you to have a PCP. If you do not select a PCP when you enroll, we will assign you a physician and notify you accordingly.

You may choose a primary care provider from any of our available network physicians who practice in these specialties: internal medicine, family medicine, and pediatrics. When you make a selection, it is effective immediately. Denver Metropolitan members: To learn how to choose a primary care provider, please call our personal physician selection number 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/chooseyourdoctor**.

Northern Colorado and Southern Colorado members: You may select a primary care provider who is not located at one of our Kaiser Permanente medical offices. To choose a primary care provider who is not located at one of our Kaiser Permanente medical offices, call the primary care provider you want to choose and make sure that he/she is accepting new patients and contact the personal physician selection number at **1-855-208-7221** (TTY **711),** and notify us of your new primary care provider.

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.

Denver Metropolitan members: To change your PCP, call our personal physician selection number 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/chooseyourdoctor**.

Northern Colorado and Southern Colorado members: To change your PCP who is located at one of our Kaiser Permanente medical offices, call our personal physician selection number at 1-855-208-7221 (TTY 711), weekdays 7 a.m. to 5:30 p.m., or make your selection at **kp.org/chooseyourdoctor**. To choose a PCP who is not located at one of our Kaiser Permanente medical offices, call the primary care physician you want to choose and make sure that he/she is accepting new patients and call our personal physician selection number at 1-855-208-7221 (TTY 711), weekdays 7 a.m. to 5:30 p.m., to notify us of your new PCP.

When you call, tell us 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) so we can tell you if you need to get a referral from your new PCP to continue the services. Also, if there is a particular network specialist or hospital that you want to use, check with us to find out if your PCP makes referrals to that specialist or uses that hospital.

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, COVID-19 vaccinations, 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.
- **Denver Metropolitan members:** Consultation (routine office) visits to specialty-caredepartments within our plan, with the exception of the anesthesia clinical pain department.
- **Northern Colorado and Southern Colorado members:** Consultation (routine office) visitsto specialty-care network providers who have been identified as eligible to receive direct referrals. You will find the specialty care providers eligible to receive direct referrals in theProvider Directory. Note: A self-referral provides coverage for routine visits only.Authorization from our plan is required for: (i) services in addition to those provided as part ofthe visit, such as surgery; and (ii) visits to specialty- care network providers not eligible to receive direct referrals; and (iii) out-of-network physicians. Services other than routine office visits with a specialty-care network provider eligible to receive self-referrals will not be covered unless authorized by our plan before services are rendered. For more information about prior authorization, see Section 2.3 in this chapter.
- Second opinions from another network provider.
- Mental health care or substance abuse services, as long as you get them from a network provider.
- Preventive care except barium enemas, as long as you get them from a network provider.
- Chiropractic services as long as you get them from a network provider.
- Routine eye exams and hearing exams, as long as you get them from a network provider.

- **Denver Metropolitan members:** 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.
- **Northern Colorado members:** Covered routine care from any Colorado Permanente Medical Group (CPMG) physician at any Kaiser Permanente medical office in our Denver Metropolitan or Southern Colorado service areas. Note: You cannot get routine care from affiliated network providers in the Denver Metropolitan or Southern Colorado service areas.
- **Southern Colorado members:** Covered routine care from any Colorado Permanente MedicalGroup (CPMG) physician at any Kaiser Permanente medical office in our Denver Metropolitan or Northern Colorado service areas. Note: You cannot get routine care fromaffiliated network providers in the Denver Metropolitan 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.

Referrals to network providers

When your PCP prescribes care that isn't available from a PCP (for example, specialty care), he or she will give you a referral to see a network specialist or another network provider as needed. If your PCP refers you to a network specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. We will send you a written referral to authorize an initial consultation or a specified number of visits with a network specialist. After your initial consultation with the network specialist, you must then return to your PCP unless we have authorized more visits as specified in the written referral that we gave you. Don't return to the network specialist after your initial consultation visit unless we have authorized additional visits in your referral. Otherwise, the services may not be covered.

For some types of network specialty care, your PCP may need to get approval in advance from our plan. If there is a particular network specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist.

Prior authorization

For the services and items listed below your network provider 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. If you ever disagree with authorization decisions, you can file an appeal as described in Chapter 9

- Services and items identified in Medical Benefits Chart found at the front of this EOC with a footnote (†).
- For certain network specialty care, your PCP will need to request that we authorize the referral before you can see the specialty care network provider. If we authorize the referral, it will be for a specific treatment plan as explained above (see “Referrals to specialists” for details)
- If your network provider 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 network provider what services have been authorized if you are not certain. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers the additional care. If it doesn't, please contact your network provider.
- 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.
- Medically necessary bariatric surgery.
- Care from a religious nonmedical health care institution described in Section 6 of this chapter.
- If your network provider makes a written referral for a transplant, we will authorize the services if we determine that they are medically necessary or covered in accord with Medicare guidelines.

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.
- We authorize a referral to an out-of-network provider described in Section 2.3 of this chapter.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.
- If you visit the service area of another Kaiser Permanente region, you can receive certain care covered under this **Evidence of Coverage** from designated providers in that service area. Please call our care away from home travel line at **1-951-268-3900** (TTY **711**) 24 hours a day, 7 days a week (except holidays), or visit our website at **kp.org/travel** 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. **Note:** Our care away from home travel line can also answer questions about covered emergency or urgent care services you receive out-of-network, including how to get reimbursement.

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. For more information, see the Medical Benefits Chart found at the front of this **EOC**.

You may get covered emergency medical care (including ambulance) when you need it anywhere in the world. However; you may have to pay for the services and file a claim for reimbursement (see Chapter 7 for more information).

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, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was not an emergency, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- Or the additional care you get is considered "urgently needed services" and you follow the rules for getting these urgently needed services (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in our service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible, and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse.

They can often answer questions about a minor concern, tell you what to do if a network facility is closed, or advise you about what to do next, including making a same-day urgent care appointment for you if it's medically appropriate. To speak with an advice nurse 24 hours a day, seven days a week, or make an appointment, please call **1-800-218-1059** (TTY **711**).

What if you are 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. Our plan covers worldwide urgent care services outside the United States under the following circumstances:

- You are temporarily outside of our service area.

- The services were necessary to treat an unforeseen illness or injury to prevent serious deterioration of your health.
- It was not reasonable to delay treatment until you returned to our service area.
- The services would have been covered had you received them from a network provider.

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 our 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, are listed in the plan’s Medical Benefits Chart (this chart is found at the front of this **EOC)**, and are 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 maximum out-of-pocket amount. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5. How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study and you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, you do need to tell us before you start participating in a clinical research study.

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what we will pay.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs:

- We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.
  - Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.
- In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

When you are part of a clinical research study, neither Medicare nor our plan will pay for any of the following:

- Generally, Medicare will not pay for the new item or service that the study is testing, unless Medicare would cover the item or service even if you were not in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies" (The publication is available at **www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf**.) 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 Receiving care from a religious nonmedical health care institution

To get care from a religious nonmedical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is voluntary and not required by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is not voluntary or is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious nonmedical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to nonreligious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - – and – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Note: Covered services are subject to the same limitations and cost-sharing required for services provided by network providers as described in the Medical Benefits Chart found at the front of the EOC, Chapters 4 and 12.

SECTION 7. Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech-generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan, you will not acquire ownership no matter how many copayments you make for the item while a member of our plan.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare before you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8. Rules for oxygen equipment, supplies, and maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, our plan will cover:

- Rental of oxygen equipment.
- Delivery of oxygen and oxygen contents.
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents.
- Maintenance and repairs of oxygen equipment.

If you leave our plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost sharing? Will it change after 36 months?

Your cost-sharing for Medicare oxygen equipment coverage is **20%** coinsurance, every time you receive equipment.

Your cost-sharing will not change after being enrolled for 36 months in our plan.

If prior to enrolling in our plan, you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in our plan is **20%** coinsurance.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle that renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining our plan, join our plan for 12 months, and then return to Original Medicare, you will pay full cost-sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in our plan and then return to Original Medicare, you will pay full cost-sharing for oxygen equipment coverage.

CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1. Understanding your out-of-pocket costs for covered service

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. It includes a Medical Benefits Chart that lists your covered services 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 2022 is stated in the Medical Benefits Chart found at the front of this **EOC.** The amounts you pay for deductibles (if your plan has a deductible), copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart found at the front of this **EOC**.

If you reach the maximum out-of-pocket amount stated in the Medical Benefits Chart found at the front of this **EOC**, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of our plan, an important protection for you is that, after you meet any deductibles (if applicable to your plan), you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends upon which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, we cover services from out-of-network providers only in certain situations, such as when you get a referral.)
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for nonparticipating providers. (Remember, we cover services from out-of-network providers only in certain situations, such as when you get a referral.)

- If you believe a provider has “balance billed” you, call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 2. Use the Medical Benefits Chart at the front of this EOC to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of our plan

The Medical Benefits Chart found at the front of this **EOC** lists the services our plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart found at the front of this **EOC** are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in our plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart found at the front of this **EOC** are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart found at the front of this **EOC** with a footnote (†). In addition, see Section 2.2 in this chapter and Chapter 3, Section 2.3, for more information about prior authorization, 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 2022** handbook. View it online at **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, cost-sharing 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 2022 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.**

Eligibility Amendments **Note:** Refer to Chapter 1 (Section 10) and Chapter 11 for information about coordination of benefits that applies to all covered services described in this Medical Benefits Chart.
Eligibility Amendments Your Group coverage includes health benefits for both same- and opposite-sex domestic partners and their Dependents. To be covered they must meet: 1. the eligibility requirements as described in the "Eligibility" section of this EOC; and 2. the conditions for domestic partnership as described in the Affidavit of Domestic Partnership. You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.
Eligibility Amendments Under your Group contract, a grandchild of you or your Spouse cannot be enrolled as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed legal guardian of the grandchild. This includes an adopted or foster grandchild.

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 benefits that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical benefits 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 benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3, in this booklet.)

All exclusions or limitations on services are described in the Medical Benefits Chart at the front of this **EOC** or in the chart below

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare		√ This exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.
Experimental medical and surgical procedures, equipment and medications • Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community		√ May be covered by Original Medicare under a Medicare-approved clinical research study. (See Chapter 3, Section 5 for more information about clinical research studies.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		√ 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.**
Home-delivered meals	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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.
Supportive devices for the feet		√ Orthopedic or therapeutic footwear 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.
Industrial frames	√	
Lenses and sunglasses without refractive value		√ This exclusion does not apply to any of the following items: • A clear balance lens if only one eye needs correction. • Tinted lenses when medically necessary to treat macular degeneration or retinitis pigmentosa.
Replacement of lost, broken, or damaged lenses or frames	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling	√	
Eyewear items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits	√	
Radial keratotomy, LASIK surgery, and other low vision aids	√	
Services to reverse voluntary, surgically induced infertility and non-prescription contraceptive supplies.	√	
Acupuncture		√ **Covered for chronic low back pain** 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 not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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-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.
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.	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Massage therapy		√ 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 necessary or 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 covered by Medicare	Not covered under any condition	Covered only under specific conditions
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 the U.S., but are not approved by the FDA		√ This exclusion applies to services provided anywhere, even outside the U.S. It doesn't apply to Medicare-covered clinical trials or covered emergency care you receive outside the U.S.
Travel and lodging expenses		√ We may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines
Psychological testing for ability, aptitude, intelligence, or interest	√	
Care in an intermediate or residential care facility, assisted living facility, or adult foster home	√	
Conception by artificial means, such as in vitro fertilization, zygote intrafallopian transfers, ovum transplants, and gamete intrafallopian transfers (except artificial insemination and related services covered by Medicare)	√	

CHAPTER 5. Using our plan's coverage for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you**. We sent you a separate document, called the **"Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs"** (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this rider, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are printed on the back cover of this booklet

SECTION 1. Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The Medical Benefits Chart found at the front of this **EOC** and the next chapter tell you what you pay for Part D drugs (Chapter 6, "What you pay for your Part D prescription drugs").

In addition to your coverage for Part D drugs, we also cover some drugs under our plan's medical benefits. Through our coverage of Medicare Part A benefits, we generally cover drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through our coverage of Medicare Part B benefits, we cover drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. The Medical Benefits Chart found at the front of this **EOC** tells you about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. We only cover Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions, and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.4 in this chapter, "What if you're in Medicare-certified hospice." For information on hospice coverage, see the hospice section of the Medical Benefits Chart at the front of this **EOC.**

If your group has purchased enhanced Part D prescription drug coverage, we cover some drugs that are not covered by Medicare Part B and Part D in accord with our formulary for non-Part D drugs.The Medical Benefits Chart at the front of this **EOC** tells you about your benefits and costs for these drugs.

The following sections discuss coverage of your drugs under our plan's Part D benefit rules. Section 9 in this chapter, "Part D drug coverage in special situations," includes more information about your Part D coverage and Original Medicare.

Section 1.2 Basic rules for our plan's Part D drug coverage

Our plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, "Fill your prescriptions at a network pharmacy or through our mail-order service.")
- Your drug must be on our **2022 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.

Our network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. Your cost-sharing may be less at pharmacies with preferred cost-sharing.

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. However, your costs may be even less for your covered drugs if you use a network pharmacy that offers preferred cost-sharing rather than a network pharmacy that offers standard cost-sharing. The **Pharmacy Directory** will tell you which of the network pharmacies offer preferred cost-sharing. You can find out more about how your out-of-pocket costs could be different for different drugs by contacting us. If you switch from one 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. Or if the pharmacy you have been using stays within the network but is no longer offering preferred cost-sharing, you may switch to a different pharmacy. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the **Pharmacy Directory**. You can also find information on our website at **kp.org/directory**.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. I/T/U pharmacies must be within our service area.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use.**Note: This scenario should happen rarely.**

To locate a specialized pharmacy, look in your Pharmacy Directory or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using our mail-order services

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, the drugs provided through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our mail-order service are marked as "mail-order" drugs on our Drug List.

Our mail-order service allows you to order up to 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 pharmacy 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 USPS delivery). 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 5 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 preferred network retail pharmacy listed in your **Pharmacy Directory** or at **kp.org/directory**. Please be aware that you may pay more if you get a 90-day supply from a network retail pharmacy instead of from our preferred mail-order pharmacy.

Refills on mail-order prescriptions. For refills, please contact your pharmacy at least 5 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 allows you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in our network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are traveling within the United States and its territories but outside the service area and you become ill or run out of your covered Part D prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines.
- If you need a Medicare Part D prescription drug in conjunction with covered out-of-network emergency care or out-of-area urgent care, we will cover up to a 30-day supply from an out-of-network pharmacy. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered emergency or urgent care are covered up to a 30-day supply in a 30-day period. These drugs are not covered under Medicare Part D; therefore, payments for these drugs do not count toward reaching the catastrophic coverage stage.
- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a network pharmacy during normal business hours.
- If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible network pharmacy or available through our mail-order pharmacy (including high-cost drugs).
- If you are not able to get your prescriptions from a network pharmacy during a disaster.

In these situations, please check first with Member Services to see if there is a network pharmacy nearby. Phone numbers for Member Services are printed on the back cover of this booklet. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from our plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1, explains how to ask us to pay you back.)

SECTION 3. Your drugs need to be on our "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

Our plan has a **2022 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 references, such as the American Hospital Formulary Service Drug Information; the DRUGDEX Information System. Our Drug List includes both brand name and generic drugs.

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. (this tier includes some brand-name drugs).
- Cost-sharing **Tier 2** for generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 3** for preferred brand-name drugs.

- Cost-sharing **Tier 4** for nonpreferred brand-name drugs (this tier includes some generic drugs).
- Cost-sharing **Tier 5** for specialty-tier drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 6** for injectable Part D vaccines (this tier includes only brand-name drugs).

To find out which cost-sharing tier your drug is in, look it up on our Drug List. The amount you pay for drugs in each cost-sharing tier is shown in the Medical Benefits Chart found at the front of this **EOC**.

Section 3.3 How can you find out if a specific drug is on our Drug List?

You have three ways to find out:

1. Check the most recent Drug List we provided electronically at **kp.org**.
2. Visit our website (**kp.org/seniorrx**). Our Drug List (**2022 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 (**2022 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 (**2022 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. 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 neither the generic drug nor other covered drugs that treat the same condition 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/seniorrx**).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2, for information about asking for exceptions.)

SECTION 5. What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by our plan have extra rules to restrict their use. In some cases, you may want us to waive the restriction for you.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be. Our plan puts each covered drug into one of six different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend upon what type of problem you have:

- If your drug is not on our Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on our Drug List or if the drug is restricted in some way?

If your drug is not on our Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask us to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, we can offer a temporary supply of a drug to you when your drug is not on our Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. **The change to your drug coverage must be one of the following types of changes:**
   - The drug you have been taking is no longer on our plan's Drug List.
   - Or the drug you have been taking is now restricted in some way (Section 4 in this chapter tells you about restrictions).
2. **You must be in one of the situations described below:**
   - **For those members who are new or who were in our plan last year:** We will cover a temporary supply of your drug during the first 90 days of your membership in our plan if you are new and during the first 90 days of the calendar year if you were in our plan last year. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
   - **For those members who have been in our plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:** We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.
   - **For current members with level of care changes**: If you enter into or are discharged from a hospital, skilled nursing facility, or long-term care facility to a different care setting or home, this is what is known as a level of care change. When your level of care changes, you may require an additional fill of your medication. We will generally cover up to a one-month supply of your Part D drugs during this level of care transition period even if the drug is not on our Drug List.

To ask for a temporary supply, call Member Services (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by our plan or ask us to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by our plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. Phone numbers for Member Services are printed on the back cover of this booklet.

You can ask for an exception

You and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask us to cover a drug even though it is not on our plan's Drug List. Or you can ask us to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. Phone numbers for Member Services are printed on the back cover of this booklet.

You can ask for an exception

You and your provider can ask us to make an exception to the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our specialty tier (Tier 5) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6. What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, we might make changes to the Drug List. For example, we might:

- Add or remove drugs from the Drug List. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.

- Move a drug to a higher or lower cost-sharing tier.
- Add or remove a restriction on coverage for a drug (for more information about restrictions to coverage, see Section 4 in this chapter).
- Replace a brand-name drug with a generic drug.

We must follow Medicare requirements before we change our Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- A new generic drug replaces a brand-name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand-name drug).
  - We may immediately remove a brand-name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand-name drug.
  - You or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."
  - If you are taking the brand-name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand-name drug. You may not get this notice before we make the change.
- Unsafe drugs and other drugs on the Drug List that are withdrawn from the market.
  - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.

- Your prescriber will also know about this change, and can work with you to find another drug for your condition.

- Other changes to drugs on the Drug List.
  - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand-name drug or change the cost-sharing tier or add new restrictions to the brand-name drug. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy
  - After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover.
  - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."

- Changes to drugs on the Drug List that will not affect people currently taking the drug: For changes to the Drug List that are not described above, if you are currently taking the drug, the following types of changes will not affect you until January 1 of the next year if you stay in our plan:
  - If we move your drug into a higher cost-sharing tier.
  - If we put a new restriction on your use of the drug.
  - If we remove your drug from the Drug List.

If any of these changes happen to a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand-name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the new year's Drug List for any changes to drugs.

SECTION 7. What types of drugs are not covered by our plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section the only exception is if the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5, in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Generally, coverage for “off-label use” is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System. If the use is not supported by any of these reference books, then our plan cannot cover its “off label use.”

Also, by law, these categories of drugs are not covered by Medicare drug plans.

- Nonprescription drugs (also called over-the-counter drugs).
- Drugs when used to promote fertility.
- Drugs when used for the relief of cough or cold symptoms.
- Drugs when used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs when used for the treatment of sexual or erectile dysfunction.
- Drugs when used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

If you receive "Extra Help" paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8. Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill our plan for our share of your covered prescription drug cost. You will need to pay the pharmacy your share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call our plan to get the necessary information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask us to reimburse you for our share. See Chapter 7, Section 2.1, for information about how to ask us for reimbursement.

SECTION 9. Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by our plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, we will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell you about the rules for getting drug coverage. The Medical Benefits Chart found at the front of this **EOC** gives you more information about drug coverage and what you pay.

Please note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage. (Chapter 10, "Ending your membership in our plan," tells you when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your **Pharmacy Directory** to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of our plan?

If you need a drug that is not on our Drug List or is restricted in some way, we will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of up to a 31-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"

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact that group's benefits administrator. He or she can help you determine how your current prescription drug coverage will work with our plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group coverage. That means your group coverage would pay first.

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.
- Unsafe amounts of opioid pain medications.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that can help make sure our members safely use their prescription opioid medications, and other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one pharmacy.
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one doctor.
- Limiting the amount of opioid or benzodiazepine medications we will cover for you.

If we think that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug misuse or with the limitation, you and your prescriber have the right to ask us for an appeal. If you choose to appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, you are receiving hospice, palliative, or end-of-life care, or you live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take.

Our program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely 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. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

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 **2022 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/seniorrx**. 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 **Yearly Deductible Stage**	Stage 2 **Initial Coverage Stage**	Stage 3 **Coverage Gap Stage**	Stage 4 **Catastrophic Coverage 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.)	**If your plan has a deductible, you begin in this stage after you end the Deductible Stage.** **If your plan does not have a deductible, you begin in this stage when you fill your first prescription of the year.** During this stage, we pay our share of the cost of your drugs and you pay your share of the cost. If your plan has a Coverage Gap Stage, you stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total **$4,430.** 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 **$7,050.** (Details are in Section 5 of this chapter.)	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 the Medical Benefits Chart at the front of this EOC, **or 25% of the price**, whichever is lower. For **brand-name drugs, you pay 25% of the price** (plus a portion of the dispensing fee). You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of **$7,050.** This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	During this stage, **we will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2022). (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. **The Part D EOB** provides more information about the drugs you take, such as increases in price and other drugs with lower cost-sharing that may be available. You should consult with your prescriber about these lower-cost options. **The Part D** EOB . 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.
- **Drug price information**. This information will display the total drug price, and any percentage change from the first fill for each prescription claim of the same quantity.
- **Available lower-cost alternative prescriptions**. This will include information about other drugs with lower cost-sharing for each prescription claim that may be available.

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 (this tier includes some brand-name drugs).
- Cost-sharing **Tier 2** for generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 3** for preferred brand-name drugs.
- Cost-sharing **Tier 4** for nonpreferred brand-name drugs (this tier includes some generic drugs).
- Cost-sharing **Tier 5** for specialty-tier drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 6** for injectable Part D vaccines (this tier includes only brand-name drugs).

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 network retail pharmacy that offers a standard cost-sharing.
- A network retail pharmacy that offers preferred cost-sharing.
- 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**.

Generally, we will cover your prescriptions only if they are filled at one of our network pharmacies. Some of our network pharmacies also offer preferred cost-sharing. You may go to either network pharmacies that offer preferred cost-sharing or other network pharmacies that offer standard cost-sharing to receive your covered prescription drugs. Your costs may be less at pharmacies that offer preferred cost-sharing.

Section 5.2 Your cost 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 **$7,050.** When you reach an out-of-pocket limit of **$7,050** 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 **$4,430 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 2022 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 **$4,430** limit in a year.

We will let you know if you reach this **$4,430** 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 $7,050

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).

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs. You pay either the copayments listed in the Medical Benefits Chart found at the front of this EOC or 25% of the negotiated price and a portion of the dispensing fee for **brand-name drugs**. If you pay 25% of the negotiated price, 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.

You also receive some 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 25% of the costs of generic drugs, whichever is lower. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the applicable cost sharing until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2022 that amount is **$7,050.**

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 **$7,050,** 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 **$7,050** 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 **$7,050** 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 **$7,050** 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.

Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is larger amount:

- Either, you pay a coinsurance of **5%** of the cost of the drug,
- Or, **$3.95** for a generic drug or a drug that is treated like a generic, and **$9.85** for all other drugs.

We will pay the rest of the cost.

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 2022 **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.

- Situation1: 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).
- Situation3: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.

I**MPORTANT NOTE:** There is no charge for covered Part D vaccines and their administration. However, there may be an office visit charge, if administered during a provider office visit.

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 **2022 Comprehensive Formulary**; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has information about how to make an appeal.

SECTION 2. How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment. You don't have to use the form, but it will help us process the information faster. You can file a claim to request payment by:

- Completing and submitting our electronic form at **kp.org** and upload supporting documentation.
- Either download a copy of the form from our website **(kp.org)** or call Member Services and ask them to send you the form. Phone numbers for Member Services are printed on the back cover of this booklet. Mail the completed form to our Claims Department address listed below.
- If you are unable to get the form, you can file your request by sending us the following information to our Claims Department address listed below:

♦ A statement with the following information:

o Your name (member/patient name) and medical/health record number.

o The date you received the services.

o Where you received the services.

o Who provided the services.

- o Why you think we should pay for the services.
- o Your signature and date signed. (If you want someone other than yourself to make the request, we will also need a completed "Appointment of representative" form, which is available at kp.org.)
- ♦ A copy of the bill, your medical record(s) for the services, and your receipt if you paid for the services

Mail your request for payment together with any bills or paid 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 12 months (for Part C medical claims) and within 36 months (for Part D claims) 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 cost

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, or 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).

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 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 1.3 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 1.4 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, 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).
- I**nformation 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 1.5 We must treat you with dignity and respect and 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 1.6 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 1.7 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 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- **You can call Member Services** (phone numbers are printed on the back cover of this booklet).
- **You can call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- **You can contact Medicare:**
  - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at **https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.**)
  - Or you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 1.9 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 1.10 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:
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). The Medical Benefits Chart found at the front of this **EOC** tells you what you must pay for your medical services. The Medical Benefits Chart found at the front of this **EOC** tells you what you must pay for your Part D prescription drugs.
  - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
- **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)

Background

Coverage decisions and appeals

Background

SECTION 1. Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the process for coverage decisions and appeals.
- For other types of problems, you need to use the process for making complaints.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by you and us.

Which one do you use?

That depends upon the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" or "coverage determination," or “at-risk determination,” and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful, and sometimes quite important, for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2. You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations, you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3, of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- You can visit the Medicare website (**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. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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 Review Organization that is not connected to us. (In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal. 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).
- You c**an get free help** from your **State Health Insurance Assistance Program** (see Section 2 in this chapter).
- **Your doctor can make a request for you.**
  - For medical care or Medicare Part B prescription drugs, 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 **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. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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:

- **Section 7** of 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** of this chapter: "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:
To find out whether we will cover the medical care you want.	You can ask us to make a coverage decision for you. Go to the next section in this chapter, **Section 5.2**.
If 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.
If you want to ask us to pay you back for medical care 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 for a medical item or service. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** after we receive your request.

- However, for a request for a medical item or service, 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- 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** if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**
  - However, for a request for a medical item or service, 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - 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 ask for 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 on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - 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), or **24 hours** if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells you how to make an appeal.
- I**f 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 on a request for a medical item or service, we will give you our answer **within 14 calendar days** of receiving your request. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.

- For a request for a medical item or service, 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- 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) or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells you how to make an 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.

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 make 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 **www.cmsgov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org.** While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1, "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."
- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. 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 that 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 gettinga "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 your request is for a medical item or service. 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 Review Organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is *yes* to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is *no* to part or all of what you requested,** we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not received, we will give you our answer **within 7 calendar days** after we receive your appeal. 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 your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- 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 applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service),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 authorize or provide the coverage we have agreed to provide **within 30 calendar days** if your request is for a medical item or service, or **within** 7 **calendar days** if your request is for a Medicare Part B prescription drug.
- If our answer is *no* to part or all of what you requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity.**" It is sometimes called the "**IRE**."

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a "fast appeal" at Level 1, you will also have a "fast appeal" at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal**.**
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service, the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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 a request for a medical item or service, 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 the review organization says **yes** to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute **within 72 hours** after we receive the decision from the review organization for standard requests or **within 24 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 get after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge or attorney adjudicator. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells you how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 in this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service; see the Medical Benefits Chart found at the front of this **EOC.** We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: "Using our plan's coverage for your medical services").

We will say *yes* or *no* to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying ***yes*** to your request for a coverage decision.
- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. When we turn down your request for payment, it's the same as saying ***no*** to your request for a coverage decision.

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, you can make an appeal. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, **please note:**

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is ***yes*** at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6. Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

? Have you read Section 4 in this chapter ("A guide to the basics of coverage decisions and appeals")? If not, you may want to read it before you start this section.

Section 6.1 This section tells what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our **2022 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 **2022 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 **2022 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 **2022 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, the pharmacy will give you 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?

If you are in this situation:	This is what you can do:
If 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.	You can ask us to make an exception. (This is a type of coverage decision.) **Start with Section 6.2 in this chapter.**
If 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.	You can ask us for a coverage decision. **Skip ahead to Section 6.4 in this chapter.**
If you want to ask us to pay you back for a drug you have already received and paid for.	You can ask us to pay you back. (This is a type of coverage decision.) **Skip ahead to Section 6.4 in this chapter.**
If 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 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 2022 Comprehensive Formulary.** (We call it the "Drug List" for short.)

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a "**formulary exception**."

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 (nonpreferred brand-name drugs) or Tier 2 for generic 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 **2022 Comprehensive Formulary** (for more information, go to Chapter 5 and look for Section 4).

Legal Terms
Asking for removal of a restriction on coverage for a drug is sometimes called asking for a "**formulary exception**."

- The extra rules and restrictions on coverage for certain drugs include:
- Being required to use the generic version of a drug instead of the brand-name drug.
- Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")

- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms
Asking to pay a lower price for a covered nonpreferred drug is sometimes called asking for a **"tiering exception."**

- If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.

- If the drug you're taking is a brand-name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand-name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.

- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (specialty-tier drugs).
- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "**alternative**" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception. If you ask us for a tiering exception, we will generally not approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

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 of this chapter 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 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 of this chapter 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 ask for 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 Review 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 you can 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 Review 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 you can 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 Review 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 you can 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 **a**nswer 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 you can appeal our decision.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days after we receive your appeal for a drug you have not received yet**. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast appeal."
  - If we do not give you a decision **within 7 calendar days**, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we 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:**
  - 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 you can appeal our decision.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer within 14 calendar days after we receive your request.

- If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- If our answer is yes to part or all of what you requested, we are also required to make payment to you within 30 calendar days after we receive your request.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can 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 it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.
- If the Independent Review Organization says yes to part or all of what you requested:
  - If the Independent Review Organization approves a request for coverage, we must provide the drug coverage that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you **within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision," you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details about how to do this are in the written notice you got after your second appeal.

The Level 3 Appeal is handled by an administrative law judge or attorney adjudicator. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 7. How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see the Medical Benefits Chart found at the front of this **EOC.**

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called **An Important Message from Medicare about Your Rights**. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- **Read this notice carefully** and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:
  - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
  - Your right to be involved in any decisions about your hospital stay, and your right to 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 will be asked to sign the written notice** to show that you received it and understand your rights.
  - You or someone who is acting on your behalf will be asked to 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 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 the notice 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 midnight the day of 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, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4 of this chapter.

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. the Medical Benefits Chart found at the front of this **EOC.)**

What happens if the answer is no?

- If the review organization says **no** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your **inpatient hospital services will end** at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says ***no*** to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost of hospital care** you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeals process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

You must ask for this review within 60 calendar days after the day the Quality Improvement Organization said **no** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- We must reimburse you for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called "upholding the decision."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an administrative law judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date, whichever comes first.) 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").

- I**f 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

During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1: We will automatically forward your case to the Independent Review Organization.

We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying **no** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 10 in this chapter tells you how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes*** to your appeal, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date, was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an administrative law judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say **no** to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 8. How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 This section is about three 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**."

- You will be asked to sign the written notice to show that you received it.
  - You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 tells you how you can give written permission to someone else to act as your representative.)

- Signing the notice shows **only** that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with us that it's time to stop getting the care.

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 in this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

If you ask for a Level 1 Appeal on time, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: Contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5 of 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 w**e must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see the Medical Benefits Chart found at the front of this **EOC**).

What happens if the reviewers say no to your appeal?

- If the reviewers say **no** to your appeal, then **your coverage will end** on the date we have told you. We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, **then you will have to pay the full cost of this care yourself**.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say ***no*** to your Level 1 Appeal, and you choose to continue getting care after your coverage for the care has ended, then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

Here are the steps for Level 2 of the appeals process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

You must ask for this review within 60 days after the day when the Quality Improvement Organization said ***no*** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue** providing coverage for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an administrative law judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

Step 1: Contact us and ask for a "fast review."

For details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are making an appeal about your medical care or Part D prescription drugs."

Be sure to ask for a "fast review." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending our plan's coverage for services you were receiving.

We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, **then you will have to pay the full cost of this care yourself**.

Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.

- To make sure we were following all the rules when we said ***no*** to your fast appeal, **we are required to send your appeal to the Independent Review Organization**. When we do this, it means that you are automatically going on to Level 2 of the appeals process.

Step-by-step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said ***no*** to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE.**"

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization **within 24 hours** of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 10 in this chapter tells you how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- The **Independent Review Organization** is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes** to your appeal, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say ***no*** to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 9. Taking your appeal to Level 3 and beyond

Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge (called an administrative law judge) or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the administrative law judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over.** We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service **within 60 calendar days** after receiving the administrative law judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the administrative law judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge or attorney adjudicator says **no** to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over.** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service **within 60 calendar days** after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge (called an administrative law judge) or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the administrative law judge or attorney adjudicator **within 72 hours** (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge or attorney adjudicator says ***no*** to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Council **within 72 hours** (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.

- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process.

Making complaints

SECTION 10. How to make a complaint about quality of care, waiting times, customer service, or other concerns

? If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 in this chapter.

Section 10.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is **only** used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint":

- **Quality of your medical care**
  - Are you unhappy with the quality of care you have received (including care in the hospital)?
- **Respecting your privacy**
  - Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- **Disrespect, poor customer service, or other negative behaviors**
  - Has someone been rude or disrespectful to you?
  - Are you unhappy with how our Member Services has treated you?

- Do you feel you are being encouraged to leave our plan?

- **Waiting times**
  - Are you having trouble getting an appointment, or waiting too long to get it?
  - Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Member Services or other staff at our plan?
  - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
- **Cleanliness**
  - Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
- **Information you get from our plan**
  - Do you believe we have not given you a notice that we are required to give?
  - Do you think written information we have given you is hard to understand?

Timeliness (these types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)

The process of asking for a coverage decision and making appeals is explained in Sections 4 through 9 of this chapter. If you are asking for a coverage 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. Please call us at **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 within 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** 2022 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 (**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 Medicare 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**.
- Sending written notice to the following address:

  Kaiser Foundation Health Plan, Inc.
  California Service Center
  P.O. Box 232407
  San Diego, CA92193-2400

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

Our plan must obey laws that protect you from discrimination or unfair treatment. 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 within the service area. 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.

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 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 Medicare Advantage, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4. Administration of this Evidence of Coverage

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this **Evidence of Coverage**.

SECTION 5. Amendment of this Agreement

Your group's Agreement with us will change periodically. If these changes affect this **Evidence of Coverage**, your group is required to inform you in accord with applicable law and your group's Agreement.

SECTION 6. Applications and statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this **Evidence of Coverage.**

SECTION 7. Assignment

You may not assign this **Evidence of Coverage** or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

SECTION 8. Attorney and advocate fees and expense

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 except as otherwise required by law.

SECTION 9. Coordination of benefits

As described in Chapter 1 (Section 10) "How other insurance works with our plan," if you

have other insurance, you are required to use your other coverage in combination with your coverage as a Senior Advantage member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For more information about primary payments in third party liability situations, see Section 18, and for primary payments in workers' compensation cases, see Section 20.

You must tell us if you have other health care coverage, and let us know whenever there are

any changes in your additional coverage.

SECTION 10. Employer responsibility

For any services that the law requires an employer to provide, we will not pay the employer, and when we cover any such services, we may recover the value of the services from the employer.

SECTION 11. Evidence of Coverage binding on members

By electing coverage or accepting benefits under this **Evidence of Coverage**, all members legally capable of contracting, and the legal representatives of all members incapable of contracting, agree to all provisions of this **Evidence of Coverage.**

SECTION 12. Government agency responsibility

For any services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such services we may recover the value of the services from the government agency.

SECTION 13. Member nonliability

Our contracts with network providers provide that you are not liable for any amounts we owe. However, you are liable for the cost of noncovered services you obtain from network providers or out-of-network providers.

SECTION.14. No waiver

Our failure to enforce any provision of this Evidence of Coverage will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

SECTION 15. Notices

Our notices to you will be sent to the most recent address we have. You are responsible for notifying us of any change in your address. If you move, please call Member Services (phone numbers are printed on the back of this booklet) and Social Security at **1-800-772-1213 (TTY 1-800-325-0778)** as soon as possible to report your address change.

Note: When we tell your group about changes to this **Evidence of Coverage** or provide your group other information that affects you, your group is required to notify the subscriber within 30 calendar days (or five days if we terminate your group's Agreement) after receiving the information from us.

SECTION 16. Overpayment recovery

We may recover any overpayment we make for services from anyone who receives such an overpayment or from any person or organization obligated to pay for the services

SECTION 17. Surrogacy

In situations where a member receives monetary compensation to act as a surrogate, our plan will seek reimbursement of all Plan Charges for covered services the member receives that are associated with conception, pregnancy and/or delivery of the child. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

SECTION 18. Third party liability

As stated in Chapter 1, Section 10, third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must ensure we receive reimbursement for those services.

Note: This Section 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 damages 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

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 maximum out-of-pocket amount.

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 **$7,050** 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 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.

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. For items ordered in advance, you pay the cost-sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the cost-sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription.

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 – A medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

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 decision 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).

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 modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. 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 costs, including amounts you have paid and what your plan has paid on your behalf, for the year have reached **$4,130.**

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 costs, including amounts you have paid and what your plan has paid on your behalf, for the year have reached $4,430.

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."

Evidence of Coverage sometimes refers to Health Plan as "we" or "us."

Kaiser Permanente – Health Plan and Medical Group.

Kaiser Permanente Region (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 2.4.

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 premiums, 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, a 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 Advantage health plan that is offered in their area.

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 – A department 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.

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 an 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 by 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 after you are eligible to join a Part D plan. 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 – Kaiser Permanente Senior Advantage.

Plan Charges – Plan Charges means the following:

- For services provided by the Medical Group or plan hospitals, the charges in Health Plan's schedule of Medical Group and plan hospitals charges for services provided to members.
- For services for which a provider (other than the Medical Group or plan 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 Cost-Sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

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.

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.

The Colorado Region's service area includes the area described in Chapter 1, Section 2.3 and network provider locations in Southern Colorado or Northern Colorado. For the purposes of premiums, cost-sharing, enrollment, and disenrollment, there are multiple Senior Advantage plans in our Region's service area. But, for the purposes of obtaining covered services, you get care from network providers anywhere inside our Region'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.

Standard Cost-Sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

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.

6.F

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-800-476-2167** (TTY **711**),8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 2500 South Havana, Aurora, CO 80014 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.**

KAISER PERMANENTE®

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Multi-language Interpreter Services

English

ATTENTION: If you speak a language other than English, language assistance services, free ofcharge, 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 tulongsa 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፡ ወደሚከተለው ቁጥር ይደውሉ **1-800-476-2167** (መስማት ለተሳናቸው: **711**).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachlicheHilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-476-2167** (TTY: **711**).

KAISER PERMANENTE®

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 **711**) (TTY: **1-800-476-2167** 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**) ।

CHIR0AA

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown in the "Schedule of Benefits (Who Pays What)" when provided by Plan Providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to Plan Providers.

   Note: The following are covered, but not under this section: Physical therapy, see "Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services"; X-ray and laboratory tests, see "X-ray, Laboratory, and Advanced Imaging 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. 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 (01-22)

CMPL0AA

ACUPUNCTURE SERVICES

1. Coverage
   Acupuncture Services are covered as shown in the "Schedule of Benefits (Who Pays What)" when provided by contracted acupuncturists and if clinically appropriate.

   Coverage includes treatment for:
   a. Neuromusculoskeletal pain due to an injury or illness; or
   b. Allergy, asthma, nausea, or vomiting.

   Services include:
   a. Acupuncture by manual stimulation.
   b. Electro-acupuncture applied to inserted needles and acupressure.

   Cupping or moxibustion are only covered in lieu of electrical stimulation.

   You may self-refer for visits to contracted acupuncturists.

2. Acupuncture Services Exclusions
   a. Rental or purchase of durable medical equipment (DME).
   b. Air purifiers, therapeutic mattresses, supplies or similar devices, appliances, or equipment. Their use or installation does not have to be for therapy or easy access.
   c. Radiology and lab tests.
   d. Prescription drugs, vitamins, herbs or food supplements. It does not matter if they are prescribed or recommended by a contracted acupuncturist.
   e. Massage or soft tissue techniques that are not part of the acupuncture treatment, except acupressure.
   f. Treatment mainly for obesity or weight control.
   g. Vocational, stroke or long term rehabilitation.
   h. Hypnotherapy.
   i. Behavior training.
   j. Sleep therapy or biofeedback.
   k. Acupuncture Services provided for maintenance or preventive care Services.
   l. Expenses for acupuncture Services provided during visits that exceed your visit limit.
   m. Expenses for any Services provided before coverage begins or after coverage ends for this benefit.
   n. Any Services provided by an acupuncturist who is not contracted. It does not matter if the Services are obtained in or out of Health Plan's Service Area.
   o. Acupuncture Services that Health Plan determines are not clinically appropriate in its utilization review. (Members may not be surcharged for such Services.)
   p. Services not authorized by Health Plan. This exclusion does not apply to Services listed in the "Coverage" section of this benefit.
   q. Any techniques or procedures not generally accepted in a majority of state acupuncture licensing boards.
   r. Benefits, items, or Services that are limited or excluded in the EOC, unless changed by this benefit.

This rider amends the EOC to provide limited coverage for acupuncture 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.

CMPL0AA (01-22)

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider 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, theft, 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 your 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 Provider, 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 or stolen 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. 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 Provider 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 Provider, 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.
      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 or stolen 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 accordance 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 Provider, unless you are 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 or stolen orthotic devices.
      vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

OPT0AB

OPTICAL BENEFIT

1. Coverage
   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 Facility 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 twelve (12) months of the initial exam. For Plan Providers located in a Kaiser Permanente Medical Office Building, go to **kp2020.org**.

   Covered Services include:
   a. The frame;
   b. Mounting of lenses in the frames; and
   c. The original fitting and subsequent adjustment of the frame.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional charge, when obtained at a Kaiser Permanente Medical Office Building.

2. Exclusions
   a. Replacement of lost or broken lenses or frames.
   b. Miscellaneous Services and supplies, such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
   c. Eyewear for protection, including but not limited to industrial eyewear, safety eyewear, athletic safety eyewear, or eyewear required as a condition of employment.

This rider amends the EOC to provide optical hardware coverage. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

OPT0AB (01-21)

RX0BL

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage

   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

   Prescribed supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.

   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

   For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Health Plan 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 not listed as generic in the 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 Provider and obtained at Plan Pharmacies; or
   b. Provider to whom a Member has been referred by a Plan Provider 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.
   b. Insulin.
   c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
   d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.

   Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. 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 Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations

   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.

b. We may apply Step Therapy to certain drugs. The exceptions are:
   i. substance use disorder drugs;
   ii. stage four advanced metastatic cancer drugs;
   iii. FDA-approved HIV infection prevention drugs.
   You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)".
   f. Drugs to shorten the length of the common cold.
   g. Drugs to enhance athletic performance.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Certain 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 (01-21)

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)

TABS0AA

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)

DMPA0AA

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for both same- and opposite-sex domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this EOC; and
(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

This rider amends the EOC to provide coverage for same- and opposite-sex domestic partners. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMPA0AA (01-18)

GREX0AA

KAISER PERMANENTE®

Grandchild Exclusion

Under your Group contract, a grandchild of you or your Spouse cannot be enrolled as your Dependent in this health benefit plan, unless you or your Spouse is the court-appointed legal guardian of the grandchild. This includes an adopted or foster grandchild.

GREX0AA_21 (01-21)

SRDC0AK

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)

KAISER PERMANENTE®

Kaiser Permanente Senior Advantage Member Services

METHOD	Member Services – contact information
CALL	**1-800-476-2167** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
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

A State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Please see Chapter 2, Section 3, for SHIP contact information.

6.F

KAISER PERMANENTE®

2500 S. Havana Street
Aurora, Colorado 80014

KAISER PERMANENTE®

April 14, 2022

County of Adams #385

Re: Newborn Premium Billing - Letter of Understanding

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 how newborns are billed, effective 1/1/2022 and in successive years, unless modified in writing.

Overview:
Newborn Adjustments based on the County's request: Subscriber tier change from single to 2-Tier or 2-Tier to Family coverage. CSC Denver Commercial Team will process monthly adjustments based on tier changes when a newborn is added based on newborn date of birth.

Newborn Rule:
Historically, Kaiser Permanente does not charge an additional premium for newborns in the month they are born. The County has requested the Health Plan modify their billing procedures for newborns to the following:

- If the child is born on Day 1 - 14, the County will charge subscriber full premium when an enrollment tier change occurs.
- If child is born on Day 15 - end of month, the County will not charge for enrollment tier change until the 1st day of the month following the birth of the newborn.
- Membership Liaison will pull monthly Newborn Report on the 1st and 15th every month and send to the County to identify newborn dates of birth.
- Membership Liaison will send monthly newborn report to the Health Plan Billing Representative by the 10th of the month, prior to invoice date of the 20th, for newborn premium adjustments, as needed.

Please indicate your agreement by signing and dating where indicated below and returning a signed copy to the Executive Account Manager.

Sincerely,
Kaiser Foundation Health Plan of Colorado

AGREED TO BY: County of Adams

By: Theresa Lautt Director of People & Total Rewards
Print Name of Authorized Group Representative and Title

Signature of Authorized Group Representative

Date: 9/13/22

APPROVED AS TO FORM
COUNTY ATTORNEY

KAISER PERMANENTE®

2022 Performance Guarantees Agreement
County of Adams

Guaranteed Performance
This Performance Guarantees Agreement is effective from January 1, 2022 through December 31, 2022. We offer performance guarantees for our fully-insured health plans backed by a percentage of your annual non-Medicare premium for Kaiser Permanente plans that have 500 or more of your non-Medicare members. Once one plan qualifies for an at-risk guarantee, other Kaiser Permanente plans with at least 100 but fewer than 500 of your non-Medicare members will report performance without financial risk. In 2023, we will conduct a review of your 2022 membership (average over 12 months) to determine the appropriate status of this agreement in each plan.

Changes in Measures
Some of our measures or targets may change year-to-year based on medical or public health trends, performance enhancements, new systems implementation and similar factors. In addition, some of the measures use definitions established by national organizations such as the National Committee for Quality Assurance (NCQA.) If the measure is no longer reported, the definition of a measure changes, or if there are changes to reporting rules or publications after these guarantees are in place we may no longer guarantee the measure.

Penalty Thresholds and Reporting Frequency
To the extent possible, we set our penalty thresholds (i.e., the performance level we guarantee and below which we pay a penalty) in alignment with industry standards. Penalty thresholds for HEDIS measures are based on the applicable state/regional or national HMO averages as reported in the NCQA Quality Compass. Typically, in the fall of each year (after the annual release of HEDIS results) we provide an annual performance report for the preceding year. Performance guarantees require annual renewal and must be requested each year by the Customer.

Proprietary and Confidential
The information contained in this agreement is proprietary and confidential. Customer agrees to not share any information contained in this document with any Kaiser Permanente competitor, nor with any other third-party unless granted specific written consent to do so by Kaiser Permanente's representative.

Penalty Payments and Force Majeure
We report performance results based on our annual (calendar year) performance. Penalty payments are determined after the end of the year and are based on the group's total non-Medicare premium for the calendar year. We pay agreed-upon penalties by check. The group is responsible for notifying their account management team of the correct payment address to which payment should be sent when processed.

Penalty payments on sample-based measures are contingent on statistically significant differences ('margins of error') from penalty thresholds. If the result on a measure is below the penalty threshold (target) we use a standard statistical test to determine whether the difference is too large to be explained by random chance. We do not pay penalties unless the result is determined to be a true difference at the 95% or better confidence level.

If we are unable to provide any of the information guaranteed in this agreement due to force majeure or federal, state or local legislative or regulatory action, the measures affected by such action will not be subject to penalties. Customer must be currently enrolled, and its account in good standing, at the end of the reporting period, December 31, 2022, in order to receive any penalty payments for missed performance measures due under this agreement. We require that Customer dispute any performance results and/or penalty due by submitting written notice to us within 60 days after the date the final report is delivered, or payment is made. Unless Customer notifies Kaiser of a dispute within such 60-day period, the report and penalty payment, if applicable, shall be considered final and not subject to dispute. Your written response must be received within 60 days of your receipt of our final report or you will forfeit any penalties otherwise due to you under this agreement.

Account Management Measures
Issues pertaining to satisfaction with account management are defined as matters that are under direct control of the Account Management Team (e.g. team availability, responses to customer questions, keeping customer informed of developments, etc.). Issues related to other health plan activities (e.g. pricing and rates, member call center services, claims, or eligibility processing) are not applicable to these measures and may be covered by other measures in this agreement.

Forfeiture on account management satisfaction measures is contingent on prompt notification (prior to September 1st of the agreement year) by the Customer of specific issues which may result in service failure, and adequate opportunity for resolution (agreement on corrective action plan and timeline). Failure of Kaiser Permanente account management to develop and execute on a corrective action plan constitutes failure on such measures.

To contact Kaiser Permanente
Thank you for giving us the opportunity to provide health care services to your employees and their families.
Please contact your Account Manager if you have questions or comments concerning this agreement.

KAISER PERMANENTE®

2022 Performance Guarantees Agreement

County of Adams

Based on projected 2022 membership, we expect the **Colorado** region will be guaranteed with premium at risk.

This Performance Guarantees Agreement is effective from January 1, 2022 through December 31, 2022.
Measures are based on annual, plan-wide performance unless specified otherwise. Penalty thresholds and results are rounded to the nearest whole number except on measures where the penalty threshold is shown with a decimal point (e.g. ≤3.0%)

2022 Performance Measures		Penalty Threshold	Penalty (% of Premium)
Member Services and Administration			
1.	Member service calls – percent answered within 30 seconds	80%	0.10%
2.	Telephone call abandonment rate	≤3.0%	0.10%
3.	First contact resolution (includes emails, same member / same issue call back within 30 days)	85%	0.10%
4.	Identification card distribution – percent within 10 business days of receipt (% of PG groups)	95%	0.10%
5.	Eligibility information available to medical groups within eight business days (% of PG groups)	95%	0.10%
6.	**County of Adams** – Premium/eligibility reconciliation with 30 calendar days (% of PG groups)	85%	0.10%
Claims			
7.	Claims financial accuracy	98.5%	0.10%
8.	Claims processing (financial incident) accuracy	97%	0.10%
9.	Claims processing within 30 calendar days (clean claims)	95%	0.10%
Member Satisfaction			
10.	Member satisfaction with health plan (CAHPS #42)[1]	≥ State Avg.[3]*	0.10%
11.	Member satisfaction with customer service composite (CAHPS #35 & #36)[2]	≥ State Avg.[3]*	0.08%
12.	Easy to get care, tests or treatment you thought your needed (CAHPS #25)[2]	≥ State Avg.[3]*	0.10%
Account Management			
12.	Customer overall satisfaction with account management/team	Satisfied	0.10%
Quality of Care			
14.	Statin Therapy for Patients with Diabetes Received Statin Therapy	≥ Natl. Avg.[4]*	0.08%
15.	Weight Assessment & Counseling Children/Adolescents – Nutrition	≥ Natl. Avg.[4]*	0.08%
16.	Appropriate Treatment for Children with Upper Respiratory Infection	≥ Natl. Avg.[4]*	0.08%
17.	Statin Therapy for Patients with Cardiovascular Disease (Total)	≥ Natl. Avg.[4]*	0.08%
18.	Colorectal Cancer Screening Rate	≥ Natl. Avg.[4]*	0.08%
19.	Mammography Screening Rate	≥ Natl. Avg.[4]*	0.08%
20.	Follow-up After Mental Illness (7 days)	≥ Natl. Avg.[4]*	0.08%
21.	Diabetes – Controlling High Blood Pressure (140/90)	≥ Natl. Avg.[4]*	0.08%
22.	Diabetes – Glycemic Poor Control Rate	≤ Natl. Avg.[4]*	0.08%
Total Percent at Risk			***2.00 %***

[1] From the NCQA CAHPS Survey, based on the percent of respondents answering eight or higher on a 0 - 10 scale
[2] From the NCQA CAHPS Survey, based on the percent of respondents answering 'usually' or 'always'
[3] Based on NCQA's State/Regional HMO Average
[4] Based on NCQA's National HMO Average
* Penalties are contingent on statistically significant differences from targets

Group Name: COUNTY OF ADAMS

Group Number: 385 Contract Period: 01/01/2022 - 12/31/2022

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
012	COUNTY OF ADAMS	Non Medicare	EMBC	$15 OVC HMO M NGF
014	COUNTY OF ADAMS - COBRA	Non Medicare	EMBC	$15 OVC HMO M NGF

Steps	Total
Employee Only	$648.76
Spouse Only	$648.76
Child Only	$648.76
Employee & Spouse	$1,362.40
Employee & Child	$1,362.40
Spouse & Child	$1,362.40
Children Only (CK)	$1,362.40
Employee, Spouse & Child/Children	$1,959.33
Employee & Children (ECK+)	$1,959.33
Spouse & Children (SCK+)	$1,959.33
Children Only (CKK+)	$1,959.33

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: COUNTY OF ADAMS

Group Number: 385 Contract Period: 01/01/2022 - 12/31/2022

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
012	COUNTY OF ADAMS	Medicare	EMBC	$15 OVC HMO M NGF
014	COUNTY OF ADAMS - COBRA	Medicare	EMBC	$15 OVC HMO M NGF

Plan /ENTL	Total
Medicare Risk AB	$191.65
Medicare Risk B	$619.08
Medicare Risk BD	$619.08
Medicare Risk CD	$191.65

Group Name: COUNTY OF ADAMS

Group Number: 385 Contract Period: 01/01/2022 - 12/31/2022

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
013	COUNTY OF ADAMS RETIREES	Non Medicare	EMBC	$15 OVC HMO M NGF
015	SR ADV RET ONLY	Non Medicare	EMBC	$15 OVC HMO M NGF

Steps	Total
Employee Only	$839.41
Spouse Only	$839.41
Child Only	$839.41
Employee & Spouse	$1,762.76
Employee & Child	$1,762.76
Spouse & Child	$1,762.76
Children Only (CK)	$1,762.76
Employee, Spouse & Child/Children	$2,534.93
Employee & Children (ECK+)	$2,534.93
Spouse & Children (SCK+)	$2,534.93
Children Only (CKK+)	$2,534.93

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: COUNTY OF ADAMS

Group Number: 385 Contract Period: 01/01/2022 - 12/31/2022

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
013	COUNTY OF ADAMS RETIREES	Medicare	EMBC	$15 OVC HMO M NGF
015	SR ADV RET ONLY	Medicare	EMBC	$15 OVC HMO M NGF

Plan /ENTL	Total
Medicare Risk AB	$191.65
Medicare Risk B	$619.08
Medicare Risk BD	$619.08
Medicare Risk CD	$191.65

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Summary of 2022 Benefit Changes

Large Group/Non-Medicare

Traditional HMO Plans

(Unless otherwise noted, changes are effective upon Renewal on or after January 1, 2022)

CLARIFICATIONS

Please be informed that any and all references to "**Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services**" will be referred to in your Evidence of Coverage (EOC) for Plan Year 2022 as "Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services".

Please be informed that any and all references to "**X-ray, Laboratory, and X-ray Special Procedures**" will be referred to in your Evidence of Coverage (EOC) for Plan Year 2022 as "X-ray, Laboratory, and Advanced Imaging Procedures".

Please be informed that any and all references to "**Prescribed Supplies**" will be referred to in your Evidence of Coverage (EOC) for Plan Year 2022 as "Diabetic Supplies".

BASE PLAN CHANGES

Video Visits – Video visits for Physical, Occupational and Speech Therapy will follow the same authorization rules and apply to the visit limits as in person visits. Video visits for ABA therapies will follow the same authorization rules as in person ABA therapy visits.

Drug Manufacturer Coupons – Members may be able to apply approved manufacturer coupons towards their cost share for certain covered drugs and/or items obtained at a pharmacy owned and operated by Health Plan. Members will owe any additional amount if the coupon does not cover the entire amount of cost sharing for the prescription or item.

Dental Services Pursuant to Transplant – Medically necessary dental services required for the direct treatment of a covered transplant procedure will be covered.

CHANGES DUE TO LEGISLATION

Colorado HB21-1307 Prescription Insulin Pricing and Access – Current law establishes a cost share cap for prescription insulin drugs not to exceed $100 per 30-day supply. This bill clarifies that the $100 cost share cap is for the covered person's entire 30-day insulin supply, regardless of the amount or type of insulin needed to fill the covered person's prescription or the number of prescriptions. This change is effective for health benefit plans issued or renewed on or after January 1, 2022.

Colorado HB 21-1140 Eliminate Donor Costs for Living Organ Donation – The law requires carriers to provide coverage for "health care services" related to living organ donation for a covered person who is a living organ donor. These "health care services" must not be subject to deductibles, copayments, coinsurance, benefit maximums, waiting periods, or other limitations on coverage for the living organ

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donation. The term "health care services" is defined in the law as a procedure to harvest an organ of a living organ donor and all services required before and after procedure. This change is effective for health benefit plans issued or renewed on or after January 1, 2022.

Colorado SB20-007 Substance Use Disorder Treatment – Carriers must provide coverage for the treatment of substance use disorders in accordance with the American Society of Addiction Medicine (ASAM) criteria for placement, medical necessity, and utilization management determinations. Health benefit plans must have coverage for at least one FDA-approved opiate antagonist for the treatment of a drug overdose. This change is effective for health benefit plans issued or renewed on or after January 1, 2022. Grandfathered health benefit plans are not impacted.

Out-of-Pocket Maximum (OPM) – The 2022 OPM limit is $8,700 for an individual and $17,400 for a family.

REMINDERS

In accord 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:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
- Prostheses (artificial replacements).
- Services for physical complications resulting from the mastectomy.

NOTE: To the extent this Summary of 2022 Benefit Changes conflicts with, modifies or supplements the information contained in your 2022 renewal packet, the information contained in your 2022 renewal packet shall supersede what is set forth above.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Adopting Amendments to Adams County's Contracts with UnitedHealthcare Services
FROM: Cindy Bero
AGENCY/DEPARTMENT: People & Culture Services
HEARD AT STUDY SESSION ON: September 21, 2021
RECOMMENDED ACTION: That the Board of County Commissioners approves the 2022 Financial Renewal and Terms Amendment to the Administrative Services Agreement, Amendment Nine to the Specific Excess Risk Insurance Policy and the 2022 Summary Plan Descriptions with UnitedHealthcare 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 the agreement (as specified in Exhibits A and B). The attached Amendment to the Specific Excess Loss Insurance Policy provides for changes as outlined in the Schedule of Benefits.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
People and Culture Services County Attorney's Office

ATTACHED DOCUMENTS:
2022 Financial Renewal and Terms Amendment
Stop Loss Amendment No. 9
2022 UHC Choice EPO Plan Summary Plan Description
2022 UHC Choice Plus HDHP/HSA Plan Summary Plan Description
2022 UHC Colorado Doctors Plan (CDP) Summary Plan Description

FISCAL IMPACT:
No

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION ADOPTING AMENDMENTS TO ADAMS COUNTY'S CONTRACTS WITH UNITEDHEALTHCARE SERVICES

WHEREAS, the Adams County Board of County Commissioners previously entered into a contract with UnitedHealthCare 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 UnitedHealthCare, 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 B; 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 UnitedHealthCare, Services Inc. and County of Adams shall remain in full force and effect through December 31, 2022; 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 UnitedHealthCare Choice EPO, Choice Plus HDHP/HSA and Colorado Doctors Plan (CDP) Summary Plan Descriptions outline the Benefits provided under the contract, and are in effect through December 31, 2022; and,

WHEREAS, the following attached documents constitute the Amendments to Adams County's contracts with UnitedHealthCare Services for the 2022 plan year:

1. Financial Renewal and Terms Amendment
2. Stop Loss Amendment No. 9
3. UHC Choice EPO Plan Summary Plan Description
4. UHC Choice Plus HDHP/HSA Plan Summary Plan Description
5. UHC Colorado Doctors Plan (CDP) Summary Plan Description

NOW, THEREFORE, BE IT RESOLVED, that the Board of County Commissioners, County of Adams, State of Colorado, hereby adopts the attached Amendments to Adams County's contracts with United Healthcare Services.

BE IT FURTHER RESOLVED, that the chair of the Board of County Commissioners is hereby authorized to execute said Amendments on behalf of Adams County.

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, 2022 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 _____ Authorized Signature	By Bambi Kenney Authorized Signature
Print Name _____	Print Name Bambi Kenney
Print Title _____	Print Title ACM
Date _____	Date 4/18/2022

APPROVED AS TO FORM
COUNTY ATTORNEY

.....

Renewal 4Q 2021v2

The Administrative Services Agreement is amended on Effective Date as noted below.

This Amendment will not affect any of the terms, provisions or conditions of the Agreement except as stated herein. Following the Effective Date and after Customer has provided one (1) months' worth of claims funding, this Amendment is deemed executed by the parties.

Effective January 1, 2020 Section 4.4 Health Care Medical Management Services is hereby deleted and replaced with the following:

Section 4.4. Personal Health Support

Health advocates and concierge services, includes the following:

- Central in-take point for all clinical and lifestyle Participant calls.
- Access to registered nurses for symptom triage and support with decisions about health care and treatment options as applicable to the Customer's elected products.
- Health education and resource navigation.
- Low to moderate health risk management.
- Premium provider / facility locating and appointment scheduling.

Personal nurses, provide targeted support.
Specialty nurses, provide clinical management for complex conditions.
Personal Health Support Website
Consumer activation and outreach campaigns, United may create consumer marketing campaigns to promote clinical, lifestyle management and advocacy services to the Customer's Participants.
Reporting, outlining program activity and impact.
Additional services include the following:
Disease Management

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Diabetes
- Congestive Heart Failure (HF)

Effective January 1, 2022, the definition of Proprietary Business Information in Section 1 – Definitions is replaced in its entirety with the following definition:

Confidential Information: Information disclosed or made available by a Party in connection with this Agreement, including without limitation the following, regardless of form or the manner in which it is furnished: (a) pricing, discounts, reimbursement terms, payment methodologies and payment processes, compensation arrangements and any similar commercial information and (b) data, information, statistics, trade secrets and any information about business, costs, operations, techniques, know-how or intellectual property. Any material that is derived from or developed from Confidential Information will be deemed Confidential Information for purposes of this Agreement, regardless of the person creating, disclosing or making available such material. Any Confidential Information included in preparations, proposals, scope documents, discussions, findings, summaries, reports and conclusions remain Confidential Information.

Confidential Information does not include: (a) information that is or becomes generally available to the public other than as a result of a disclosure by a receiving Party in violation of this Agreement or other agreement between the Customer and United, (b) information either obtained from a third party or already in a receiving Party's possession before receipt from the other Party, if the receiving Party can demonstrate such information was lawfully obtained and not subject to another obligation of confidentiality, and (c) information independently developed without reference to Confidential Information, if the receiving Party can demonstrate such independence through contemporaneous written records.

Effective January 1, 2022, Sections 9.4 Proprietary Business Information and 9.2 Access to Information are replaced entirely with the following:

Section 9.2 Use of Confidential Information. Neither Party may disclose the other's Confidential Information to any person or entity other than to the receiving Party's employees and Business Associates needing access to such information to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement.

Notwithstanding the foregoing, (i) United may disclose Customer Confidential Information to its affiliates and subcontractors as needed for those entities to provide services under this Agreement, (ii) Customer will not be prohibited from providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the Plan Sponsor, Participants, or individuals eligible to become Participants of the Plan, to the extent required by applicable law and regulation, (iii) Customer may only use United's Confidential Information for Plan administration purposes and (iv) before United's Confidential Information can be disclosed, United may require a mutually agreed upon confidentiality agreement consistent with applicable law and regulation.

Neither party may sell, license or grant any other rights to the other Party's Confidential Information.

If a Party is requested or required to disclose Confidential Information by subpoena, legal process or applicable law, including public records acts, such Party shall (to the extent permitted by law), provide the other Party with immediate written notice of that request or requirement. Such Party shall reasonably cooperate in any efforts by the other Party to seek an appropriate protective order or other remedy or otherwise challenge or narrow the scope of that disclosure request or requirement. If a protective order or other remedy is not obtained, such Party shall furnish only that portion of the Confidential Information that is legally required.

If Customer requests that United provide information about the Plan that is in United's possession after the Agreement terminates and any applicable run out period has expired, then United may, in its discretion, provide such information subject to a fee.

Effective January 1, 2022, all references to out of network programs in the Agreement, each as applicable, are replaced in their entirety. As such, Section 4.3 Managed Care Network Services is amended to include the following sub-section:

Out of Network Programs. United offers out of network programs that strive to increase savings to Customer by accessing discounts or negotiating reductions on out of network claims. United offers a mix of out of network programs that offer varying degrees of discounts, consumer advocacy, and cost controls. Customers elected out of network programs are identified in Exhibit A – Fees. Programs are subject to change or termination at United's discretion.

EXHIBIT A – FEES

The Medical Fees ("Fees") are as stated below. Customer acknowledges that Fees paid for administrative services are reasonable. If authorized by Customer pursuant to this Agreement or by subsequent authorization, certain Fees will be paid through a withdrawal from the Bank Account. 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.

Medical Fees

The following financial terms are effective for the period January 1, 2022 through December 31, 2024, unless otherwise specified.

The Medical Fees ("Fees"described below, excluding optional and non-standard fees, are adjusted as set forth in the applicable performance standard(s).

Effective January 1, 2022 through December 31, 2022

The Fees listed below are based upon an estimated minimum of 974 enrolled Employees.

Choice and Choice Plus HSA: $28.66 per Employee per month.

Doctor's Plan: $31.66 per Employee per month.

Average Contract Size: 2.16

Effective January 1, 2023 through December 31, 2023

Choice and Choice Plus HSA: $29.23 per Employee per month.

Doctor's Plan: $32.29 per Employee per month.

Effective January 1, 2024 through December 31, 2024

Choice and Choice Plus HSA: $29.82 per Employee per month.

Doctor's Plan: $32.94 per Employee per month.

Payment Integrity Services

Service Description	Fee
Advanced Analytics and Recovery • United's large-scale analytics to identify additional recovery opportunities. • Claims re-examined every month for up to 12 months. • Post-adjudicated claims.	24% of the gross recovery amount
Credit Balance Recovery • Review, validate, and recover credit balances (dollars) on existing patient accounts through a combination of analysis and technology. • On-site at hospitals and facilities. • Post-adjudicated claims.	10% of the gross recovery amount.
Focused Claim Review • Review of claims for inappropriate billing of services not documented in clinical notes.	22% of the gross recovery amount.

• Board certified, same-specialty medical directors. Pre-adjudicated claims or post-adjudicated claims.	
Fraud, Waste, and Abuse Management • Detection and recovery of wasteful, abusive, and/or fraudulent claims. • Search claims for patterns which indicate possible waste or error by identifying specific claims for additional review. • Pre-adjudicated claims or post-adjudicated claims.	22% of the gross recovery or prevented amount
Hospital Bill and Premium Audit Services • In-depth review of hospital medical records or other related documentation compared to claimed amounts to ensure billing accuracy. • Post-adjudicated claims.	22% of the gross recovery amount
Litigation and Arbitration Fees for Recoveries • Litigation, arbitration, or other judicial process to recover any Overpayments and other Plan recovery opportunities. • Outside attorneys' fees and costs or administrative process fees directly incurred with litigation, arbitration, or other judicial process. • Pre-adjudicated claims or post-adjudication claims.	Outside attorneys' fees and costs or administrative process fees will be deducted from the gross recovery prior to the assessment of any applicable United fees (as indicated in this Exhibit).
Third Party Liability - Subrogation and Injury Coverage Coordination • Services to prevent the payment of Plan benefits, or recover Plan benefits, which should be paid by a third party. • Does not include benefits paid in connection with coordination of benefits, Medicare, or other Overpayments. • Pre-adjudicated claims or post-adjudicated. claims. • Customer will not engage any entity except United to provide such services without prior United approval.	33.33% of the applicable savings amount.

Other Fees

Service Description	Fee
Consolidated Appropriations Act, 2021 ("CAA") Support Services. United will support Customer's compliance with the requirements of the CAA, including the No Surprises Act ("NSA"), by the respective enforcement date as follows: • NSA medical billing and the independent dispute resolution ("IDR"): o United will determine if a claim is subject to the NSA billing protections. o If United and a provider are unable to come to an agreement within the prescribed negotiation period for a claim subject to the NSA billing protections, United will manage, direct, and make decisions and submissions to support the IDR for Customer. o All qualifying payment amounts under the NSA will be calculated based on an insurance market across all self-insured group health plans administered by United. o United will not be using third party provider networks for services covered by the NSA. o The fees for programs in which the parties share in the savings achieved off a provider's billed charge	For the 2022 plan year, United will not charge separate services fees outside of base rates for the CAA Support Services. Customer remains responsible for the $50 government agency administration assessment and fees charged by the IDR arbitrator. Fees for CAA Support Services for plan years after 2022 will be provided at a future date once regulatory guidance is received and final compliance requirements are determined.

will continue to apply to all services covered under the NSA. o Customer shall fund all settlement amounts and payments required as a result of any IDR process decision through the Bank Account. o Customer shall fund the $50 IDR administration fee and all IDR arbitrator fees through the Bank Account. • Revised medical Plan ID cards (if United provides Plan Participants with ID cards currently). • Provider directory enhancements. • Continuity of care and external appeals support for surprise medical bills. • Support related to Mental Health Parity Non-Quantified Treatment Limitations audits initiated by the U.S. Department of Labor, U.S. Department of Health and Human Services or the U.S. Department of Treasury. • Provide language to support Customer's anti-gag clause attestation requirement.	
Naviguard Program • Offers a reimbursement methodology applicable to out of network claims which calculates allowed amounts based on what a healthcare provider generally accepts for the same or similar service. • Includes an advocacy component where Participants can access dedicated resources, and on-line tools and materials to help Participants stay in network and where assistance is provided in explaining reimbursement methodologies. • If the provider objects to what it was paid from the application of the allowed amount, or member contacts United for support with resolving a balance bill, United will increase compensation for a particular claim if: (a) United reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the allowed amount, and (b) United believes that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes over payment of claims).	25% of the Savings Obtained. Savings Obtained means the amount that would have been payable to a health care provider if no reductions were achieved, including amounts payable by both the Participant and the Plan, minus the amount that is payable to the health care provider after the application of the reimbursement calculation, including amounts payable by both the Participant and the Plan. The fee per individual claim will not exceed $15,000.
External Reviews	If and when applicable, for each subsequent external review beyond the limited number of free reviews based upon Customer's total enrollment, a fee of $500 will apply per review.
Interest Rate on Fees and Underfunding Bank Account	Prime +4%
Run-out Claims Administration 6 months of runout	Two months of Administration Fees.
Pharmacy Benefit Rebates - Termination	Pursuant to the termination section of this Agreement, if Customer terminates the Pharmacy Benefit Services portion of this Agreement only during the Term of the Agreement and termination is for any reason other than for cause, United may retain all Rebates that have not been remitted to Customer as of the effective date of such termination.

Disclosure: A United affiliate provides payment services to the healthcare industry and offers medical providers with various payment methods and options, including electronic payments, virtual cards and checks. Some options are available to medical providers for a fee and may result in the receipt of transaction fees or other compensation (e.g., 1% to 3% of the total transaction amount) by a United affiliate. This has no impact on the Fees paid by Customer under this Agreement.

EXHIBIT B – PERFORMANCE GUARANTEES FOR HEALTH BENEFITS

The Fees at risk do not include Customer-elected optional and non-standard programs Fees, all credits, Payment Integrity Programs Fees, Out-of-Network Programs Fees, Commission Funds, Consultant Funds, and ancillary product Fees.

The Fees payable by Customer under this Agreement will be adjusted through a credit to its 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, 2022 through December 31, 2022 (each twelve month period is a, "Guarantee Period"). With respect to the aspects of United's performance addressed in this exhibit, these fee adjustments are Customer's exclusive financial remedies.

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		$3,143
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		
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		$3,143

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%	
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	$3,143
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%	
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 United's 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	$3,143
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	$3,143
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 is each assigned a customer service quality score, using United's 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	$3,143
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	$1,571
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	$1,571
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	N/A
Gradients	Not applicable	

Effective January 1, 2022 through December 31, 2023 (each twelve month period is a, "Guarantee Period")

Pharmacy Financials				
Definition	Contracted pharmacy rates that will be delivered to You.			
Measurement and Criteria		**01/01/2022**	**01/01/2023**	
	Combined Discount Guarantee - Broad Network			
	Retail Brand, Average Wholesale Price (AWP) less	18.0%	18.0%	
	Retail Generic, AWP less	82.0%	82.0%	
	Mail Order Brand, AWP less	25.0%	25.0%	
	Mail Order Generic, AWP less	86.0%	86.0%	
	The Guaranteed Discount amount will be determined by multiplying the AWP by the guaranteed discount off AWP by each component and adding the amounts together.			
	Dispensing Fees - Broad Network			

	Retail Brand	$0.75	$0.70	
	Retail Generic	$0.75	$0.70	
	Dispensing fee totals are calculated by multiplying the actual scripts for each type by the contracted rate for that script type.			
	Minimum Rebate Guarantee (Advantage PDL)			
	Rebate Sharing Percentage	80.0%	80.0%	
	Basis, per script	Brand	Brand	
	Retail - 30 and 90 Day	$155.70	$165.39	
	Mail Order	$348.98	$350.19	
	Specialty	$1,213.68	$1,290.85	

Level	Customer Specific
Period	Annually
Payment Period	Annually
Payment Amount -- Discounts	The amount the actual discounts are less than the combined guaranteed Retail, Mail, and Specialty discount amount.
Payment Amount -- Dispensing Fees	The amount the combined actual dispensing fee exceeds the combined contracted dispensing fee.
Payment Amount -- Rebates	The amount the combined actual Rebate amount is less than the combined guaranteed Rebate amount.
Conditions	**Discount & Dispense Fee Specific Conditions** • Discounts are based on actual Network Pharmacy brand and generic usage of retail and mail order drugs. The guaranteed discount amount will be determined by multiplying the AWP by the contracted discount rate off AWP by component. • Does not apply to items covered under the Plan for which no AWP measure exists. • Discounts calculated based on AWP less the ingredient cost; discount percentages are the discounts divided by the AWP. Discounts for retail and mail order generic prescriptions represent the average AWP based on savings off Maximum Allowable Cost (MAC) pricing for MAC generics and percentage discount savings off AWP for non-MAC generics. All other discounts represent the percentage discount savings off of AWP. • The arrangement excludes generic medications launched as an 'at-risk' product, generic medication with pending litigation, compound drugs, retail out of network claims, mail order drugs (for dispensing fee arrangement) and Indian Health Service Claims. • The Arrangement excludes usual & customary claims, vaccines, long term care facility claims, over-the-counter claims. • The Arrangement includes veterans' affairs facility claims. • The Mail Order guarantee includes drugs dispensed for 46 days or greater. • When a drug is identified as a brand name drug, it will be considered a brand name drug for the calculation of discount guarantees. When a drug is identified as a generic drug, it will be considered a generic drug for the calculation of discount guarantees. • Specialty drugs dispensed outside United's specialty Pharmacy Network are included in the retail guarantees. Specialty drugs dispensed through United's specialty Pharmacy Network are excluded from the Retail and Mail guarantees. • Drugs in the following Specialty therapeutic categories are included in the retail guarantees: None. **Rebate Specific Conditions** • Assumes implementation of United's Advantage PDL • Client directed deviations from the PDL and PDL exclusions or uptiers, or clinical programs may result in changes to pricing and guarantees, which will be factored in at the time of rebate payment and/or reconciliation.

• Calculation of the guaranteed rebate amount will exclude ineligible claims including claims where the plan is not the primary payer, claims approved by formulary exception, claims not covered by Customer's benefit design or PDL, claims from 340B, long term care or federal government pharmacies, consumer card or discount card program claims and direct member reimbursement claims.

• Rebate guarantee payments or reconciliations may be adjusted in the event of a change impacting the level of rebates available due to the introduction of any new product (e.g. biosimilar, authorized brand alternative, lower cost non-Generic Drug alternative) or the reduction of WAC on a Brand Drug subject to Rebates.

United reserves the right to modify or eliminate this arrangement as follows based upon changes in Rebates:

• if changes made to United's PDL, for the purpose of achieving a lower net drug cost for Customer and United's other ASO customers, result in significant reductions to the Rebate level

• if the percentage of enrolled pharmacy members with coverage access to authorized brand alternatives exceeds 10%

• in the event that there are material deviations to the anticipated timing of drugs that will come off patent and no longer generate Rebates

• if there is a change impacting the availability or amount of Rebates offered by drug manufacturer(s), including changes related to the elimination or material modification of a drug manufacturer(s) historic models or practices related to the provision of Rebates

• if Customer changes or does not elect an incented plan design

• United will pay Rebates consistent with the Agreement. A reconciliation of the Rebate amounts will occur after the end of each annual contract period and when Rebate payments are substantially complete. The reconciliation calculates the minimum rebate amount by multiplying the actual number of scripts filled by the applicable rebate amount for that script type.

• Rebate Administrative Fee: United maintains systems and processes necessary for managing and administering Rebate programs. As consideration for these efforts, pharmaceutical manufacturers pay United administrative fees in addition to Rebates. Customer acknowledges that United retains Rebate Administration fees.

• If Customer terminates pharmacy benefit services with United prior to 12/31/2023, United will retain any and all pending or future Rebates payable under the Agreement as of the effective date of the termination of pharmacy benefit services.

• Drugs in the following Specialty therapeutic categories are included in the retail per-Brand guarantees: None.

• Vaccines are excluded from the claim counts.

General Conditions

• All pricing guarantees shall remain in effect for the entire contract period of 01/01/2022 through 12/31/2023 ("Pharmacy Pricing Term"). Each twelve month period is a Guarantee Period.

• Specialty drugs typically covered under the medical benefit (administered / handled by a provider, administered in a physician's office, ambulatory or home infusion), and/or transitioned to the pharmacy benefit, are excluded from all guarantees.

• On mail order drugs, specialty drugs, and retail pharmacy drugs and services including dispensing fees, United will retain the difference between what United reimburses the Network Pharmacy and Customer's payment for a prescription drug product or service.

• Pricing and guarantees assume enrollment of 974 Employees and 2,102 Participants; pricing and guarantees may be revised or withdrawn if actual enrollment varies by 10% or more from assumptions.

• The lessor of three logic (non-ZBL) will apply to Participant payments. Participants pay the lessor of the discounted price, the usual and customary charge or the cost share amount.

• All pricing guarantees require the selection of United as the exclusive mail provider.

United will have no financial guarantee obligation under the Agreement for any partial Guarantee Period if Customer terminates prior to the end of the Pharmacy Pricing Term.

	• United reserves the right to revise or revoke this arrangement if: a) changes in federal, state or other applicable law or regulation require modifications; b) there are material changes to the AWP as published by the pricing agency that establishes the AWP as used in these arrangements; c) Customer makes benefit changes that impact the arrangements; d) there is a material industry change in pricing methodologies resulting in a new source or benchmark; e) it is not accepted within ninety (90) days of the issuance of our initial quote; f) if Customer changes their mail service benefit; g) Customer utilizes a vendor, that facilitates steering members to different drugs or pharmacies to the extent these services impact the financial guarantees under this Agreement.

Specialty Pharmacy	
Specialty Pharmacy Discount Guarantee	
Definition	Specialty drug discount level based on actual specialty drug utilization for the specialty drugs dispensed through United's specialty Pharmacy Network. United reserves the right to change the designation of a drug from specialty to non-specialty based on market conditions.
Measurement	Discount targets for individual drugs dispensed through United's specialty Pharmacy Network. See chart below. Specialty drugs not included on the list below and dispensed through United's specialty Pharmacy Network will be guaranteed at a discount of 14.0%.
Criteria	Actual utilization, using Average Wholesale Price (AWP) in dollars, using our data, of specialty drugs through our specialty Pharmacy Network will be multiplied against the discount targets for the individual drugs to determine the overall discount target dollars. This total will be compared to actual discounts achieved for these drugs during the Guarantee Period. The overall discount target dollars may be adjusted based on utilization of unlisted drugs to which the separate 14.0% discount applies. This total will be compared to actual discounts achieved for these drugs during the Guarantee Period.
Level	Customer Specific
Period	Annual
Payment Period	Annual
Payment Amount	The amount the actual discounts are less than the combined guaranteed Retail, Mail, and Specialty discount amount.
Conditions	• Discounts calculated based on the AWP less the ingredient cost; discount percentages are the discounts divided by the AWP. Discounts for retail generic prescriptions represent the average savings off AWP based on Maximum Allowable Cost (MAC) pricing for MAC generics and percentage discount savings off AWP for non-MAC generics. All other discounts represent the percentage discount savings off of AWP. • Specialty drugs dispensed outside United's specialty Pharmacy Network, drugs for which no AWP measure exists and non-drug items are excluded. • Listed drugs which cease to be defined as specialty drugs during the Guarantee Period will be reconciled outside of the Specialty Pharmacy guarantee in the channel in which they are dispensed (retail or mail order). • Specialty drugs typically covered under the medical benefit (administered / handled by a provider, administered in a physician's office, ambulatory or home infusion), and/or transitioned to the pharmacy benefit, are excluded from all guarantees. • United reserves the right to revise or revoke this guarantee if: a) changes in federal, state or other applicable law or regulation require modifications; b) there are material changes to the AWP as published by the pricing agency that establishes the AWP as used in this guarantee; c) Customer makes benefit changes that impact the guarantee; d) there is a material industry change in pricing methodologies resulting in a new source or benchmark • On specialty drugs, United will retain the difference between what United reimburses the Network Pharmacy and Customer's payment for a prescription drug product or service.

Specialty Drug Category	Drug Name	Guarantee Pricing (AWP-%)	Specialty Drug Category	Drug Name	Guarantee Pricing (AWP-%)
ANEMIA	ARANESP	15.3%	INFLAMMATORY CONDITIONS	RINVOQ	14.9%
ANEMIA	EPOGEN	14.1%	INFLAMMATORY CONDITIONS	SILIQ	12.3%
ANEMIA	PROCRIT	14.4%	INFLAMMATORY CONDITIONS	SIMPONI	14.9%
ANEMIA	RETACRIT	14.9%	INFLAMMATORY CONDITIONS	SKYRIZI	18.9%
ANTICONVULSANT	DIACOMIT	13.3%	INFLAMMATORY CONDITIONS	STELARA	14.9%
ANTICONVULSANT	EPIDIOLEX	13.3%	INFLAMMATORY CONDITIONS	TALTZ	12.3%
ANTIHYPERLIPIDEMIC	JUXTAPID	14.1%	INFLAMMATORY CONDITIONS	TREMFYA	14.9%
ANTI-INFECTIVE	ARIKAYCE	13.8%	INFLAMMATORY CONDITIONS	XELJANZ	14.9%
ANTI-INFECTIVE	DARAPRIM	13.3%	INFLAMMATORY CONDITIONS	XELJANZ XR	14.9%
ANTI-INFECTIVE	PYRIMETHAMINE	13.3%	IRON OVERLOAD	DEFERASIROX	33.7%
ASTHMA	FASENRA	13.3%	IRON OVERLOAD	EXJADE	13.0%
ASTHMA	NUCALA	15.3%	IRON OVERLOAD	FERRIPROX	13.3%
CARDIOVASCULAR	NORTHERA	14.8%	IRON OVERLOAD	JADENU	14.3%
CARDIOVASCULAR	VYNDAMAX	16.1%	LIVER DISEASE	OCALIVA	15.9%
CARDIOVASCULAR	VYNDAQEL	13.3%	MONOCLONAL ANTIBODY MISCELLANEOUS	BENLYSTA	14.3%
CNS AGENTS	AUSTEDO	13.3%	MOOD DISORDER DRUGS	SPRAVATO	14.3%
CNS AGENTS	FIRDAPSE	11.3%	MULTIPLE SCLEROSIS	AMPYRA	12.6%
CNS AGENTS	HETLIOZ	14.8%	MULTIPLE SCLEROSIS	AUBAGIO	13.3%
CNS AGENTS	INGREZZA	13.8%	MULTIPLE SCLEROSIS	AVONEX	14.8%
CNS AGENTS	RILUTEK	14.3%	MULTIPLE SCLEROSIS	BETASERON	14.9%
CNS AGENTS	RILUZOLE	92.7%	MULTIPLE SCLEROSIS	COPAXONE	15.5%
CNS AGENTS	RUZURGI	12.3%	MULTIPLE SCLEROSIS	DALFAMPRIDIN	89.8%
CNS AGENTS	SABRIL	16.9%	MULTIPLE SCLEROSIS	DIMETHYL FUMARATE	33.7%
CNS AGENTS	TETRABENAZINE	41.9%	MULTIPLE SCLEROSIS	EXTAVIA	14.9%
CNS AGENTS	TIGLUTIK	6.9%	MULTIPLE SCLEROSIS	GILENYA	14.8%
CNS AGENTS	VIGABATRIN	18.4%	MULTIPLE SCLEROSIS	GLATIRAMER	70.0%
CNS AGENTS	VIGADRONE	17.4%	MULTIPLE SCLEROSIS	GLATOPA	69.4%
CNS AGENTS	XENAZINE	16.4%	MULTIPLE SCLEROSIS	MAVENCLAD	14.8%
CNS AGENTS	XYREM	7.2%	MULTIPLE SCLEROSIS	MAYZENT	13.3%
CYSTIC FIBROSIS	BETHKIS	12.3%	MULTIPLE SCLEROSIS	PLEGRIDY	14.3%
CYSTIC FIBROSIS	CAYSTON	15.3%	MULTIPLE SCLEROSIS	REBIF	14.8%
CYSTIC FIBROSIS	KALYDECO	14.3%	MULTIPLE SCLEROSIS	REBIF REBIDOSE	14.8%
CYSTIC FIBROSIS	KITABIS PAK	13.3%	MULTIPLE SCLEROSIS	TECFIDERA	14.8%

CYSTIC FIBROSIS	ORKAMBI	14.3%	MULTIPLE SCLEROSIS	VUMERITY	13.3%
CYSTIC FIBROSIS	PULMOZYME	15.9%	NARCOLEPSY	WAKIX	14.3%
CYSTIC FIBROSIS	SYMDEKO	14.3%	NEUTROPENIA	FULPHILA	14.6%
CYSTIC FIBROSIS	TOBI	14.6%	NEUTROPENIA	GRANIX	14.6%
CYSTIC FIBROSIS	TOBI PODHALER	14.6%	NEUTROPENIA	LEUKINE	14.6%
CYSTIC FIBROSIS	TOBRAMYCIN	37.8%	NEUTROPENIA	NEULASTA	14.6%
CYSTIC FIBROSIS	TRIKAFTA	14.3%	NEUTROPENIA	NEUPOGEN	14.6%
ENDOCRINE	BUPHENYL	15.6%	NEUTROPENIA	NIVESTYM	14.6%
ENDOCRINE	CARBAGLU	8.2%	NEUTROPENIA	UDENYCA	14.6%
ENDOCRINE	CHENODAL	10.2%	NEUTROPENIA	ZARXIO	14.6%
ENDOCRINE	CLOVIQUE	33.7%	NEUTROPENIA	ZIEXTENZO	14.3%
ENDOCRINE	CUPRIMINE	14.9%	ONCOLOGY - INJECTABLE	ELIGARD	13.4%
ENDOCRINE	CYSTADANE	11.3%	ONCOLOGY - INJECTABLE	INTRON A	14.3%
ENDOCRINE	CYSTARAN	13.8%	ONCOLOGY - INJECTABLE	LEUPROLIDE	53.2%
ENDOCRINE	DEPEN TITRATABS	14.8%	ONCOLOGY - INJECTABLE	SYLATRON	14.3%
ENDOCRINE	D-PENAMINE	13.8%	ONCOLOGY - INJECTABLE	SYNRIBO	12.3%
ENDOCRINE	EGRIFTA	14.3%	ONCOLOGY - ORAL	ABIRATERONE	33.7%
ENDOCRINE	FIRMAGON	14.3%	ONCOLOGY - ORAL	AFINITOR	14.9%
ENDOCRINE	GATTEX	15.6%	ONCOLOGY - ORAL	AFINITOR DISPERZ	14.9%
ENDOCRINE	H.P. ACTHAR	14.3%	ONCOLOGY - ORAL	ALECENSA	14.9%
ENDOCRINE	ISTURISA	11.3%	ONCOLOGY - ORAL	ALKERAN	16.3%
ENDOCRINE	JYNARQUE	13.3%	ONCOLOGY - ORAL	ALUNBRIG	12.8%
ENDOCRINE	KEVEYIS	13.8%	ONCOLOGY - ORAL	AYVAKIT	15.3%
ENDOCRINE	KORLYM	12.3%	ONCOLOGY - ORAL	BALVERSA	14.3%
ENDOCRINE	KUVAN	13.5%	ONCOLOGY - ORAL	BEXAROTENE	34.1%
ENDOCRINE	MYALEPT	8.2%	ONCOLOGY - ORAL	BOSULIF	14.3%
ENDOCRINE	NATPARA	14.1%	ONCOLOGY - ORAL	BRAFTOVI	14.8%
ENDOCRINE	NITYR	12.8%	ONCOLOGY - ORAL	CABOMETYX	13.3%
ENDOCRINE	OCTREOTIDE ACETATE	57.3%	ONCOLOGY - ORAL	CALQUENCE	14.3%
ENDOCRINE	PENICILLAMINE	33.7%	ONCOLOGY - ORAL	CAPECITABINE	33.7%
ENDOCRINE	PROCYSBI	8.2%	ONCOLOGY - ORAL	CAPRELSA	10.2%
ENDOCRINE	RAVICTI	15.9%	ONCOLOGY - ORAL	COMETRIQ	11.8%
ENDOCRINE	SAMSCA	14.3%	ONCOLOGY - ORAL	COPIKTRA	15.3%
ENDOCRINE	SANDOSTATIN	14.6%	ONCOLOGY - ORAL	COTELLIC	13.3%
ENDOCRINE	SIGNIFOR	8.2%	ONCOLOGY - ORAL	DAURISMO	13.3%
ENDOCRINE	SODIUM PHENYLBUTYRATE	33.7%	ONCOLOGY - ORAL	ERIVEDGE	13.3%
ENDOCRINE	SOMATULINE DEPOT	14.3%	ONCOLOGY - ORAL	ERLEADA	14.3%

ENDOCRINE	SOMAVERT	11.5%	ONCOLOGY - ORAL	ERLOTINIB	33.7%
ENDOCRINE	SYPRINE	14.3%	ONCOLOGY - ORAL	ETOPOSIDE	33.7%
ENDOCRINE	THIOLA	12.3%	ONCOLOGY - ORAL	EVEROLIMUS	33.7%
ENDOCRINE	TOLVAPTAN	33.7%	ONCOLOGY - ORAL	FARYDAK	12.3%
ENDOCRINE	TRIENTINE	47.7%	ONCOLOGY - ORAL	GILOTRIF	8.2%
ENDOCRINE	XERMELO	13.8%	ONCOLOGY - ORAL	GLEEVEC	16.3%
ENDOCRINE	XURIDEN	13.3%	ONCOLOGY - ORAL	GLEOSTINE	16.3%
ENZYME DEFICIENCY	CHOLBAM	5.1%	ONCOLOGY - ORAL	HYCAMTIN	15.6%
ENZYME DEFICIENCY	CYSTAGON	11.8%	ONCOLOGY - ORAL	IBRANCE	13.8%
ENZYME DEFICIENCY	GALAFOLD	14.8%	ONCOLOGY - ORAL	ICLUSIG	13.6%
ENZYME DEFICIENCY	MIGLUSTAT	33.7%	ONCOLOGY - ORAL	IDHIFA	15.3%
ENZYME DEFICIENCY	NITISINONE	33.7%	ONCOLOGY - ORAL	IMATINIB MESYLATE	84.7%
ENZYME DEFICIENCY	ORFADIN	3.1%	ONCOLOGY - ORAL	IMBRUVICA	14.8%
ENZYME DEFICIENCY	PALYNZIQ	12.3%	ONCOLOGY - ORAL	INLYTA	14.4%
ENZYME DEFICIENCY	STRENSIQ	12.1%	ONCOLOGY - ORAL	INREBIC	13.3%
ENZYME DEFICIENCY	SUCRAID	13.0%	ONCOLOGY - ORAL	IRESSA	15.3%
ENZYME DEFICIENCY	TEGSEDI	8.2%	ONCOLOGY - ORAL	JAKAFI	13.3%
ENZYME DEFICIENCY	ZAVESCA	8.2%	ONCOLOGY - ORAL	KISQALI	15.3%
GAUCHERS DISEASE	CERDELGA	14.3%	ONCOLOGY - ORAL	KISQALI FEMARA	15.9%
GROWTH HORMONE DEFICIENCY	GENOTROPIN	14.9%	ONCOLOGY - ORAL	LENVIMA	15.3%
GROWTH HORMONE DEFICIENCY	HUMATROPE	15.5%	ONCOLOGY - ORAL	LONSURF	13.3%
GROWTH HORMONE DEFICIENCY	INCRELEX	14.3%	ONCOLOGY - ORAL	LORBRENA	12.3%
GROWTH HORMONE DEFICIENCY	NORDITROPIN	16.8%	ONCOLOGY - ORAL	LYNPARZA	13.0%
GROWTH HORMONE DEFICIENCY	NUTROPIN AQ	15.0%	ONCOLOGY - ORAL	MATULANE	13.8%
GROWTH HORMONE DEFICIENCY	OMNITROPE	15.3%	ONCOLOGY - ORAL	MEKINIST	12.3%
GROWTH HORMONE DEFICIENCY	SAIZEN	18.3%	ONCOLOGY - ORAL	MEKTOVI	14.8%
GROWTH HORMONE DEFICIENCY	SEROSTIM	14.3%	ONCOLOGY - ORAL	MELPHALAN	33.7%
GROWTH HORMONE DEFICIENCY	ZOMACTON	15.5%	ONCOLOGY - ORAL	MESNEX	14.8%
GROWTH HORMONE DEFICIENCY	ZORBTIVE	13.8%	ONCOLOGY - ORAL	NERLYNX	15.1%
HEMATOLOGIC	BERINERT	13.3%	ONCOLOGY - ORAL	NEXAVAR	13.3%
HEMATOLOGIC	CABLIVI	14.3%	ONCOLOGY - ORAL	NILANDRON	15.9%
HEMATOLOGIC	CINRYZE	15.3%	ONCOLOGY - ORAL	NILUTAMIDE	28.6%
HEMATOLOGIC	DOPTELET	14.3%	ONCOLOGY - ORAL	NINLARO	14.3%
HEMATOLOGIC	FIRAZYR	14.3%	ONCOLOGY - ORAL	NUBEQA	14.3%

HEMATOLOGIC	HAEGARDA	13.3%	ONCOLOGY - ORAL	ODOMZO	14.6%
HEMATOLOGIC	ICATIBANT	14.3%	ONCOLOGY - ORAL	PEMAZYRE	14.8%
HEMATOLOGIC	MOZOBIL	14.3%	ONCOLOGY - ORAL	PIQRAY	12.8%
HEMATOLOGIC	MULPLETA	14.3%	ONCOLOGY - ORAL	POMALYST	13.8%
HEMATOLOGIC	OXBRYTA	12.8%	ONCOLOGY - ORAL	PURIXAN	13.3%
HEMATOLOGIC	PROMACTA	14.3%	ONCOLOGY - ORAL	REVLIMID	15.6%
HEMATOLOGIC	RUCONEST	14.1%	ONCOLOGY - ORAL	ROZLYTREK	16.3%
HEMATOLOGIC	TAKHZYRO	14.3%	ONCOLOGY - ORAL	RUBRACA	15.3%
HEMATOLOGIC	TAVALISSE	14.3%	ONCOLOGY - ORAL	RYDAPT	16.3%
HEMOPHILIA - INFUSED	ADVATE	43.8%	ONCOLOGY - ORAL	SPRYCEL	16.3%
HEMOPHILIA - INFUSED	ADYNOVATE	34.7%	ONCOLOGY - ORAL	STIVARGA	12.8%
HEMOPHILIA - INFUSED	AFSTYLA	34.6%	ONCOLOGY - ORAL	SUTENT	15.6%
HEMOPHILIA - INFUSED	ALPHANATE/VON WILLEBRAND	42.6%	ONCOLOGY - ORAL	TABLOID	16.3%
HEMOPHILIA - INFUSED	ALPHANINE SD	49.8%	ONCOLOGY - ORAL	TAFINLAR	14.3%
HEMOPHILIA - INFUSED	ALPROLIX	14.3%	ONCOLOGY - ORAL	TAGRISSO	14.3%
HEMOPHILIA - INFUSED	BENEFIX	15.3%	ONCOLOGY - ORAL	TALZENNA	14.3%
HEMOPHILIA - INFUSED	COAGADEX	30.6%	ONCOLOGY - ORAL	TARCEVA	16.2%
HEMOPHILIA - INFUSED	CORIFACT	28.6%	ONCOLOGY - ORAL	TARGRETIN	14.8%
HEMOPHILIA - INFUSED	ELOCTATE	28.6%	ONCOLOGY - ORAL	TASIGNA	14.3%
HEMOPHILIA - INFUSED	FEIBA	40.7%	ONCOLOGY - ORAL	TEMODAR	15.6%
HEMOPHILIA - INFUSED	HEMOFIL M	44.9%	ONCOLOGY - ORAL	TEMOZOLOMIDE	52.1%
HEMOPHILIA - INFUSED	HUMATE-P	37.7%	ONCOLOGY - ORAL	THALOMID	15.6%
HEMOPHILIA - INFUSED	IDELVION	14.3%	ONCOLOGY - ORAL	TIBSOVO	14.3%
HEMOPHILIA - INFUSED	IXINITY	14.3%	ONCOLOGY - ORAL	TRETINOIN	44.7%
HEMOPHILIA - INFUSED	JIVI	23.5%	ONCOLOGY - ORAL	TUKYSA	14.6%
HEMOPHILIA - INFUSED	KOATE	42.9%	ONCOLOGY - ORAL	TURALIO	14.8%
HEMOPHILIA - INFUSED	KOATE-DVI	42.9%	ONCOLOGY - ORAL	TYKERB	15.6%
HEMOPHILIA - INFUSED	KOGENATE FS	47.8%	ONCOLOGY - ORAL	VENCLEXTA	13.3%
HEMOPHILIA - INFUSED	KOVALTRY	46.2%	ONCOLOGY - ORAL	VERZENIO	13.8%
HEMOPHILIA - INFUSED	MONONINE	32.1%	ONCOLOGY - ORAL	VITRAKVI	15.3%
HEMOPHILIA - INFUSED	NOVOEIGHT	44.8%	ONCOLOGY - ORAL	VIZIMPRO	9.2%
HEMOPHILIA - INFUSED	NOVOSEVEN RT	38.9%	ONCOLOGY - ORAL	VOTRIENT	14.3%
HEMOPHILIA - INFUSED	NUWIQ	48.7%	ONCOLOGY - ORAL	XALKORI	12.8%
HEMOPHILIA - INFUSED	PROFILNINE	30.7%	ONCOLOGY - ORAL	XELODA	16.3%

HEMOPHILIA - INFUSED	REBINYN	18.4%	ONCOLOGY - ORAL	XOSPATA	15.3%
HEMOPHILIA - INFUSED	RECOMBINATE	41.9%	ONCOLOGY - ORAL	XPOVIO	15.1%
HEMOPHILIA - INFUSED	RIXUBIS	14.6%	ONCOLOGY - ORAL	XTANDI	14.3%
HEMOPHILIA - INFUSED	TRETTEN	15.2%	ONCOLOGY - ORAL	YONSA	14.3%
HEMOPHILIA - INFUSED	VONVENDI	13.3%	ONCOLOGY - ORAL	ZEJULA	14.6%
HEMOPHILIA - INFUSED	WILATE	42.9%	ONCOLOGY - ORAL	ZELBORAF	13.8%
HEMOPHILIA - INFUSED	XYNTHA	39.0%	ONCOLOGY - ORAL	ZOLINZA	15.6%
HEMOPHILIA - INJECTABLE	HEMLIBRA	13.3%	ONCOLOGY - ORAL	ZYDELIG	15.3%
HEPATITIS B	ADEFOVIR DIPIVOXIL	33.7%	ONCOLOGY - ORAL	ZYKADIA	13.8%
HEPATITIS B	BARACLUDE	14.6%	ONCOLOGY - ORAL	ZYTIGA	14.3%
HEPATITIS B	ENTECAVIR	61.9%	ONCOLOGY - TOPICAL	TARGRETIN	14.8%
HEPATITIS B	EPIVIR HBV	15.1%	ONCOLOGY - TOPICAL	VALCHLOR	10.8%
HEPATITIS B	HEPSERA	14.5%	OPHTHALMIC	OXERVATE	13.3%
HEPATITIS B	LAMIVUDINE HBV	33.7%	OSTEOPOROSIS	FORTEO	14.7%
HEPATITIS B	VEMLIDY	14.1%	OSTEOPOROSIS	TYMLOS	14.1%
HEPATITIS C	EPCLUSA	14.8%	PARKINSONS DISEASE	APOKYN	12.4%
HEPATITIS C	HARVONI	15.9%	PARKINSONS DISEASE	INBRIJA	10.2%
HEPATITIS C	LEDIPASVIR/SOFOSBUVIR	15.9%	PULMONARY DISEASE	ESBRIET	14.3%
HEPATITIS C	MAVYRET	14.8%	PULMONARY DISEASE	OFEV	13.3%
HEPATITIS C	PEGASYS	17.3%	PULMONARY HYPERTENSION	ADCIRCA	14.3%
HEPATITIS C	PEGINTRON	18.3%	PULMONARY HYPERTENSION	ADEMPAS	14.3%
HEPATITIS C	SOFOSBUVIR/VELPATASVIR	14.8%	PULMONARY HYPERTENSION	ALYQ	59.2%
HEPATITIS C	SOVALDI	14.8%	PULMONARY HYPERTENSION	AMBRISENTAN	33.7%
HEPATITIS C	VIEKIRA PAK	14.3%	PULMONARY HYPERTENSION	BOSENTAN	33.7%
HEPATITIS C	VOSEVI	14.8%	PULMONARY HYPERTENSION	LETAIRIS	13.5%
HEPATITIS C	ZEPATIER	14.7%	PULMONARY HYPERTENSION	OPSUMIT	13.5%
IMMUNE MODULATOR	ACTIMMUNE	15.1%	PULMONARY HYPERTENSION	ORENITRAM	14.3%
IMMUNE MODULATOR	ARCALYST	15.9%	PULMONARY HYPERTENSION	REVATIO	14.1%
INFERTILITY	CETROTIDE	18.0%	PULMONARY HYPERTENSION	SILDENAFIL	95.7%
INFERTILITY	CHORIONIC GONADOTROPIN	33.7%	PULMONARY HYPERTENSION	TADALAFIL	33.7%
INFERTILITY	FOLLISTIM AQ	25.0%	PULMONARY HYPERTENSION	TRACLEER	14.3%
INFERTILITY	GANIRELIX ACETATE	16.4%	PULMONARY HYPERTENSION	TYVASO	13.8%
INFERTILITY	GONAL-F	23.6%	PULMONARY HYPERTENSION	UPTRAVI	15.6%
INFERTILITY	GONAL-F RFF	23.6%	PULMONARY HYPERTENSION	VENTAVIS*	13.8%
INFERTILITY	MENOPUR	17.6%	TRANSPLANT	ASTAGRAF XL	14.9%

INFERTILITY	NOVAREL	33.7%	TRANSPLANT	CELLCEPT	14.2%
INFERTILITY	OVIDREL	18.0%	TRANSPLANT	CYCLOSPORINE	52.3%
INFERTILITY	PREGNYL	33.7%	TRANSPLANT	CYCLOSPORINE MODIFIED	55.0%
INFLAMMATORY CONDITIONS	ACTEMRA	15.0%	TRANSPLANT	ENVARSUS XR	14.3%
INFLAMMATORY CONDITIONS	CIMZIA	16.4%	TRANSPLANT	EVEROLIMUS	33.7%
INFLAMMATORY CONDITIONS	COSENTYX	14.3%	TRANSPLANT	GENGRAF	72.0%
INFLAMMATORY CONDITIONS	DUPIXENT	14.9%	TRANSPLANT	MYCOPHENOLATE MOFETIL	93.5%
INFLAMMATORY CONDITIONS	EMFLAZA	11.8%	TRANSPLANT	MYCOPHENOLIC ACID DR	33.7%
INFLAMMATORY CONDITIONS	ENBREL	14.8%	TRANSPLANT	MYFORTIC	15.1%
INFLAMMATORY CONDITIONS	HUMIRA	16.4%	TRANSPLANT	NEORAL	24.6%
INFLAMMATORY CONDITIONS	ILUMYA	14.9%	TRANSPLANT	PROGRAF	14.9%
INFLAMMATORY CONDITIONS	KEVZARA	10.8%	TRANSPLANT	RAPAMUNE	15.1%
INFLAMMATORY CONDITIONS	KINERET	14.3%	TRANSPLANT	SANDIMMUNE	27.9%
INFLAMMATORY CONDITIONS	OLUMIANT	13.3%	TRANSPLANT	SIROLIMUS	33.7%
INFLAMMATORY CONDITIONS	ORENCIA	15.0%	TRANSPLANT	TACROLIMUS	79.3%
INFLAMMATORY CONDITIONS	OTEZLA	14.3%	TRANSPLANT	ZORTRESS	14.3%
INFLAMMATORY CONDITIONS	RIDAURA	14.9%			

*Includes Nebulizer

UnitedHealthcare Insurance Company

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-877-294-1429

AMENDMENT NO. 9

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, 2022.

UnitedHealthcare Insurance Company

William J Golden, President

Timothy J. Burch, Secretary

ACCEPTED BY: _____

Title: _____

Date: _____

APPROVED AS TO FORM
COUNTY ATTORNEY

.....

UHIC AMEND (07/06)

UnitedHealthcare Insurance Company

A Stock Company

185 Asylum Street, Hartford, Connecticut

Phone: 1-877-294-1429

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, 2022

Administrator: United HealthCare Services, Inc.

Coverage specified herein is applicable only during the Policy Period from January 1, 2022 through December 31, 2022, 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, 2022 and Paid from January 1, 2022 through December 31, 2022.

Specific Deductible per Covered Person: $300,000

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: $85.82 per subscriber per month

EXPERIENCE REFUND ENDORSEMENT

Policyholder: Adams County Government

Effective Date: January 1, 2022

In consideration for the premium shown in the Schedule of Excess Loss, the Excess Loss Insurance Policy (the "Policy") will be revised with the addition of Experience Refund Provision.

EXPERIENCE REFUND

The Company will pay the Policyholder an Experience Refund of 25% of Net Profit if the Company issues the Policyholder a Policy/Amendment that provides insurance for a Subsequent Policy Period and insurance is continuous from the first day of the Policy Period through the entire Subsequent Policy Period.

NET PROFIT

Net Profit is calculated as:

a. 60% of the sum of all premiums paid by the Policyholder for the Specific Excess Loss Insurance for the Policy Period; minus

b. the sum of all Specific Excess Loss Insurance claims for the Policy Period.

CALCULATION OF REFUND

Company will calculate and send to the Policyholder, the Experience Refund, if due, 6 months after the end of the Policy Period. A premium credit in the amount of the Experience Refund will be applied to the next available bill.

If Specific Excess Loss Insurance claims are paid after an Experience Refund has been paid to the Policyholder, and such claims relate to the Policy Period for which the Experience Refund has been paid a new Net Profit will be calculated and the Policyholder shall reimburse Company for any reduction in the Experience Refund within thirty (30) days after written notice by the Company. Company may, at its option be reimbursed for any reduction on a previously paid Experience Refund by subtracting the reduced amount from any future payable claim.

All other provisions of the Excess Loss Insurance Policy remain unaffected by this Endorsement.

William J Golden, President

Timothy J. Burch, Secretary

SUMMARY PLAN DESCRIPTION

Adams County Government Medical
Select Doctors Plan

Effective: January 1, 2022

Group Number: 701043

UnitedHealthcare®

Summary Plan Description Table of Contents

Summary Plan Description

United Healthcare Services, Inc.

What Is the Summary Plan Description?

This *Summary Plan Description (SPD)* is a summary of the Covered Health Care Services available to you under the Adams County Government ("Plan Sponsor") Self-Funded health benefit plan. This *SPD* is a legal document that describes Benefits for the portion of the Plan for which United Healthcare Services, Inc. ("Claims Administrator") administers claims payment, either directly or in conjunction with one of the Claims Administrator's affiliates.

For the purposes of this provision "Self-Funded" means that the Plan Sponsor, on behalf of the Plan, has the sole responsibility to pay, and provide funds, to pay for all Plan benefits. The Claims Administrator has no liability or responsibility to provide these funds. The Claims Administrator is a private healthcare claims administrator. The Claims Administrator is not the Plan Administrator for the Plan. Although the Claims Administrator will assist you in many ways, it does not guarantee any Benefits. The Plan Sponsor is solely responsible for the benefit plan design and funding payment of Benefits.

In addition to this *SPD*, the Plan includes:

- The *Schedule of Benefits.*
- Amendments.
- Addendums.

If there should be an inconsistency between the contents of this summary and the Plan, your rights shall be determined under the Plan and not under this summary. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of the official plan document by written request to the Plan Administrator, for a nominal charge.

Can This SPD Change?

The Plan Sponsor may, from time to time, change this *SPD* by attaching legal documents called SMMs and/or Amendments that may change certain provisions of this *SPD*. When this happens the Plan Sponsor will send you a new *SPD*, SMM or Amendment.

Other Information You Should Have

The Plan Sponsor intends to continue this Plan, but reserves the right, in its sole discretion, to change, interpret, withdraw or add Benefits, or to end the Plan, as permitted by law, without your approval.

On its effective date, this *SPD* replaces and overrules any *SPD* that the Plan Sponsor may have previously issued to you. This *SPD* will in turn be overruled by any *SPD* issued to you in the future.

The Plan will take effect on the date shown in the Plan. Coverage under the Plan starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Plan Sponsor's location.

The Plan is governed by ERISA unless the Plan Sponsor is not an employee health and welfare plan as defined by ERISA.

Introduction to Your SPD

This *SPD* and the other Plan documents describe your Benefits, as well as your rights and responsibilities, under the Plan.

What Are Defined Terms?

Certain capitalized words have special meanings. The Plan Sponsor has defined these words in *Section 9: Defined Terms.*

When the Plan Sponsor uses the words "you" and "your," the Plan Sponsor is referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms.*

How Do You Use This Document?

Read your entire *SPD*) and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *SPD* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *SPD* at www.myuhc.com.

Review the Benefit limitations of this *SPD* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *SPD* and your Benefits work. Call the Claims Administrator if you have questions about the limits of the coverage available to you.

If there is a conflict between this *SPD* and any summaries provided to you by the Plan Sponsor, this *SPD* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact the Claims Administrator?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact the Claims Administrator for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Plan.

Additional information including eligibility criteria is available under the County of Adams Comprehensive Health and Welfare Benefit Plan ("Plan").

Be Aware the Plan Does Not Pay for All Health Care Services

The Plan does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Physician. The Claims Administrator and the Plan Sponsor do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver your care. The Claims Administrator arranges for Physicians and other health care professionals and facilities to participate in a Network. The Claims Administrator's credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds the Allowed Amount.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Plan's exclusions.

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Plan. You must file the claim in a format that contains all of the information the Claims Administrator requires to process the claim, as described in *Section 5: How to File a Claim.*

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, the Plan will not pay Benefits for health care services for that condition or disability until the prior coverage ends. The Plan will pay Benefits as of the day your coverage begins under the Plan for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Claims Administrator and Plan Sponsor Responsibilities

Determine Benefits

Plan Sponsor and the Claims Administrator make administrative decisions regarding whether the Plan will pay for any portion of the cost of a health care service you intend to receive or have received. Plan Sponsor's and the Claims Administrator's decisions are for payment purposes only. Plan Sponsor and the Claims Administrator do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

Plan Sponsor and the Claims Administrator have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *SPD*, the *Schedule of Benefits* and/or Amendments.
- Make factual determinations relating to Benefits.

Plan Sponsor and the Claims Administrator may assign this discretionary authority to other persons or entities including Claims Administrator’s affiliates that may provide administrative services for the Plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

Process Payment for the Plan's Portion of the Cost of Covered Health Care Services

The Claims Administrator processes the Plan's payment of Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means the Claims Administrator processes only the payment of the Plan's portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Plan.

Process Plan Payment to Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from the Plan. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to the Plan.

Process Plan Payment for Covered Health Care Services Provided by Out-of-Network Providers

The Claims Administrator processes the Plan's payment of Benefits after receiving your request for payment that includes all required information. See *Section 5: How to File a Claim.*

Review and Determine Benefits in Accordance with the Claims Administrator's Reimbursement Policies

The Claims Administrator develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that the Claims Administrator accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), the Claims Administrator's reimbursement policies are applied to provider billings the Claims Administrator shares its reimbursement policies with Physicians and other providers in the Claims Administrator's Network through the Claims Administrator's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by the Claims Administrator's reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts the Plan does not pay, including amounts that are denied because one of the Claims Administrator's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of the Claims Administrator's reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

The Claims Administrator may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, the Claims Administrator will use comparable methodology(ies). The Claims Administrator and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to the Claims Administrator's website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

The Claims Administrator may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but it is recommended that you discuss them with your Physician.

UnitedHealthcare Select

United Healthcare Services, Inc.

Schedule of Benefits

How Do You Access Benefits?

Selecting a Network Primary Care Physician

You must select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Participant in order to obtain Benefits. In general health care terminology, a Primary Care Physician may also be referred to as a *PCP*. A Network Primary Care Physician will be able to coordinate all Covered Health Care Services and promote continuity of care. If you are the custodial parent of an Enrolled Dependent child, you must select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Participant for that child.

You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable state law) as the Network Primary Care Physician for an Enrolled Dependent child. You do not need a referral from a Primary Care Physician and may seek care directly from a Specialist, including a Physician who specializes in obstetrics or gynecology.

You may change your Network Primary Care Physician by calling the telephone number shown on your ID card.

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits,* Benefits are not available for services provided by out-of-Network providers. This Benefit plan does not provide an out-of-Network level of Benefits.

Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider.

Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Benefits for facility services apply when Covered Health Care Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or an out-of-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Benefits also include Emergency Health Care Services.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Plan Sponsor, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

The Claims Administrator requires prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call the Claims Administrator at the telephone number on your ID card.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, the Claims Administrator's final coverage determination will be changed to account for those differences, and the Plan will only pay and the Claims Administrator will only process payments for Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Claims Administrator processes payments for Benefits under the Plan), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Claims Administrator will process payments for the Plan as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain prior authorization before receiving Covered Health Care Services.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Limits are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term and Description Table

Payment Term And Description	Amounts
	The Amount You Pay **Network**
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. **Coupons:** The Plan may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	***Network*** No Annual Deductible.
Out-of-Pocket Limit	
The maximum you pay per year for Copayments or Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts or the Recognized Amount when applicable. **Coupons:** The Plan may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	***Network*** For single coverage, the Out-of-Pocket Limit is $2,000. If more than one person in a family is covered under the Plan, the single coverage Out-of-Pocket Limit stated above does not apply. For family coverage, the family Out-of-Pocket Limit is $4,500. The Out-of-Pocket Limit includes the Annual Deductible.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount or the Recognized Amount when applicable.	

Payment Term And Description	Amounts
	The Amount You Pay Network
Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

Schedule of Benefits Table

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 9: *Defined Terms*. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Ambulance Services		
Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 20% *Air Ambulance:* 20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	
Does the Annual Deductible Apply?	*Ground Ambulance:* Not Applicable *Air Ambulance:* Not Applicable	
Non-Emergency Ambulance What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance:* 20% *Air Ambulance:* 20%	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance:* Yes *Air Ambulance:* Yes	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	*Ground Ambulance:* Not Applicable *Air Ambulance:* Not Applicable	
Cellular and Gene Therapy		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Clinical Trials		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Congenital Heart Disease (CHD) Surgeries		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$250 per Inpatient Stay	Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Dental Services - Accident Only		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Diabetes Self-Management Items What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Plan*.	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Plan*.	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Not Applicable	
Durable Medical Equipment (DME), Orthotics and Supplies		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums. You must purchase, rent, or obtain the DME from the vendor the Claims Administrator identifies or purchase it directly from the prescribing Network Physician.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Emergency Health Care Services - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$500 per Visit	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Copayment, Coinsurance and/or deductible. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Gender Dysphoria		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Plan*.	
Habilitative Services		
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.
Outpatient What Is the Copayment or Coinsurance You Pay? This	Chiropractic/Manipulative Treatment $30 per visit	Outpatient therapies: • Physical therapy.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
May Include a Copayment, Coinsurance or Both.	All other therapies $15 per Visit	• Occupational therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. • Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Hearing Aids		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to $3,500 every year for Covered Persons over age 19. Benefits are unlimited to age 19. Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Home Health Care		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		administration of intravenous infusion. For the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Hospice Care		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Hospital - Inpatient Stay		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$250 per Inpatient Stay	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Infertility Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Diagnosis and treatment of medical condition causing infertility. No coverage for: • Services and related expenses for infertility treatments.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		• Surrogate parenting, donor eggs, donor sperm and host uterus.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$25 per service $150 per service at a Hospital-based lab	If the service is provided in a doctor's office, additional co-pays, deductible or co-insurance may apply. Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$25 per service $150 per service at an outpatient Hospital-based diagnostic center	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Prostate Specific Antigen Test What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*None*	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Not applicable*	
Does the Annual Deductible Apply?	*Not Applicable*	
Major Diagnostic and Imaging - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$100 per service $250 per service at an outpatient Hospital-based diagnostic center	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Mental Health Care and Substance-Related and Addictive Disorders Services		
Inpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$250 per Inpatient Stay	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Outpatient What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None per visit *Partial Hospitalization/Intensive Outpatient Treatment* $250 per session for Partial Hospitalization/ Intensive Outpatient Treatment	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Virtual Behavioral Health Therapy and Coaching	***Designated Network***	There are no deductibles, Copayments or Coinsurance

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*AbleTo Therapy 360* None	you must meet or pay for when receiving these services.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Ostomy Supplies		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	No coverage for: • deodorants • filters • lubricants • tape • appliance cleaners • adhesive and remover • other items not listed
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Pharmaceutical Products - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Physician Fees for Surgical and Medical Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		if those services were provided by a Network provider; however Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Physician's Office Services - Sickness and Injury		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Primary Care Physician* None per visit for a Primary Care Physician office visit or $75 per visit for a Specialist office visit 20% per visit for home visits	In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy* and *Manipulative Treatment*. • Habilitative therapy services described under *Habilitative Services*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Pregnancy - Maternity Services		
It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.		
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits except that an Annual 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*.	
Preventive Care Services		
Physician office services What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Not Applicable	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Annual Deductible Apply?	Not Applicable	
Lab, X-ray or other preventive tests What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Not Applicable	
Does the Annual Deductible Apply?	Not Applicable	
Breast pumps What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Not Applicable	
Does the Annual Deductible Apply?	Not Applicable	
Prosthetic Devices		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998.*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Reconstructive Procedures		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	Chiropractic/Manipulative Treatment $30 per visit Pulmonary Rehabilitation Therapy $30 per visit All other therapies $15 per Visit	Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 24 Manipulative Treatments. • 20 visits of speech therapy. • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	***Not Applicable***	
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20% Colonoscopy None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes Colonoscopy Not applicable	
Does the Annual Deductible Apply?	Not Applicable Colonoscopy	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
	Not applicable	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 days per calendar year combined with *Habilitative Inpatient Services*. No coverage for: • Custodial care or maintenance care • Domiciliary care • Respite care, except when part of hospice care. • Services of personal care attendants • Individualized treatment programs designed to prepare a person for work.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Surgery - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$200 per date of service	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Therapeutic Treatments - Outpatient		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Transplantation Services		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Transplantation services must be received from a Designated Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider.
Urgent Care Center Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		• Outpatient surgery procedures described under *Surgery - Outpatient*. Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Not Applicable	
Virtual Care Services		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Not Applicable	
Does the Annual Deductible Apply?	Not Applicable	
Vision Exams		
What Is the Copayment or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Covered only for children up to age 18. Limited to 1 exam every 2 years.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	No coverage for: • Glasses and contact lenses, including fitting charges. • Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Surgery that allows you to see better without glasses or

Covered Health Care Service	The Amount You Pay Network	What are the Limitations & Exceptions?
		other vision correction (such as Lasik surgery).
Does the Annual Deductible Apply?	Not Applicable	

Allowed Amounts

Allowed Amounts are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
    - For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
    - For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
    - For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
    - For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Allowed Amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines, or as required by law, as described in the SPD.

For Designated Network Benefits and Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a [Designated Network and] Network provider, Allowed Amounts are our contracted fee(s) with that provider.

When Covered Health Care Services are received from an out-of-Network provider as described below, Allowed Amounts are determined as follows:

- **For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act* with respect to a visit as defined by the Secretary, the Allowed Amount is based on one of the following in the order listed below as applicable:
    - The reimbursement rate as determined by a state *All Payer Model Agreement*.

- The reimbursement rate as determined by state law.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
- The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
- **For Air Ambulance transportation provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

When Covered Health Care Services are received from an out-of-Network provider, except as described above, Allowed Amounts are determined as follows: an amount negotiated by the Claims Administrator, a specific amount required by law (when required by law), or an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the out-of-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Allowed Amount (which includes your Coinsurance, Copayment, and deductible) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to out-of-network providers that have questions about the Allowed Amounts and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Allowed Amount, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its [Employees][Participants] (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Allowed Amount for that particular claim.

Provider Network

The Claims Administrator or its affiliates arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not Adams County Government or the Claims Administrator's employees. It is your responsibility to choose your provider.

The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card to request a copy. If you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.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. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with the Claims Administrator to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of the Claims Administrator's products. Refer to your provider directory or contact the Claims Administrator for help.

Additional Network Availability

Certain Covered Health Care Services defined below may also be provided through the *W500* Network. Contact **www.myuhc.com** or the telephone number on your ID card for the *W500* provider directory. You are eligible for Benefits when these certain Covered Health Care Services are received from providers who are contracted with the Claims Administrator through the *W500* Network.

These Covered Health Care Services are limited to the services listed below, as described in *Section 1: Covered Health Care Services*:

- *Emergency Health Care Services - Outpatient.*
- *Hospital - Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Care Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Care Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if the Claims Administrator determines that specific Covered Health Care Services are not available from a Doctors Plan Network provider, you may be eligible for Benefits when Covered Health Care Services are received from a *W500* Network provider. In this situation, before you receive these Covered Health Care Services, your Doctors Plan Plus Network Physician will notify the Claims Administrator and, if the Claims Administrator confirms that the Covered Health Care Services are not available from a Doctors Plan Plus Network provider, the Claims Administrator will work with you and your Doctors Plan Plus Network Physician to coordinate these Covered Health Care Services through a *W500* Network provider.

Designated Providers

If you have a medical condition that the Claims Administrator believes needs special services, the Claims Administrator may direct you to a Designated Provider chosen by the Claims Administrator. If you require certain complex Covered Health Care Services for which expertise is limited, the Claims Administrator may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, the Plan may reimburse certain travel expenses.

In both cases, Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by the Claims Administrator.

You or your Network Physician must notify the Claims Administrator of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify the Claims Administrator in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Benefits will not be paid.

Health Care Services from Out-of-Network Providers

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify the Claims Administrator and, if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers

If the Claims Administrator determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, the Claims Administrator may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date the Claims Administrator notifies you, the Claims Administrator will select a single Network Physician for you.

If you do not use the selected Network Physician, Benefits will not be paid.

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Plan is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Plan.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Plan.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the *Schedule of Benefits*.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount or the Recognized Amount when applicable, you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying the Claims Administrator.

Please note that in listing services or examples, when the Plan says "this includes," it is not the Claims Administrator's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Plan states specifically that the list "is limited to."

Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as the Claims Administrator determines appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.

- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

  - "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
  - "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
  - "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when the Claims Administrator determines the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial.

- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Plan.

Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for CHD services.

Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.

- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME), Orthotics and Supplies. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Plan*.

Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *SPD*.

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998*.

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

Benefits do not include:

- Any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body. Implantable devices are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
- Powered exoskeleton devices.

The Claims Administrator will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Medical Supplies and Equipment*.

Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn or improve skills and functioning for daily living. The Claims Administrator will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.

  - Licensed physical therapist.
  - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

The Claims Administrator may require the following be provided:

- Treatment plan.
- Medical records.
- Clinical notes.
- Other necessary data to allow the Claims Administrator to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, the Claims Administrator may request a treatment plan that includes:

- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.
- Frequency of treatment plan updates.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices*.

Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid and associated fitting charges and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that

exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *SPD*. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's guidelines for hospice care.

Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Infertility Services

Diagnosis and treatment of medical condition causing infertility.

Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Presumptive Drug Tests and Definitive Drug Tests.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.

- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis* (*ABA*)) that are the following:
    - Focused on the treatment of core deficits of Autism Spectrum Disorder.
    - Provided by a *Board Certified Behavior Analyst* (*BCBA*) or other qualified provider under the appropriate supervision.
    - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

  This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *SPD*.

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo Therapy 360, Inc. (“AbleTo Therapy 360”) for Covered Persons with certain co-occurring behavioral and medical conditions.

AbleTo Therapy 360 provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by the Claims Administrator), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided

for administration of the Pharmaceutical Product under the corresponding Benefit category in this *SPD*. Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Plan.*

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, the Claims Administrator may direct you to a Designated Dispensing Entity. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

The Claims Administrator may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

The Claims Administrator also has special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify the Claims Administrator regarding your Pregnancy.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

  If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

  - Which pump is the most cost effective.
  - Whether the pump should be purchased or rented.
  - Duration of a rental.
  - Timing of purchase or rental.

Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *SPD*.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Devices, Appliances and Prosthetics*.

Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided

as described under *Home Health Care*. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic Endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow including CAR-T cell therapy.
- Heart.

- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small bowel.
- Pancreas.
- Small bowel.
- Cornea.

Donor costs that are directly related to organ removal are Covered Health Care Services for which Benefits are payable through the organ recipient's coverage under the Plan.

You can call the Claims Administrator at the telephone number on your ID card for information about the Claims Administrator's specific guidelines regarding Benefits for transplant services.

Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, 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 contacting the Claims Administrator at myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video-conferencing or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, or fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Vision Exams

Routine vision exams received from a health care provider in the provider's office or outpatient facility for Covered Persons over the age of 18.

Section 2: Exclusions and Limitations

How Are Headings Used in this Section?

To help you find exclusions, this section contains headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

Plan Does Not Pay Benefits for Exclusions

The Plan will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through an SMM or Amendment to the Plan.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when the exclusion or limitation says that "this includes," it is not the Plan's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the exclusion or limitation will state specifically that the list "is limited to."

Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
7. Art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.
3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.

5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Powered and non-powered exoskeleton devices.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator’s designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 1, *Covered Health Care Services*.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*

Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

Gender Dysphoria

1. Cosmetic Procedures, including the following:
   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal.
   - Hair transplantation.

- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters and related urologic supplies.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices* in *Section 1: Covered Health Care Services*. This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under Diabetes Services in *Section 1: Covered Health Care Services*.
2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care, including *American Society of Addiction Medicine (ASAM) Criteria* for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
    - Nutritional education is required for a disease in which patient self-management is a part of treatment.
    - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
    - Air conditioners, air purifiers and filters and dehumidifiers.
    - Batteries and battery chargers.
    - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
    - Car seats.

- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
- Exercise equipment.
- Home modifications such as elevators, handrails and ramps.
- Hot and cold compresses.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive

if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.

3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.
7. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident or stroke.
8. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
9. Biofeedback.
10. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
12. Surgical and non-surgical treatment of obesity.
13. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
14. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
15. Helicobacter pylori (H. pylori) serologic testing.
16. Intracellular micronutrient testing.

Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
   - Has not been involved in your medical care prior to ordering the service, or
   - Is not involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. The following services related to a Gestational Carrier or Surrogate:
   - All costs related to reproductive techniques including:
     - Assistive reproductive technology.
     - Artificial insemination.
     - Intrauterine insemination.
     - Obtaining and transferring embryo(s).
   - Health care services including:
     - Inpatient or outpatient prenatal care and/or preventive care.
     - Screenings and/or diagnostic testing.
     - Delivery and post-natal care.

     The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.
   - All fees including:
     - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
     - Surrogate insurance premiums.
     - Travel or transportation fees.
3. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

- Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval.
- Donor sperm – The cost of procurement and storage of donor sperm.

4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
5. The reversal of voluntary sterilization.

6. Fetal reduction surgery.
7. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination except. Termination of pregnancy is ONLY covered if mothers' life is at risk and in the event of incest or rape.

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).
8. In vitro fertilization regardless of the reason for treatment.

Services Provided under another Plan

1. Health care services for which other coverage is required by federal, state or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Plan Sponsor's that are not required by law to buy or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)
3. Health services for transplants involving animal organs.

Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back at the Claims Administrator's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.*

Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long-term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.

6. Rest cures.
7. Services of personal care aides.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
3. Eye exercise or vision therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
5. Bone anchored hearing aids except when either of the following applies:
   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

   More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Plan.

   Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this *SPD* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Plan when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health care services received after the date your coverage under the Plan ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Plan ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services the Claims Administrator would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Plan Sponsor.

Additional information including eligibility criteria is available under the County of Adams Comprehensive Health and Welfare Benefit Plan (“Plan”).

What If You Are Hospitalized When Your Coverage Begins?

The Plan will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Plan.

These Benefits are subject to your previous carrier's obligations under state law or contract.

You should notify the Claims Administrator of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network provider. What If You Are Eligible for Medicare?

Your Benefits may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B, except as specified under law.

Your Benefits may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but do not follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, the Plan Sponsor may end the Plan and/or all similar benefit plans at any time for the reasons explained in the Plan.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Claims Administrator will still process Plan payments on claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, the Claims Administrator will not process Plan payments on claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Participant's coverage ends.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Plan Ends**

  Your coverage ends on the date the Plan ends. In this event, the Plan Sponsor is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Participant," "Dependent" and "Enrolled Dependent."

- **The Claims Administrator Receives Notice to End Coverage**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends on the last day of the calendar month in which the Claims Administrator receives the required notice from the Plan Sponsor to end your coverage, or on the date requested in the notice.

- **Participants Retires or Is Pensioned**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends the last day of the calendar month in which the Participant is retired or receiving benefits under the Plan Sponsor 's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Plan, and only if the Participant continues to meet any applicable eligibility requirements. The Plan Sponsor can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

The Plan will provide at least 30 days advance required notice to the Participant that coverage will end on the date identified in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If the Claims Administrator and the Plan Sponsor find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact the Plan Sponsor has the right to demand that you pay back all Benefits the Plan paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. The Plan will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental or physical handicap or disability.
- The Enrolled Dependent child depends mainly on the Participant for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Plan.

You must furnish the Plan Sponsor with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before the Plan Sponsor agrees to this extension of coverage for the child, the Plan Sponsor may require that a Physician examine the child. The Plan Sponsor will choose the Physician and the Plan will pay for that examination.

The Plan Sponsor may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at the Plan's expense. The Plan Sponsor will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of the Plan Sponsor's request as described above, coverage for that child will end.

Continuation of Coverage

If your coverage ends under the Plan, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Plan Sponsors that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Plan Sponsor is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

The Claims Administrator is not the Plan Sponsor's designated "plan administrator" as that term is used in federal law, and the Claims Administrator does not assume any responsibilities of a "plan administrator" according to federal law.

The Claims Administrator is not obligated to provide continuation coverage to you if the Plan Sponsor or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Plan Sponsor or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying the Claims Administrator in a timely manner of your election of continuation coverage.

Section 5: How to File a Claim

Claims Procedures

You can obtain a claim form by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. If you do not have a claim form, attach the bill from your provider to a brief letter of explanation. Verify that your provider's bill contains the *Required Information* listed below. If any *Required Information* is missing from the bill, you can include it in your letter.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Claims Administrator. You must file the claim in a format that contains all of the information the Claims Administrator requires, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to the Claims Administrator within one year of the date of service, Benefits for that health care service will be denied or reduced, as determined by the Claims Administrator. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

How Are Outpatient Prescription Drug Benefits Paid?

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
- You pay Coinsurance and you believe that the amount of the Coinsurance was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

Required Information

When you request payment of Benefits from the Claims Administrator, you must provide the Claims Administrator with all of the following information:

- The Participant's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with the Claims Administrator at the address on your ID card.

Payment of Benefits

Except as required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*, you may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to “third parties” include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan’s obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a 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 7: Coordination of Benefits*.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in a form of other consideration that the Claims Administrator in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes to other plans for which the Claims Administrator processes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to the Claims Administrator in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. The Claims Administrator will notify you of the decision regarding your complaint within 60 days of receiving it.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact the Claims Administrator in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

For medical claims, the appeals address is:

UnitedHealthcare - Appeals

P.O. Box 30432,

Salt Lake City, Utah 84130-0432

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by the Claims Administrator during the determination of the appeal, the Claims Administrator will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the first level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as defined above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the decision letter to you.

Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. The Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If the Claims Administrator needs more information from your Physician to make a decision, the Claims Administrator will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

External Review Program

You may be entitled to request an external review of the Claims Administrator's determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by the Claims Administrator.
- The Claims Administrator fails to respond to your appeal within the timeframe required by the applicable regulations.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting the Claims Administrator at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received the Claims Administrator's final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)*. The Claims Administrator have entered into agreements with three or more *IRO*s that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review includes all of the following:

- A preliminary review by the Claims Administrator of the request.
- A referral of the request by the Claims Administrator to the *IRO*.
- A decision by the *IRO.*

After receipt of the request, the Claims Administrator will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes this review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an *IRO* to conduct such review. The Claims Administrator will assign requests by either rotating the assignment of claims among the *IRO*s or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days after the date you receive the *IRO's* request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

The Claims Administrator will provide to the assigned *IRO* the documents and information considered in making the Claims Administrator's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by the Claims Administrator.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. The Claims Administrator will include it with the documents forwarded to the *IRO.*

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The *IRO* will provide written notice of its determination (the *"Final External Review Decision"*) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and the Claims Administrator, and it will include the clinical basis for the determination.

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* agrees with UnitedHealthcare’s determination , 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 main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive either of the following:

- An adverse benefit determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:
  - The life or health of the individual.
  - The individual's ability to regain maximum function.

In addition, you must have filed a request for an expedited internal appeal.

- A final appeal decision, that either:
  - Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
  - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Claims Administrator will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an *IRO* in the same manner the Claims Administrator utilizes to assign standard external reviews to *IRO*s. The Claims Administrator will provide all required documents and information the Claims Administrator used in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available method in a timely manner. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the IRO's final external review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call the Claims Administrator at the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to the Claims Administrator within:	48 hours after receiving notice of additional information required

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an urgent care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial request for Benefits is complete, within:	15 days
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*The Claims Administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial claim is complete, within:	30 days
• after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the Primary Plan. How much this Plan will reimburse you, if anything, will also depend in part on the Allowable Expense. The term, “Allowable Expense,” is further explained below.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** 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.
- **Secondary Plan.** 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. Allowable Expense is defined below.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. 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.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits 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][Plan] year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are 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. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(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.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child

resides more than one half of the [calendar][Plan] year excluding any temporary visitation.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **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 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 C.1. can determine the order of benefits.

4. **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 C.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. 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.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Care Service by following the steps below.

- The Plan determines the amount it would have paid based on the Allowable Expense.
- The Plan pays the entire difference between the Allowable Expense and the amount paid by the Primary Plan, as long as this amount is not more than the Plan would have paid had it been the only plan involved.
- 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 applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the Allowable Expense.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is an Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the Primary Plan and this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a network provider for the Primary Plan and a non-Network provider for this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a non-Network provider for the Primary Plan and a Network provider for this Plan, the Allowable Expense is the reasonable and customary charges allowed by the Primary Plan. When the provider is a non-Network provider for both the Primary Plan and this Plan, the Allowable Expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "*Determining the Allowable Expense When this Plan is Secondary to Medicare*".

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will treat the provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

If this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Care Services by following the steps below.

- The Plan determines the amount it would have paid had it been the only plan involved.
- 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.

The maximum combined payment you may receive from all plans cannot exceed 100% of the applicable Allowable Expense.

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 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 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. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Allowed Amounts.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of 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 you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Section 8: General Legal Provisions

What Is Your Relationship with the Claims Administrator and Plan Sponsor?

It is important for you to understand the Claims Administrator's role with respect to the Plan and how it may affect you. The Claims Administrator helps administer the claims payment for the Plan Sponsor's Plan in which you are enrolled. The Claims Administrator and the Plan Sponsor do not provide medical services or make treatment decisions. This means:

- The Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Care Services, which are more fully described in this *SPD*.
- The Plan may not pay for all treatments you or your Physician may believe are needed. If the Plan does not pay, you will be responsible for the cost.

The Plan Sponsor and the Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan Sponsor and the Claims Administrator will use individually identifiable information about you as permitted or required by law, including in the Claims Administrator's operations and in the Claims Administrator's research. The Plan Sponsor and the Claims Administrator will use de-identified data for commercial purposes including research.

Please refer to the Claims Administrator's *Notice of Privacy Practices* for details.

What Is the Claims Administrator's Relationship with Providers and Plan Sponsors?

The Claims Administrator has agreements in place that govern the relationships between it and Plan Sponsors and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Care Services to Covered Persons.

Plan Sponsors and the Claims Administrator do not provide health care services or supplies, or practice medicine. Plan Sponsors and the Claims Administrator arrange for health care providers to participate in a Network and the Claims Administrator processes the Plan's payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. Network providers are not the Plan Sponsor's employees. Network providers are not the Claims Administrator's employees. The Plan Sponsor and the Claims Administrator are not responsible for any act or omission of any provider.

The Claims Administrator is not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator is not responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

The Plan Sponsor is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Plan's Service Fee to the Claims Administrator.
- The funding of Benefits on a timely basis.
- Notifying you of when the Plan ends.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act ("ERISA")*, *29 U.S.C. §1001 et seq*., the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in *ERISA*. If

you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Plan Sponsors?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a participant responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Plan Sponsor is that of employer and employee, Dependent or other classification as defined in the Plan.

Notice

When the Claims Administrator provides written notice regarding administration of the Plan to an authorized representative of the Plan Sponsor, that notice is deemed notice to all affected Participants and their Enrolled Dependents. The Plan Sponsor is responsible for giving notice to you.

Statements by the Plan Sponsor or Participants

All statements made by the Plan Sponsor or by a Participant shall, in the absence of fraud, be deemed representations and not warranties. The Claims Administrator will not use any statement made by the Plan Sponsor to void the Plan after it has been in force for two years unless it is a fraudulent statement.

Does the Claims Administrator Pay Incentives to Providers?

The Claims Administrator pays Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. The applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments 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 receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Copayment and/or Coinsurance as described in your *Schedule of Benefits*.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Are Incentives Available to You?

Sometimes the Claims Administrator may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, you should discuss taking part in such programs with your Physician. Contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card if you have any questions.

Does the Claims Administrator Receive Rebates and Other Payments?

The Plan Sponsor and the Claims Administrator may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. The Plan Sponsor and the Claims Administrator do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Who Interprets Benefits and Other Provisions under the Plan?

The Plan Sponsor and the Claims Administrator have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions set out in the Plan, including this *SPD*, the *Schedule of Benefits* and any *Summary Material Modifications (SMM)*, and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

The Plan Sponsor and the Claims Administrator may assign this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Sponsor may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that the Plan Sponsor does so in any particular case shall not in any way be deemed to require the Plan Sponsor to do so in other similar cases.

Who Provides Administrative Services?

The Claims Administrator provides claims administrative services or, as the Claims Administrator determines, the Claims Administrator may arrange for various persons or entities to provide claims administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as the Claims Administrator determines. The Claims Administrator is not required to give you prior notice of any such change, nor is the Claims Administrator required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

What is the Future of the Plan?

Although Plan Sponsor expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or *Employee Retirement Income Security Act of 1974 (ERISA)*, or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Amendments to the Plan

To the extent permitted by law, the Plan Sponsor has the right, as it determines and without your approval, to change, interpret, withdraw or add Benefits or end the Plan.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of applicable state law provisions not otherwise preempted by ERISA or federal statutes or regulations (of the jurisdiction in which the Plan is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Plan unless it is made by an Amendment or SMM. All of the following conditions apply:

- Amendments to the Plan are effective upon the Plan's next anniversary date, except as otherwise permitted by law.
- SMMs to the Plan are effective on the date the Plan Sponsor specifies.
- No agent has the authority to change the Plan or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Plan.

How Does the Claims Administrator Use Information and Records?

The Claims Administrator may use your individually identifiable health information as follows:

- To administer the Plan and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

The Claims Administrator may request additional information from you to decide your claim for Benefits. The Claims Administrator will keep this information confidential. The Claims Administrator may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how the Claims Administrator may use or disclose your information is found in the Claims Administrator *Notice of Privacy Practices.*

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Claims Administrator with all information or copies of records relating to the services provided to you. The Claims Administrator has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Participant's enrollment form. UnitedHealthcare agrees that such information and records will be considered confidential.

The Claims Administrator has the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Plan.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Plan, the Claims Administrator and the Claims Administrator's related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to the Claims Administrator *Notice of Privacy Practices.*

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from the Claims Administrator, the Claims Administrator also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as needed. The Claims Administrator's designees have the same rights to this information as the Claims Administrator has.

Does the Plan Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, the Plan Sponsor may require that a Network Physician of its choice examine you at the Plan's expense.

Is Workers' Compensation Affected?

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

How Are Benefits Paid When You Are Medicare Eligible?

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan Sponsor's Plan is the secondary payer as described in *Section 7: Coordination of Benefits,* the Claims Administrator will process the Plan Sponsors payment of Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan Sponsor's Plan is the secondary payer, the Claims Administrator will process the Plan Sponsor's payment of any Benefits available to you under the Plan as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

The Plan has the right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation Example:

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.

- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or the Plan's agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.
    - Obtaining the Plan's consent or the Plan's agents' consent before releasing any party from liability or payment of medical expenses.
    - Complying with the terms of this section.

    Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect

include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile Plan - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without the Plan's written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of the Plan's interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of the Plans discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

When Does the Plan Receive Refunds of Overpayments?

If the Plan pays Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to the Plan if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

You cannot bring any legal action against the Plan or the Claims Administrator to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against the Plan or the Claims Administrator you must do so within three years of the date the Plan notified you of its final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

What Is the Entire Plan?

The *SPD*, the *Schedule of Benefits*, and any SMMs and/or Amendments, make up the entire Plan.

Section 9: Defined Terms

Addendum - any attached written description of additional or revised provisions to the Plan. The Benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in *42 CFR 414.605*.

Allowed Amounts - for Covered Health Care Services, incurred while the Plan is in effect, Allowed Amounts are determined by the Claims Administrator or as required by law as shown in the *Schedule of Benefits*.

Allowed Amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops these guidelines, in its discretion, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Plan. It is effective only when distributed by the Plan Sponsor or Plan Administrator. It is subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Ancillary Services - items and services provided by out-of-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by an out-of-Network Physician when no other Network Physician is available.

Annual Deductible - the total of the Allowed Amount, or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before the Plan will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts or the Recognized Amount when applicable. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Care Services that are available under the Plan.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Claims Administrator - the organization that provides certain claim administration and other services for the Plan.

Coinsurance - the charge, stated as a percentage of the Allowed Amount or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Care Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Copayment.
- The Allowed Amount, or the Recognized Amount when applicable.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Medically Necessary.
- Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *SPD* under *Section 2: Exclusions and Limitations*.
- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness and Substance-Related and Addictive Disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available and prevailing medical standards and clinical guidelines. In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:
    - "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
    - "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described as a Covered Health Care Service in this *SPD* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Provided to a Covered Person who meets the Plan's eligibility requirements.
- Not excluded in this *SPD* under *Section 2: Exclusions and Limitations.*

Covered Person - the Participant or a Dependent, but this term applies only while the person is enrolled under the Plan. The Plan Sponsor uses "you" and "your" in this *SPD* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Dependent – An eligible Dependent is considered to be:

- Your legal Spouse by marriage, Domestic Partner as defined in *Section 9: Defined Terms* or common law (a copy of the marriage certificate or common law affidavit is required).
- Civil Union partners (certificate required).
- You and/or your Spouse's, Domestic Partner's or civil union partner's biological children under the age of 26.
    - Children born through a gestational carrier or surrogate are not Dependents under the terms of the Plan unless the surrogate is an eligible Dependent under the terms of the plan and submits legal guardianship of the child to the Plan Administrator.
    - A child of any age who is medically certified as disabled and dependent upon you or your Spouse, civil union partner or domestic partner for their total support.
    - Children placed for adoption or for whom you have obtained legal guardianship.
    - A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled, except under certain circumstances. Contact the Plan Administrator for details.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that the Claims Administrator has identified as Designated Providers. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Care Service for the treatment of specific diseases or condition; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Care Services through live audio and video technology.

Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.
- They must be financially interdependent.

The Participant and Domestic Partner must jointly register their domestic partnership with either Denver or Boulder in order to add the Domestic Partner onto Benefits (an affidavit will not be accepted). The following requirements apply for each:

Denver

Committed Partnership Registry

The City and County of Denver allows couples who are not married to recognize their commitment through the Committed Partnership Registry.

The Registry is open to any two partners who:

- Are unmarried, eighteen years of age or older, and competent to enter into a contract;
- Are not prohibited from marrying each other under the law of this state by reason of a blood relationship or other comparable domestic partnership;
- Are sharing a common household; and
- Do not already have different partners under the provisions of the Denver Committed Partnership Ordinance, the Colorado Civil Unions Act or any other comparable domestic partnership provision.

Boulder

Who are Domestic Partners:

Domestic Partners are two people who have signed an affidavit swearing that they are:

- Are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship;
- Are each other’s sole domestic partner;
- Are both at least 18 years of age and competent to contract;
- Share a life and home together;
- Are not related by kinship closer than would bar marriage in the State of Colorado; and

- Are not married.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Plan Sponsor or other person connected to the Plan Sponsor who meets the eligibility requirements shown in both the Plan Sponsor's Plan and supporting documents. An Eligible Person must live within the United States.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening exam (as required under section *1867 of the Social Security Act, 42 U.S.C.* 1395dd or as would be required under such section if such section applied to an *Independent Freestanding Emergency Department*) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, “to stabilize” has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.
- Emergency Health Care Services include items and services otherwise covered under the Plan when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:

  a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient’s medical condition.

  b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

  c) The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Enrolled Dependent - a Dependent who is properly enrolled under the Plan.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- The Claims Administrator may, as the Claims Administrator determines, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
    - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*: and
    - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - A Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Independent Freestanding Emergency Department - a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Care Services.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment - a structured outpatient treatment program.

- For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.

- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medicaid - a federal program administered and operated individually by participating state and territorial governments. The program provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - health care services that are all of the following as determined by the Claims Administrator or the Claims Administrator's designee.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator has the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by the Claims Administrator.

The Claims Administrator develops and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting the Claims Administrator's determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Care Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by the Claims Administrator, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with the Claims Administrator's affiliate to participate in the Claims Administrator's Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of the Claims Administrator's products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date it is placed on a tier by the Claims Administrator's PDL Management Committee.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria* providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Plan. The Plan Sponsor sets the period of time that is the Open Enrollment Period.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Participant - a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan. A Participant must live and/or work in the United States.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications, products or devices administered in connection with a Covered Health Care Service by a Physician.

Pharmaceutical Product List - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration* (*FDA*). This list is subject, from time to time, to the Claims Administrator's review and change. You may find out which tier a particular Pharmaceutical Product has been placed by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that the Claims Administrator describes a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - the Plan Sponsor's Self-Funded group health benefit plan.

The "What Is the *Summary Plan Description*?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Plan Sponsor - the employer, or other defined or otherwise legally established group, to whom the Plan is issued. The "What Is the *Summary Plan Description*?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Prescription Drug List (PDL) Management Committee - the committee that the Claims Administrator designates for, among other responsibilities, placing Pharmaceutical Products into specific tiers.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- 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.

Recognized Amount - the amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Care Services when provided by out-of-Network providers:.

- Out-of-Network Emergency Health Care Services.

- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

1) An *All Payer Model Agreement* if adopted,

2) State law, or

3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee - an Employee under the age of 65 who meets the retirement eligibility rules as defined by Adams County policy guidelines. Retirees over 65 years of age actively enrolled in Medicare are not eligible for coverage.

Secretary - as that term is applied in the *No Surprises Act* of the C*onsolidated Appropriations Act (P.L. 116-260)*.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Service Fee - the periodic fee required for each Participant and each Enrolled Dependent, in accordance with the terms of the Plan.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *SPD* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse - an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Summary Material Modification (SMM) - any attached written description of additional Covered Health Care Services not described in this *SPD.* Covered Health Care Services provided by a SMM may be subject to payment of additional Service Fees. SMMs are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the SMM.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Transitional Living - Mental health care services and substance-related and addictive disorders services provided through facilities, group homes and supervised apartments which provide 24-hour supervision , including those defined in the *American Society of Addiction Medicine (ASAM) Criteria* and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

The Claims Administrator has a process by which the Claims Administrator compiles and reviews clinical evidence with respect to certain health care services. From time to time, the Claims Administrator issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) the Claims Administrator may, as the Claims Administrator determines, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

Clinical Programs and Resources

Care Management

Care Management Solutions

Standard Personal Health Support

The Claims Administrator provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support 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.

Personal Health Support 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 Personal Health Support 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 Personal Health Support program includes:

- **Admission counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If you are hospitalized, a Personal Health Support 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 Personal Health Support nurse to confirm that medications, needed equipment, or follow-up services are in place. The nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a Personal Health Support nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Complex Medical Conditions, Programs and Services

Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about CRS, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Congenital Heart Disease (CHD) Resource Services

The Claims Administrator provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call the Claims Administrator at the number on your ID card.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Care Service under the Plan.

Kidney Disease Programs

Comprehensive Kidney Solution (CKS) program

For participants diagnosed with Kidney Disease, your Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) Stage 4/5 through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a “best practices” approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.

Coverage for dialysis and kidney-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS of your decision.

Kidney Resource Services program (KRS) program End-Stage Renal Disease (ESRD)

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Travel and Lodging Assistance Program*.

Travel and Lodging Assistance Program

Your Plan Sponsor is providing you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Allowed Amounts are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Allowed Amount for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offers a lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Facility.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Decision Support

In order to help you make informed decisions about your health care, the Claims Administrator has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access to health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.
- Information on providers and programs.

Conditions for which this program is available include:

- Back pain.
- Knee & hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.

- Breast cancer.
- Coronary disease.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for behavioral health. You can visit the site by going to myuhc.com.

The program is provided through AbleTo Therapy 360, Inc. Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Disease Management

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
    - Education about the specific disease and condition.
    - Medication management and compliance.
    - Reinforcement of on-line behavior modification program goals.
    - Preparation and support for upcoming Physician visits.
    - Review of psychosocial services and community resources.
    - Caregiver status and in-home safety.

- Use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Women's Health/Reproductive

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get educational information and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Neonatal Resource Services

Neonatal Resource Services (NRS) is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

When you enroll in this program, the Plan pays Benefits for neonatal intensive care unit (NICU) services provided by Designated Provider's participating in the Neonatal Resource Services (NRS) program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions.

To take part in the NRS program, call a neonatal nurse at 1-866-534-7209. The Plan will only pay Benefits under the NRS program if NRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

You or a covered Dependent may also:

- Call the Claims Administrator.
- Call NRS at 1-888-936-7246 and select the NRS prompt.

To receive NICU Benefits, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under the Covered Health Care Service Category.

Consumer Solutions and Self-Service Tools

Plan Sponsor believes in giving you tools to help you be an educated health care consumer. To that end, Plan Sponsor has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE: Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. The Claims Administrator and the Plan Sponsor are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

www.myuhc.com

UnitedHealthcare's member website, www.myuhc.com, provides information at your fingertips anywhere and anytime you have access to the Internet. www.myuhc.com opens the door to a wealth of health information and self-service tools.

With www.myuhc.com you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

If you have not already registered on www.myuhc.com, simply go to www.myuhc.com and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit www.myuhc.com and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to www.myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Health Survey

You and your Spouse are invited to learn more about health and wellness at www.myuhc.com and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

If you need any assistance with the online survey, please call the number on your ID card.

Outpatient Prescription Drug Schedule of Benefits

United Healthcare Services, Inc.

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore, your Copayment and/or Coinsurance may change or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that the Claims Administrator has developed. Supply limits are subject, from time to time, to the Claims Administrator's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from the Claims Administrator or the Claims Administrator's designee. The reason for obtaining prior authorization from the Claims Administrator is to determine whether the Prescription Drug Product, in accordance with the Claims Administrator's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

The Plan may also require you to obtain prior authorization from the Claims Administrator or the Claims Administrator's designee so the Claims Administrator can determine whether the Prescription Drug Product, in accordance with the Claims Administrator's approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from the Claims Administrator.

If you do not obtain prior authorization from the Claims Administrator before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to the Claims Administrator's review and change. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

If you do not obtain prior authorization from the Claims Administrator before the Prescription Drug Product is dispensed, you can ask the Claims Administrator to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Claims Administrator as described in this *Summary Plan Description (SPD)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after the Claims Administrator reviews the documentation provided and the Claims Administrator determines that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

The Claims Administrator may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Outpatient Prescription Drug Plan are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

What Do You Pay?

The Claims Administrator may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table. You are not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

The amount you pay for any of the following under this Outpatient Prescription Drug Plan will be included in calculating any Out-of-Pocket Limit stated in this *SPD*:

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. The Claims Administrator's contracted rates (the Claims Administrator's Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
Copayment Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Coinsurance*** Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. ***Copayment and Coinsurance*** Your Copayment and/or Coinsurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. **Special Programs:** The Claims Administrator may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. **Copayment/Coinsurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts. You are not responsible for paying a Copayment and/or Coinsurance for PPACA Zero Cost Share Preventive Care Medications.

Payment Term And Description	Amounts
Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, the Claims Administrator may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status. **Coupons:** The Claims Administrator may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.	

Outpatient Prescription Drug Schedule of Benefits Table

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits.

Outpatient Prescription Drug Benefits	**What Is the Amount You Pay?** **This May Include a Copayment, Coinsurance or Both**	**Description and Supply Limits**
Specialty Prescription Drug Products		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	Specialty Prescription Drug Product: $100 per Prescription Order or Refill up to 31 days. Specialty Prescription Drug Product: $250 per Prescription Order or Refill up to 90 days.	The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products

Outpatient Prescription Drug Benefits	What Is the Amount You Pay? This May Include a Copayment, Coinsurance or Both	Description and Supply Limits
		obtained at Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.
Prescription Drugs from a Retail Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	For a Tier 1 Prescription Drug Product: $10 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $35 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $50 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: $50 of the Prescription Drug Charge per Prescription Order or Refill.	• A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered.
Prescription Drug Products from a Mail Order Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.	For a Tier 1 Prescription Drug Product: $25 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $87.50 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $125 of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: $125 of the Prescription Drug Charge per Prescription Order or Refill.	When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. To maximize your Benefit, ask your

Outpatient Prescription Drug Benefits	What Is the Amount You Pay? This May Include a Copayment, Coinsurance or Both	Description and Supply Limits
		Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.

Outpatient Prescription Drug Plan

United Healthcare Services, Inc.

This portion of the Plan provides Benefits for Prescription Drug Products.

Because this section is part of a legal document, the Plan Sponsor wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings. The Claims Administrator has defined these words in either the *Summary Plan Description (SPD)* in *Section 9: Defined Terms* or in this Plan in *Outpatient Prescription Drug Defined Terms*.

When the Plan Sponsor uses the words "you" and "your" the Plan Sponsor is referring to people who are Covered Persons, as the term is defined in *Section 9: Defined Terms*.

NOTE: The Coordination of Benefits provision in this *SPD* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Outpatient Prescription Drug Plan. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the *SPD*.

Introduction Outpatient Prescription Drug Plan

Coverage Policies and Guidelines

The Claims Administrator's Prescription Drug List (PDL) Management Committee makes tier placement changes on the Claims Administrator's behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat, or according to whether it was prescribed by a Specialist.

The Claims Administrator may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the Claims Administrator during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from the Plan as described in this *SPD* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Springs, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom the Claims Administrator has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Prescription Drug Product.

When Does the Claims Administrator Limit Selection of Pharmacies?

If the Claims Administrator determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, the Claims Administrator may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date the Claims Administrator notifies you, the Claims Administrator will choose a Network Pharmacy for you.

Rebates and Other Payments

The Claims Administrator and Pinnacol Assurance may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. As determined by the Claims Administrator, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

The Claims Administrator, and a number of the Claims Administrator's affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Plan*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Plan*. The Claims Administrator is not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, the Claims Administrator may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

The Claims Administrator may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. You may access information on these programs by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, the Claims Administrator may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy but do not inform the Claims Administrator, no Benefit will be paid.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products

are subject to Benefit enhancement, reduction or no Benefit by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom the Claims Administrator has an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid.

Please see *Outpatient Prescription Drug Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy supply limits apply.

Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Outpatient Prescription Drug Plan Exclusions

Exclusions from coverage listed in this *SPD* also apply to this Outpatient Prescription Drug Plan. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by the Claims Administrator to be experimental, investigational or unproven.
7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. A Pharmaceutical Product for which Benefits are provided under the medical Benefits portion of the Plan in this *SPD*. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
11. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in this *SPD*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
12. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
13. Certain unit dose packaging or repackagers of Prescription Drug Products.
14. Medications used for cosmetic purposes.
15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Claims Administrator determines do not meet the definition of a Covered Health Care Service.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

17. Prescription Drug Products when prescribed to treat infertility.
18. Certain Prescription Drug Products for tobacco cessation.
19. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
20. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Claims Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Claims Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
21. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator PDL Management Committee.
22. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
23. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.
24. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
26. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
27. Certain Prescription Drug Products that have not been prescribed by a Specialist.
28. A Prescription Drug Product that contains marijuana, including medical marijuana.
29. A Prescription Drug Product with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

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.

32. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Outpatient Prescription Drug Defined Terms

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Claims Administrator identifies as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by the Claims Administrator.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with the Claims Administrator or with an organization contracting on the Claims Administrator's behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Claims Administrator identifies as a Generic product based on available data resources. This includes, data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by the Claims Administrator.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with the Claims Administrator or an organization contracting on the Claims Administrator's behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Claims Administrator as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by the Claims Administrator PDL Management Committee.
- December 31st of the following calendar year.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting the Claims Administrator at **myuhc.com** or the telephone number on your ID card.

Prescription Drug Charge - the rate the Plan has agreed to pay the Claims Administrator on behalf of its Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to the Claims Administrator's review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that the Claims Administrator designates for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Outpatient Prescription Drug Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered in a Network pharmacy.
- Certain injectable medications administered in a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters including continuous glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Federal Notice

Language Assistance Services

The Claims Administrator provides free language services to help you communicate with us. The Claims Administrator offers interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY 711. The Claims Administrator is available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：日本語 **(Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به‌طور رایگان در اختیار شما می باشد.
1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

(Khmer) 1-866-633-2446.

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

Notice of Non-Discrimination

The Claims Administrator[1] does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

United HealthCare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "The Claims Administrator" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

This group health plan does not discriminate in premium amounts, contributions charged or eligibility for coverage based on any individual's genetic information. The plan does not use, request or require genetic information about anyone covered by the plan. Genetic information, within the context of GINA, includes the following: an individual's genetic tests; the genetic tests of an individual's family members (up to fourth-degree relatives by birth, marriage or adoption); manifestation of disease or disorder in family members of an individual; an individual's request for or receipt of genetic services; and genetic information of a fetus carried by an individual or his or her family.

Any Health Risk Assessment (HRA) completed by a person covered by this plan is in compliance with regulations under GINA.

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Summary Plan Description (SPD)* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below. These changes will apply to any "non-grandfathered" plan. Contact your Plan Administrator to determine whether or not your plan is a "grandfathered" or a "non-grandfathered plan". Under the *Patient Protection and Affordable Care Act (PPACA)* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

  Ambulatory patient services; emergency services, hospitalization; laboratory services; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:

  - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.

  - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.

  - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

  Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law).

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

  Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the plan is subject to the statute known as *Michelle's Law*. This law amends *ERISA*, the *Public Health Service Act*, and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or Injury.

- If you do not have a grandfathered plan, in-network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:

  - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
  - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
  - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
  - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

- Retroactive rescission of coverage under the plan is permitted, with 30 days advance written notice, only in the following two circumstances:

  - The individual performs an act, practice or omission that constitutes fraud.
  - The individual makes an intentional misrepresentation of a material fact.

- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:

  - Direct access to OB/GYN care without a referral or authorization requirement.
  - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
  - Prior authorization is not required before you receive services in the emergency department of a hospital.

If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Effective for plans that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or *UnitedHealthcare* for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call the Claims Administrator at the number listed on your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from the Claims Administrator will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call the Claims Administrator at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, the Claims Fiduciary will review its decision. The Claims Fiduciary will also send you its written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, the Claims Fiduciary will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call the Claims Administrator at the number listed on your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact the Claims Administrator at the number listed on your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you.

If your plan includes coverage for Mental Health or Substance Use, the following applies:

Mental Health/Substance Use Disorder Parity

Effective for grandfathered and non-grandfathered large group Plans that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and substance use disorder conditions that are Covered Health Care Services under the Plan must be treated in the same manner and provided at the same level as Covered Health Care Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance-Related and Addictive Disorders Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Plan are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Copayments, Coinsurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Plan, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
if the initial claim is complete, within:	30 days
after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Fiduciary must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, the Claims Administrator will send you written notice of the decision from the Claims Administrator within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, the Claims Administrator will notify you of the information needed within 15 days after it was received, and may request a one-time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial request for Benefits is complete, within:	15 days
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Fiduciary must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

*The Claims Administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, the Claims Administrator will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to the Claims Administrator within:	48 hours after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an urgent care request for Benefits.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information through the submission of your appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by the Claims Administrator during the determination of the appeal, the Claims Administrator will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of the Claims Administrator's decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

Administrative Statement

If the Plan is not subject to *ERISA*, the following information applies to you.

Claims Fiduciary: The Claims Administrator is your Plan's Claims Fiduciary and has been delegated this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan. The Claims Fiduciary shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Fiduciary shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: Your Plan is self-funded. The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Fiduciary. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Insurance Company. The named fiduciary of Plan is Adams County Government, the Plan Sponsor.

The Plan Sponsor has selected a provider Network established by UnitedHealthcare Insurance Company

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343
952-936-1300

Person designated as Agent for Service of Legal Process: Adams County Government

Summary Plan Description

Adams County Government
Choice Plan

Effective: January 1, 2022
Group Number: 701043

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorder Administrator: 1-800-847-2744.
- 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:

- 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.

Additional information including eligibility criteria is available under the County of Adams Comprehensive Health and Welfare Benefit Plan ("Plan").

The Plan Administrator intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. The Plan Administrator is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Adams County Government Choice Health Benefit Plan works. If you have questions contact People and Culture Services or call the number on 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 People & Culture Services.
- Capitalized words in the SPD have special meanings and are defined in Section 13, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 13, *Glossary*.
- The Plan Administrator is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries provided to you, this SPD will control.

SECTION 2 - 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 4, *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.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

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. If you receive a Covered Health

Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

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. However, if you are currently receiving treatment for Covered Health Services from a provider whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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 the Claims Administrator the 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 the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations,

you are not responsible for any difference between Eligible Expenses and the amount the provider bills.

- For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the Non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
- For Covered Health Services that are **Emergency Health Services provided by a Non-Network provider**, you are not responsible, and the Non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Services that are **Air Ambulance services provided by a Non-Network provider**, you are not responsible, and the Non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, 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 our contracted fee(s) with that provider.
- When Covered Health Services are received from a Non-Network provider as arranged by the Claims Administrator, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act* with respect to a visit as defined

by the Secretary, the Eligible Expense is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement*.
- The reimbursement rate as determined by state law.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act)*, an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Services provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:

  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:

  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expense are determined as follows: an amount negotiated by the Claims Administrator, a specific amount required by law (when required by law), or an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment, and deductible) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Employees (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

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, or the Recognized Amount when applicable, 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 4, *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 4, *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 14, *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 3 - PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services for which you need to contact Personal Health Support.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support 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 Personal Health Support Nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

Personal Health Support 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 Personal Health Support 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 Personal Health Support program includes:

- **Admission counseling** – Personal Health Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If you are hospitalized, a Personal Health Support 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 Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support 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 Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.

- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Contacting UnitedHealthcare or Personal Health Support is easy.
Simply call the number on your ID card.

Network providers are responsible for notifying the Claims Administrator before they provide certain services to you.

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 9, *Coordination of Benefits (COB)*. You are not required to provide notification before receiving Covered Health Services.

SECTION 4 - PLAN HIGHLIGHTS

What this section includes:
- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Designated Network (includes United UnitedHealth Premium®) and Network Amounts
Copays In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.	
■ Emergency Health Services.	$200
■ Physician's Office Services - Primary Physician.	**Designated Network** $30 **Network** $30
■ Physician's Office Services – Specialist Physician.	**Designated Network** $40 **Network** $80
■ Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.	$30
■ Urgent Care Center Services.	$40
■ Virtual Visits.	$30

Plan Features	Designated Network (includes United UnitedHealth Premium®) and Network Amounts
Copays do not apply toward the Annual Deductible. Copays do apply toward the Out-of-Pocket Maximum.	
Annual Deductible ■ Individual. ■ Family (not to exceed the Individual amount for all Covered Persons in a family). **Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	$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. **Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum. The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 14, *Outpatient Prescription Drugs*.	$4,500 $9,000

Plan Features	Designated Network (includes United UnitedHealth Premium®) and Network Amounts
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 5, *Additional Coverage Details*.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 14, *Glossary*.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*
	Designated Network and Network
Ambulance Services	*Ground and/or Air Ambulance*
■ Emergency Ambulance.	95% after you meet the Annual Deductible
■ Non-Emergency Ambulance. Eligible Expenses for Air Ambulance transport provided by a non-Network	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
provider will be determined as described in Section 3, *How the Plan Works*.	
Cellular and Gene Therapy Services must be received at a Designated Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	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 See *Congenital Heart Disease (CHD) Surgeries* in Section 5, *Additional Coverage Details*, for additional details.	95% after you meet the Annual Deductible
Dental Services - Accident Only	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
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 14, *Outpatient Prescription Drugs*.
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 5, *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. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 3: *How the Plan Works*.	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 14, *Outpatient Prescription Drugs*.
Hearing Aids See Section 5, Additional Coverage Details, for limits.	Depending upon where the Covered Health Service is provided, Benefits will be the

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
	same as those stated under each Covered Health Service category in this section.
Home Health Care See Section 5, *Additional Coverage Details*, for limits.	95% after you meet the Annual Deductible
Hospice Care See Section 5, *Additional Coverage Details*, for limits.	95% after you meet the Annual Deductible
Hospital - Inpatient Stay	95% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient	
■ Lab testing - Outpatient.	100% at a freestanding lab 95% at a Hospital-based lab after you meet the Annual Deductible 100% after you pay the applicable Copayment per visit at a Physician's office-based lab No copayment applies when no Physician charge is assessed.
■ X-ray and Other Diagnostic Testing - Outpatient.	100% after you pay a Copayment of $150 per date of service at a free-standing center 95% at a Hospital-based lab after you meet the Annual Deductible 100% after you pay the applicable Copayment per visit at a Physician's office-based lab No copayment applies when no Physician charge is assessed.
■ PSA Screenings	100%

Covered Health Services[1]	**Benefit** *(The Amount Payable by the Plan based on Eligible Expenses)*
	Designated Network and Network
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	100% after you pay a Copayment of $150 per date of service at a free-standing center 95% at a Hospital-based lab after you meet the Annual Deductible
Mental Health Services	
■ Inpatient.	95% after you meet the Annual Deductible
■ Outpatient.	100% after you pay a Copayment of $30 per visit
■ Outpatient – Group Visit.	100% after you pay a Copayment of $20 per visit
	95% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
■ Virtual Behavioral Health Therapy and Coaching	**Designated Network (AbleTo Therapy 360)** 100%
Neurobiological Disorders - Autism Spectrum Disorder Services	
■ Inpatient.	95% after you meet the Annual Deductible
■ Outpatient.	100% after you pay a Copayment of $30 per visit
■ Outpatient – Group Visit.	100% after you pay a Copayment of $20 per visit
	95% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Ostomy Supplies	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
Pharmaceutical Products - Outpatient ■ Primary Physician. ■ Specialist Physician.	**Designated Network** 100% after you pay a Copayment of $30 per visit **Network** 100% after you pay a Copayment of $30 per visit **Designated Network** 100% after you pay a Copayment of $40 per visit **Network** 100% after you pay a Copayment of $80 per visit
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 3, *How the Plan Works*, under *Eligible Expenses*.	95% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury ■ Primary Physician. ■ Specialist Physician.	**Designated Network** 100% after you pay a Copayment of $30 per visit **Network** 100% after you pay a Copayment of $30 per visit **Designated Network**

Covered Health Services[1]	**Benefit** *(The Amount Payable by the Plan based on Eligible Expenses)*
	Designated Network and Network
	100% after you pay a Copayment of $40 per visit **Network** 100% after you pay a Copayment of $80 per visit
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 5, *Additional Coverage Details*, for limits.	95% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 5, *Additional Coverage Details*, for visit limits.	100% after you pay a Copayment of $30 per visit

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
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 Colonoscopies are covered at 100% of eligible expenses, no member cost share, regardless of diagnosis.
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 5, *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
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

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)* Designated Network and Network
Urgent Care Center Services	100% after you pay a Copayment of $40 per visit
Virtual Care Services Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	100% after you pay a Copayment of $30 per visit
Vision Examinations See Section 5, Additional Coverage Details, for limits.	100% after you pay a Copayment of $30 per visit

SECTION 5 - 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 Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call the Claims Administrator or Personal Health Support.

This section supplements the second table in Section 4, *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 Personal Health Support. 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 7, *Exclusions and Limitations*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

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 13, *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.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Clinical Trials

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.

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).

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 14, *Outpatient Prescription Drugs*.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen.
- Equipment to assist mobility, such as a standard wheelchair.
- Hospital beds.
- Delivery pumps for tube feedings.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.
- Orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Note: DME is different from prosthetic devices - see *Prosthetic Devices* in this section.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three years.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within one business day 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 2, *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 14, *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:
  - Bilateral mastectomy or breast reduction
  - Clitoroplasty (creation of clitoris)
  - Hysterectomy (removal of uterus)
  - Labiaplasty (creation of labia)
  - Metoidioplasty (creation of penis, using clitoris)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  -)
  - Breast Construction
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of urethra)
  - Vaginectomy (removal of vagina)
  - Vaginoplasty (creation 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.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

■ Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

■ Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to $3,500 per calendar year and limited to a single purchase (including repair/replacement) per hearing impaired ear every 3 calendar years for Covered Persons over age 19.

Benefits are unlimited to age 19.

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 13, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 13, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are limited to 60 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Benefits are limited to 275 days during the entire period of time you are covered under this Plan. Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are

described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

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.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo Therapy 360, Inc. ("AbleTo Therapy 360") for Covered Persons with certain co-occurring behavioral and medical conditions.

AbleTo Therapy 360 provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

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.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

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.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health

Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Office visit copays are waived for the diagnosis and treatment of asthma and or diabetes when no other services are provided.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

No copay applies to office visits after the first visit, unless non routine maternity health services are provided.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 6, *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 4, *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 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 13, *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.

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.

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 13, *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.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.

- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received by a Designated Provider.

Benefits are also available for cornea transplants. You are not required to notify the Claims Administrator or Personal Health Support 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.

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.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 13, *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 Care Services

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, 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 contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video-conferencing or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Vision Examinations

The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a Network provider in the provider's office or outpatient facility every other calendar year. Benefits are limited to children up to age 18 only.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

SECTION 6 – CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools.
- Disease Management Services.
- Complex Medical Conditions Programs and Services.
- Wellness Programs.
- Women's Health/Reproductive.

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.

If you need any assistance with the online survey, please call the number on your ID card.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- Mammograms for women.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access to health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.
- Information on providers and programs.

Conditions for which this program is available include:

- Back pain.
- Knee & hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.
- Breast cancer.
- Coronary disease.

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.
- 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.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and

provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for Behavioral Health.

The program is provided through AbleTo Therapy 360, Inc. Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Disease Management Services

Disease Management Services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - Education about the specific disease and condition.
  - Medication management and compliance.
  - Reinforcement of on-line behavior modification program goals.
  - Preparation and support for upcoming Physician visits.
  - Review of psychosocial services and community resources.
  - Caregiver status and in-home safety.
  - Use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Comprehensive Kidney Solution (CKS) program

For participants diagnosed with Kidney Disease, your Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a "best practices" approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS of your decision.

Kidney Resource Services (KRS) program
End-Stage Renal Disease (ESRD)

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have

been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the *Travel and Lodging Assistance Program*, refer to the provision below.

Travel and Lodging Assistance Program

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 the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offers a lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem, 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.

Women's Health/Reproductive

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Neonatal Resource Services (NRS)

NRS is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant's admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant's needs.

To take part in the NRS program you or a covered Dependent can call the Claims Administrator at the telephone number on your ID card or call NRS directly at 1-866-534-7209.

SECTION 7 - 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 5, *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 5, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 4, *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 4, *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, animal-assisted 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 5, *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 5, *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 5, *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 5, *Additional Coverage Details*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 5, *Additional Coverage Details*. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria.

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. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

4. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.

5. The replacement of lost or stolen prosthetic devices.

6. Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details*.

7. Oral appliances for snoring.

8. Powered and non-powered exoskeleton devices.

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 14, *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-administered or self-infused 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. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 5, *Additional Coverage Details*.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

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 13, *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 5, *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 5, *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 5, *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 5, *Additional Coverage Details*.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 5, *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 5, *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 7, *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 5, Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorder.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living Services.

8. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.

9. Non-Medical 24-Hour Withdrawal Management.

10. High intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This

exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

3. Food of any kind. Foods that are not covered include:

   - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU), unless they are the only source of nutrition. Infant formula available over the counter is always excluded.
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.

4. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. (This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.)
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Electric scooters.
   - Exercise equipment and treadmills.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.

- Medical alert systems.
- Motorized beds, non-Hospital beds, comfort beds and mattresses.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Safety equipment.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 13, *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).
   - Sclerotherapy treatment of veins.
   - 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 5, *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 5, *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 5, *Additional Coverage Details*.

16. Congenital Heart Disease surgery that is not received by a Designated Provider.

17. Intracellular micronutrient testing.

18. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

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 care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

2. The following services related to a Gestational Carrier or Surrogate:

   - All costs related to reproductive techniques including:
     Assistive reproductive technology.
     Artificial insemination.
     Intrauterine insemination.
     Obtaining and transferring embryo(s).

- Health care services including:
  Inpatient or outpatient prenatal care and/or preventive care.
  Screenings and/or diagnostic testing.
  Delivery and post-natal care.

The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

- All fees including:
  - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
  - Surrogate insurance premiums.
  - Travel or transportation fees.

3. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

   - Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval.
   - Donor sperm – The cost of procurement and storage of donor sperm.

4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

5. The reversal of voluntary sterilization.

6. Fetal reduction surgery.

7. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination except. Termination of pregnancy is ONLY covered if mothers' life is at risk and in the event of incest or rape.

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

8. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 9, *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 5, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving animal organs.

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 5, *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 5, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 13, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 13, *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 5, *Additional Coverage Details*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1.. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

4. Eye exercise or vision therapy.

5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That do not meet the definition of a Covered Health Service in Section 13, *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 5, *Additional Coverage Details*.
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

SECTION 8 - 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 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 People & Culture Services. 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

Except as required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*, you may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a 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 [9][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 13, *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*.

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 and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the IRO within ten business days following the date you receive the IRO's request for the additional information. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

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 agrees with UnitedHealthcare's determination, 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

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
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
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 9 - COORDINATION OF BENEFITS (COB)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The Secondary Plan may determine its benefits based on the benefits paid by the Primary Plan. How much this Plan will reimburse you, if anything, will also depend in part on the Allowable Expense. The term, "Allowable Expense," is further explained below.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** 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.
- **Secondary Plan.** 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. Allowable Expense is defined below.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. 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.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits 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][Plan] year is the Primary Plan; or
      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

   b) For a dependent child whose parents are divorced or separated or are 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. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
      (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.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a) The Plan covering the Custodial Parent.
b) The Plan covering the Custodial Parent's spouse.
c) The Plan covering the non-Custodial Parent.
d) The Plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **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 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 C.1. can determine the order of benefits.

4. **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 C.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. 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.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary to any plan other than Medicare, 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 applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the Allowable Expense.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is an Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the Primary Plan and this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a network provider for the Primary Plan and a non-Network provider for this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a non-Network provider for the Primary Plan and a Network provider for this Plan, the Allowable Expense is the reasonable and customary charges allowed by the Primary Plan. When the provider is a non-Network provider for both the Primary Plan and this Plan, the Allowable Expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare".

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).

- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will treat the provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

If this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Services by following the steps below.

- The Plan determines the amount it would have paid had it been the only plan involved.
- 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.

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 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. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of 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 you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 10 - 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 11 - 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.
- 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.
- 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, the Company has the right to demand that you pay back all Benefits the Company 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 People & Culture Services 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 People & Culture Services 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.

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 12 - 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 Claims Administrator has agreements in place that govern the relationships between it and the Company and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

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 are not responsible 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.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("*ERISA*"), *29 U.S.C. §1001 et seq.*, the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in *ERISA*. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor.*

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 do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums 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 including Claims Administrator's affiliates that provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

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.

- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments 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 receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in your *Plan Highlights*.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 6, *Clinical Programs and Resources*.

Rebates and Other Payments

The Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Company and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) is the official plan document that has been adopted by the Company. There is no other document that controls the benefits under the Plan.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for

any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

SECTION 13 - 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.

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance helicopter or airplane as defined in *42 CFR 414.605*.

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.

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network Physician when no other Network Physician is available.

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 4, *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.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the charge, stated as a percentage of Eligible Expenses or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*[1] *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 2, *How the Plan Works* and Section 14, *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 4, Plan Highlights and Section 5, Additional Coverage Details.
- Provided to a Covered Person who meets the Plan's eligibility requirements.
- Not identified in Section 7, *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 your ID card. This information is available to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Covered Person - either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan.

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 4, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.
- They must be financially interdependent.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by People & Culture Services upon your request.

The Participant and Domestic Partner must jointly register their domestic partnership with either Denver or Boulder in order to add the Domestic Partner onto Benefits (an affidavit will not be accepted). The following requirements apply for each:

Denver

Committed Partnership Registry

The City and County of Denver allows couples who are not married to recognize their commitment through the Committed Partnership Registry.

The Registry is open to any two partners who:

- Are unmarried, eighteen years of age or older, and competent to enter into a contract;

- Are not prohibited from marrying each other under the law of this state by reason of a blood relationship or other comparable domestic partnership;
- Are sharing a common household; and
- Do not already have different partners under the provisions of the Denver Committed Partnership Ordinance, the Colorado Civil Unions Act or any other comparable domestic partnership provision.

Boulder

Who are Domestic Partners:

Domestic Partners are two people who have signed an affidavit swearing that they are:

- Are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship;
- Are each other's sole domestic partner;
- Are both at least 18 years of age and competent to contract;
- Share a life and home together;
- Are not related by kinship closer than would bar marriage in the State of Colorado; and
- Are not married.

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator'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 the Claims Administrator accepts.

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 – with respect to an Emergency:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
    a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

e. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

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 5, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 5, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the

Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Gender Dysphoria - A disorder characterized by the diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

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.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

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 treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health.

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 - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator - the organization or individual designated by the Plan Administrator who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. 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 4, *Plan Highlights* to determine whether or not your Benefit plan offers Network Benefits and Section 2, *How the Plan Works*, for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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 4, *Plan Highlights* to determine whether or not your Benefit plan offers Non-Network Benefits and Section 2, *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 4, *Plan Highlights* for the

Out-of-Pocket Maximum amount. See Section 2, *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. A Participant must live and/or work in the United States.

Personal Health Support - 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.

Pharmaceutical Product(s) – *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The Adams County Government Choice Health Benefit Plan.

Plan Administrator - Adams County Government or its designee.

Plan Sponsor - Adams County Government, references to "we", "us" and "our" refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- 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.

Recognized Amount – the amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee - an Employee under the age of 65 who meets the retirement eligibility rules as defined by Adams County policy guidelines. Retirees over 65 years of age actively enrolled in Medicare are not eligible for coverage.

Secretary – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*.

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.

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.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg and is therefore biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

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 Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, 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 stable and safe housing and the opportunity to learn how to manage 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 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 14 - 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 13, *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 8, *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[1,2,3] **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[1,2,3] 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.

[3]Covered Persons cost share on covered insulin products cannot exceed $100 per 31 day supply or $300 per 90 day supply per perscription.

Note: The Coordination of Benefits provision described in Section 9, *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 8, *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 8, *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 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 included on the PDL, including those drugs that you purchase prior to meeting any applicable deductible. As determined by UnitedHealthcare, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug* section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 7, *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 14, *Outpatient Prescription Drugs*) portion of the Plan.

   This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. Available over-the-counter medications that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician.

   - Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent.
   - Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement.

   Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

5. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product.

6. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.

7. Prescription Drug Products dispensed outside of the United States, except in an Emergency.

8. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *SPD*. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

9. Certain Prescription Drug Products for tobacco cessation.

10. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

11. The amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

12. The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

13. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

14. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee.

15. Prescribed, dispensed or intended for use during an Inpatient Stay.

16. Prescribed, dispensed for appetite suppression, and other weight loss products.

17. Prescribed to treat infertility.

18. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that UnitedHealthcare and the Company determines do not meet the definition of a Covered Health Service.

19. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

20. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

22. Certain 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 13, *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. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

31. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

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 including continuous glucose monitors.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- Certain injectable medications administered in a Network Pharmacy.

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(PPACA Zero Cost Share) - 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.

For the purposes of this definition PPACA means Patient Protection and Affordable Care Act of 2010.

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 15 - 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 – 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.

You 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 II– 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 հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏫ ᏰᎵ ᏗᏟᏃᎮᏗ ᏗᏎᏍᏗ ᏥᎪᏜᎳ ᎢᏓ ᏣᏤᎵ ᏙᎯ ᏰᎡ ᏗᎫᎪᏙᏗ ᎪᏟᏍᏙᏗ ᏆᎾᏂᏍᏗᎢ, ᏧᏐᏅᏍᏓ 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 y<u>a</u>, apela micha nana aiimma yvt nan aivlli keyu h<u>o</u> ish isha hinla kvt chim aiivlhpesa. Tosholi y<u>a</u> asilhha ch<u>i</u> hokmvt ch<u>i</u> achukm<u>a</u>ka holisso kallo iskitini y<u>a</u> tvli aianumpuli holhtena y<u>a</u> ibai achvffa yvt peh pila h<u>o</u> ish <u>i</u> p<u>a</u>ya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kama‘ilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n’efu n’akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၣ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒၣ်နဝဲလၢတလိၣ်ဟ့ၣ်အပှ့ၤဘၣ်နူ့ၣ်လီၤ.လၢတၢ်ကယ့န့ၢ်ပှၤကတိၤကျိၤထံတၢ်တဂၤအဂီၢ်ကိးဘၣ်လီတဲစိအကျိၤလၢကရၢဖိအတလိၣ်ဟ့ၣ်အပှ့ၤလၢအအိၣ်လၢနတၢ်အိၣ်ဆူၣ်အိၣ်ချ့အတၢ်ရဲၣ်တၢ်ကျဲ အကားအလိၤဒီးဆိၣ်လီၤနီၢ်ဂံၢ် 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 پێناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ąh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77

Language	Translated Taglines
	bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíilchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ਼ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-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

Language	Translated Taglines
	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	ܐܚܬܘܢ ܐܝܬܠܘܟܘܢ ܢܡܘܣܐ ܕܩܒܠܬܘܢ ܗܝܪܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܓܢܐܝܬ ܠܡܫܐܠܬܐ ܡܢ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܬܠܝܦܘܢ ܕܐܝܠܗ ܡܛܒܥܐ ܥܠ ܦܬܩܐ ܕܚܘܠܡܢܐ ܘܕܘܫ 0 .TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non

Language	Translated Taglines
	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

Summary Plan Description

Adams County Government
Choice Plus Plan with Health Savings Account

Effective: January 1, 2022
Group Number: 701043

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorder Administrator: 1-800-847-2744.
- 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:

- 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.

Additional information including eligibility criteria is available under the County of Adams Comprehensive Health and Welfare Benefit Plan ("Plan")

The Plan Administrator intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. The Plan Administrator is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Adams County Government Choice Plus Health Benefit Plan works. If you have questions contact People & Culture Services or call the number on 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 People and Culture Services.
- Capitalized words in the SPD have special meanings and are defined in Section 13, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 13, *Glossary*.
- The Plan Administrator is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries provided to you, this SPD will control.

SECTION 2 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive 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.

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.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security*

Act), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

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. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

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. However, if you are currently receiving treatment for Covered Health Services from a provider whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

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 the Claims Administrator the 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 the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.
- For Non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.
  - For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
  - For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

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 our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act* with respect to a visit as defined by the Secretary, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act)*, an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Services provided by a non-Network provider**, the Eligible **Expense** is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expense are determined as follows: an amount negotiated by the Claims Administrator, a specific amount required by law (when required by law), or an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment, and deductible) is yours.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the Eligible Expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Employees (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

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, or the Recognized Amount when applicable,you must pay each calendar year for some Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following will never apply to the Out-of-Pocket Maximum:

- Charges for Non-Covered Health Services.
- The amount of any reduced benefits if you don’t notify the Claims Administrator.
- Charges that exceed eligible expenses.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying Personal Health Support	No	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable.	No	No

SECTION 3 - PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services for which you need to contact Personal Health Support.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support 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 Personal Health Support Nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

Personal Health Support 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 Personal Health Support 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 Personal Health Support program includes:

- **Admission counseling** – Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If you are hospitalized, a Personal Health Support 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 Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support 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 Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.

- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Contacting UnitedHealthcare or Personal Health Support is easy.
Simply call the number on your ID card.

Network providers are responsible for notifying the Claims Administrator before they provide certain services to you.

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 9, *Coordination of Benefits (COB)*. You are not required to provide notification before receiving Covered Health Services.

SECTION 4 - PLAN HIGHLIGHTS

What this section includes:
- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network Amounts	Non-Network Amounts
Annual Deductible		
■ Individual.	$1,400	$2,100
■ Family (not to exceed the Individual amount for all Covered Persons in a family).	$2,800	$4,200
Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.		
The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 14, *Outpatient Prescription Drugs*.		

Plan Features	Network Amounts	Non-Network Amounts
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. **Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum. The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 14, *Outpatient Prescription Drugs*.	 $6,550 $7,900	 $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 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 5, *Additional Coverage Details*.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 14, *Glossary*.

Covered Health Services[1]	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***	
	Network	**Non-Network**
Ambulance Services	*Ground and/or Air Ambulance*	*Ground and/or Air Ambulance*
■ Emergency Ambulance.	80% after you meet the Annual Deductible	Same as Network
■ Non-Emergency Ambulance. Ground or Air Ambulance, as the Claims Administrator determines appropriate. Eligible Expenses for Air Ambulance transport provided by a non-Network provider will be determined as described in Section 3, *How the Plan Works*.	80% after you meet the Annual Deductible	Same as Network
Cellular and Gene Therapy Services must be received at a Designated Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Non-Network Benefits are not available
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers	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)*	
	Network	**Non-Network**
Congenital Heart Disease (CHD) Surgeries See *Congenital Heart Disease (CHD) Surgeries* in Section 5, *Additional Coverage Details*, for additional details.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible	Same as Network
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	
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 14, *Outpatient Prescription Drugs*.	
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% 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 Coinsurance and/or deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described	80% after you meet the Annual Deductible	Same as Network

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
under *Eligible Expenses* in Section 3: *How the Plan Works*.		
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 14, *Outpatient Prescription Drugs*.	
Hearing Aids See Section 5, Additional Coverage Details, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Home Health Care See Section 5, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Hospice Care See Section 5, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient		
■ Lab testing - Outpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ X-ray and Other Diagnostic Testing - Outpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ PSA Screenings	100%	50% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Mental Health Services		
■ Inpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Outpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
	80% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible	50% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
■ Virtual Behavioral Health Therapy and Coaching	**Designated Network (AbleTo Therapy 360)** 100% after you meet the Annual Deductible; Benefits for the Initial Consultation will be paid at 100%	Non-Network Benefits are not available.
Neurobiological Disorders - Autism Spectrum Disorder Services		
■ Inpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Outpatient.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
	80% for Partial Hospitalization/Intensive Outpatient Treatment after you	50% for Partial Hospitalization/Intensive Outpatient Treatment after you

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
	meet the Annual Deductible	meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 3, *How the Plan Works*, under *Eligible Expenses*.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Service category in this section.	
Preventive Care Services ■ Physician Office Services. ■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps.	100% 100% 100%	Non-Network Benefits are not available
Prosthetic Devices See Section 5, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-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 5, *Additional Coverage Details*, for visit limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 5, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services ■ Inpatient. ■ Outpatient.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible 80% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible	50% after you meet the Annual Deductible 50% after you meet the Annual Deductible 50% for Partial Hospitalization/Intensive Outpatient Treatment after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Transplantation Services	80% after you meet the Annual Deductible	Non-Network Benefits are not available
Travel and Lodging Covered Health Services must be received by a Designated Provider.	For patient and companion(s) of patient undergoing transplant procedures	
Urgent Care Center Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Virtual Care Services Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible	Non-Network Benefits are not available
Vision Examinations See Section 5, Additional Coverage Details, for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

[1]Please notify the Claims Administrator before receiving Covered Health Services, as described in Section 5, *Additional Coverage Details*.

SECTION 5 - 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 Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call the Claims Administrator or Personal Health Support.

This section supplements the second table in Section 4, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call the Claims Administrator or Personal Health Support. 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 7, *Exclusions and Limitations*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

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 13, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers non-Emergency transportation provided by a licensed professional ambulance (either ground or Air Ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Non-Network Benefits, if you are requesting non-Emergency Air Ambulance services, (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must provide pre-service notification as soon as possible before transport.

If you do not provide notification as required, Benefits will be reduced to 50% of Eligible Expenses.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Clinical Trials

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.

For Non-Network Benefits you must provide pre-service notification as soon as the possibility of participation in a Clinical Trial arises. If you do not provide notification as required, BenefitsBenefits 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).

For Non-Network Benefits you must provide pre-service notification as soon as the possibility of a CHD surgery arises. If you do not provide notification as required, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

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 14, *Outpatient Prescription Drugs*.

For Non-Network Benefits, you must provide pre-service notification before obtaining any DME for the management and treatment of diabetes that cost more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not provide notification as required, Benefits will be reduced to 50% of Eligible Expenses.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen.
- Equipment to assist mobility, such as a standard wheelchair.
- Hospital beds.
- Delivery pumps for tube feedings.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.

- Orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include dedicated speech generating 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 these 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 dedicated speech generating 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.

For Non-Network Benefits, you must provide pre-service notification before obtaining any DME or orthotic that cost more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, 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 one business day 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 2, *How the Plan Works*.

Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

Please remember for Non-Network Benefits, you must notify the Claims Administrator within one business day of the admission or on the same day of admission if reasonably possible if you are admitted to a non-Network Hospital as a result 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 14, *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:
  - Bilateral mastectomy or breast reduction
  - Clitoroplasty (creation of clitoris)
  - Hysterectomy (removal of uterus)
  - Labiaplasty (creation of labia)
  - Metoidioplasty (creation of penis, using clitoris)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Breast Construction

- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of urethra)
- Vaginectomy (removal of vagina)
- Vaginoplasty (creation 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: For Non-Network Benefits you must notify the Claims Administrator as soon as the possibility for any of surgery arises.

If you do not provide notification as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay.

It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

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.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to $3,500 per calendar year and limited to a single purchase (including repair/replacement) per hearing impaired ear every 3 calendar years for Covered Persons over age 19.

Benefits are unlimited to age 19.

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 13, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 13, *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.

For Non-Network Benefits, you must provide pre-service notification 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.

For Non-Network Benefits, you must notify provide pre-service notification five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible.. If you do not provide notification as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must notify the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

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.

For Non-Network Benefits for a scheduled admission, you must provide pre-service notification five business days before admission, or as soon as reasonably possible for a non-scheduled admission (including Emergency admissions).

If you do not provide notification as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

For Non-Network Benefits for Genetic Testing and sleep studies, you must provide pre-service notification five business days before scheduled services are received. If you do not provide pre-service notification as required, 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.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

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.

For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility and Partial Hospitalization/Day Treatment), you must provide pre-service notification five business days before admission or as soon as is reasonably possible for a non-scheduled admission (including Emergency admissions).

In addition, for Non-Network Benefits you must provide pre-service 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, with or without medication management.

Please call the number that appears on your ID card. If you do not provide notification as required, Benefits will be reduced to 50% of Eligible Expenses.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo Therapy 360, Inc. ("AbleTo Therapy 360") for Covered Persons with certain co-occurring behavioral and medical conditions.

AbleTo Therapy 360 provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Except for the initial consultation, Covered Persons with a high deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no deductibles, Copayments or Coinsurance for the initial consultation.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

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.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

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.

For Non-Network Benefits for a scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility and Partial Hospitalization/Day Treatment), you must provide pre-service notification five business days before admission or as soon as is reasonably possible for a non-scheduled admission (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; psychological testing; extended outpatient treatment visits, with or without medication management. Pre-service notification is also required for Benefits provided for Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

Please call the phone number that appears on your ID card. If you do not provide notification as required, Benefits will be reduced to 50% of Eligible Expenses.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

Please 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.

For Non-Network Benefits, you must provide notification as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not provide notification as required, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 6, *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 4, *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 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 provide pre-service notification before obtaining prosthetic devices that exceed $1,000 in cost per device. If you do not provide notification as required, 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 13, *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.

For Non-Network Benefits you must provide pre-service notification 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 you do not provide notification as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

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.

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 13, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 60 days per calendar year.

For Non-Network Benefits, you must provide pre-service notification five business days before admission, or as soon as is reasonably possible for non-scheduled admissions.

If you do not provide notification as required, Benefits will be reduced to 50% of Eligible Expenses.
In addition, for Non-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

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.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

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.

For Non-Network Benefits for a scheduled admission for Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility and Partial Hospitalization/Day Treatment you must provide pre-service notification five business days before admission or as soon as is reasonably possible for a non-scheduled admission (including Emergency admissions).

In addition, for Non-Network Benefits you must provide notification before the following services are received. Services requiring advance notification: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management; medication assisted treatment programs for substance-related and addictive disorders.

Please call the phone number that appears on your ID card. If you do not provide notification as required, 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 sleep apnea surgery you must provide pre-service notification 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 you do not provide notification as required, 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 provide pre-service notification for the following outpatient therapeutic services 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, intensity modulated radiation therapy and MR-guided focused ultrasound.
If you do not provide notification as required, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received by a Designated Provider.

Benefits are also available for cornea transplants. You are not required to notify the Claims Administrator or Personal Health Support 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.

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.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 13, *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 Care Services

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, 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 contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video-conferencing or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Vision Examinations

The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a Network provider in the provider's office or outpatient facility every other calendar year. Benefits are limited to children up to age 18 only.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

SECTION 6 – CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools.
- Disease Management Services.
- Complex Medical Conditions Programs and Services.
- Wellness Programs.
- Women's Health/Reproductive.

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.

If you need any assistance with the online survey, please call the number on your ID card.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- Mammograms for women.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access to health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.
- Information on providers and programs.

Conditions for which this program is available include:

- Back pain.
- Knee & hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.
- Breast cancer.
- Coronary disease.

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.
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered on **www.myuhc.com**, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information, including Annual Deductibles.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for Behavioral Health.

The program is provided through AbleTo Therapy 360, Inc. Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Disease Management Services

Disease Management Services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - Education about the specific disease and condition.
  - Medication management and compliance.
  - Reinforcement of on-line behavior modification program goals.
  - Preparation and support for upcoming Physician visits.
  - Review of psychosocial services and community resources.
  - Caregiver status and in-home safety.
  - Use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Comprehensive Kidney Solution (CKS) program

For participants diagnosed with Kidney Disease, your Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a "best practices" approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS of your decision.

Kidney Resource Services (KRS) program
End-Stage Renal Disease (ESRD)

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the *Travel and Lodging Assistance Program*, refer to the provision below.

Travel and Lodging Assistance Program

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 the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offers a lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem, 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.

Women's Health/Reproductive

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Neonatal Resource Services (NRS)

NRS is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant's admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant's needs.

To take part in the NRS program you or a covered Dependent can call the Claims Administrator at the telephone number on your ID card or call NRS directly at 1-866-534-7209.

SECTION 7 - 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 5, *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 5, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 4, *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 4, *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, animal-assisted 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 5, *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 5, *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 5, *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 5, *Additional Coverage Details*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 5, *Additional Coverage Details*. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria.

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. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

4. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.

5. The replacement of lost or stolen prosthetic devices.

6. Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details*.

7. Oral appliances for snoring.

8. Powered and non-powered exoskeleton devices.

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 14, *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-administered or self-infused 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. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 5, *Additional Coverage Details*.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

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 13, *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 5, *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 5, *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 5, *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 5, *Additional Coverage Details*.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 5, *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 5, *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 7, *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 5, Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorder.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living Services.

8. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.

9. Non-Medical 24-Hour Withdrawal Management.

10. High intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

   - Nutritional education is required for a disease in which patient self-management is a part of treatment.
   - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

3. Food of any kind. Foods that are not covered include:

   - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU), unless they are the only source of nutrition. Infant formula available over the counter is always excluded.
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.

4. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. (This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.)
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Electric scooters.
   - Exercise equipment and treadmills.
   - Hot tubs.

- Humidifiers.
- Jacuzzis.
- Medical alert systems.
- Motorized beds, non-Hospital beds, comfort beds and mattresses.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Safety equipment.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 13, *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).
   - Sclerotherapy treatment of veins.
   - 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 5, *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 5, *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 5, *Additional Coverage Details*.

16. Congenital Heart Disease surgery that is not received by a Designated Provider.

17. Intracellular micronutrient testing.

18. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

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 care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

2. The following services related to a Gestational Carrier or Surrogate:

   - All costs related to reproductive techniques including:
     Assistive reproductive technology.
     Artificial insemination.
     Intrauterine insemination.

Obtaining and transferring embryo(s).
- Health care services including:
  Inpatient or outpatient prenatal care and/or preventive care.
  Screenings and/or diagnostic testing.
  Delivery and post-natal care.

The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

- All fees including:
  - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
  - Surrogate insurance premiums.
  - Travel or transportation fees.

3. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

   - Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval.
   - Donor sperm – The cost of procurement and storage of donor sperm.

4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

5. The reversal of voluntary sterilization.

6. Fetal reduction surgery.

7. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination except. Termination of pregnancy is ONLY covered if mothers' life is at risk and in the event of incest or rape.

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

8. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 9, *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 5, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving animal organs.

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 5, *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 5, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 13, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 13, *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 5, *Additional Coverage Details*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3. Bone anchored hearing aids except when either of the following applies:

   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.
4. Eye exercise or vision therapy.

5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That do not meet the definition of a Covered Health Service in Section 13, *Glossary*.

- That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
- That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
- For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
- That exceed Eligible Expenses or any specified limitation in this SPD.
- For which a non-Network provider waives the Annual Deductible or Coinsurance amounts.

6. Foreign language and sign language services.

7. Long term (more than 30 days) storage of blood, umbilical cord or other material.

8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details*.
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

SECTION 8 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on 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 People & Culture Services. 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

Except as required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*, you may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a 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 [9][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 13, *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.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

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 their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

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 and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the IRO within ten business days following the date you receive the IRO's request for the additional information. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

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 agrees with UnitedHealthcare's determination, 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

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
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

*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 9 - COORDINATION OF BENEFITS (COB)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The Secondary Plan may determine its benefits based on the benefits paid by the Primary Plan. How much this Plan will reimburse you, if anything, will also depend in part on the Allowable Expense. The term, "Allowable Expense," is further explained below.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** 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.
- **Secondary Plan.** 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. Allowable Expense is defined below.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. 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.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits 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][Plan] year is the Primary Plan; or
      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

   b) For a dependent child whose parents are divorced or separated or are 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. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
      (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.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a) The Plan covering the Custodial Parent.
b) The Plan covering the Custodial Parent's spouse.
c) The Plan covering the non-Custodial Parent.
d) The Plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **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 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 C.1. can determine the order of benefits.

4. **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 C.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. 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.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary to any plan other than Medicare, 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 applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the Allowable Expense.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is an Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the Primary Plan and this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a network provider for the Primary Plan and a non-Network provider for this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a non-Network provider for the Primary Plan and a Network provider for this Plan, the Allowable Expense is the reasonable and customary charges allowed by the Primary Plan. When the provider is a non-Network provider for both the Primary Plan and this Plan, the Allowable Expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare".

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).

- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will treat the provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

If this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Services by following the steps below.

- The Plan determines the amount it would have paid had it been the only plan involved.
- 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.

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 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. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of 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 you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 10 - 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 11 - 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.
- 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.
- 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 People & Culture Services 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 People & Culture Services 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.

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 12 - 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 Claims Administrator has agreements in place that govern the relationships between it and the Company and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

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 are not responsible 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.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("*ERISA*"), *29 U.S.C. §1001 et seq.*, the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in *ERISA*. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- Must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Company is that of employer and employee, Dependent or other classification as defined in the SPD.

Interpretation of Benefits

The Company and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums 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 including Claims Administrator's affiliates that provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

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.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The

applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments 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 receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in your *Plan Highlights*.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 6, *Clinical Programs and Resources*.

Rebates and Other Payments

The Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Company and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) is the official plan document that has been adopted by the Company. There is no other document that controls the benefits under the Plan.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

SECTION 13 - 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.

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance helicopter or airplane as defined in *42 CFR 414.605*.

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.

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network Physician when no other Network Physician is available.

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 4, *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.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the charge, stated as a percentage of Eligible Expenses or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*[1] *and Section 15, Outpatient Prescription Drugs*.

Company - Adams County Government.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).

- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorder Services or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Included in Section 4, Plan Highlights and Section 5, Additional Coverage Details.
- Provided to a Covered Person who meets the Plan's eligibility requirements.
- Not identified in Section 7, *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 your ID card. This information is available to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Covered Person - either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - an individual who meets the eligibility requirements specified in the Plan.

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 has been identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on

UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.
- They must be financially interdependent.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by People and Culture Services upon your request.

The Participant and Domestic Partner must jointly register their domestic partnership with either Denver or Boulder in order to add the Domestic Partner onto Benefits (an affidavit will not be accepted). The following requirements apply for each:

Denver

Committed Partnership Registry

The City and County of Denver allows couples who are not married to recognize their commitment through the Committed Partnership Registry.

The Registry is open to any two partners who:

- Are unmarried, eighteen years of age or older, and competent to enter into a contract;
- Are not prohibited from marrying each other under the law of this state by reason of a blood relationship or other comparable domestic partnership;
- Are sharing a common household; and
- Do not already have different partners under the provisions of the Denver Committed Partnership Ordinance, the Colorado Civil Unions Act or any other comparable domestic partnership provision.

Boulder

Who are Domestic Partners:

Domestic Partners are two people who have signed an affidavit swearing that they are:

- Are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship;
- Are each other's sole domestic partner;
- Are both at least 18 years of age and competent to contract;
- Share a life and home together;
- Are not related by kinship closer than would bar marriage in the State of Colorado; and
- Are not married.

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator'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 the Claims Administrator accepts.

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 – with respect to an Emergency:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
    a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
    b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
    c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
    d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
    e. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

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 5, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 5, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.

- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Gender Dysphoria - A disorder characterized by the diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

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.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

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 treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health.

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 - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator - the organization or individual designated by the Plan Administrator who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. 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 4, *Plan Highlights* to determine whether or not your Benefit plan offers Network Benefits and Section 2, *How the Plan Works*, for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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 4, *Plan Highlights* to determine whether or not your Benefit plan offers Non-Network Benefits and Section 2, *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 4, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 2, *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. A Participant must live and/or work in the United States.

Personal Health Support - 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.

Pharmaceutical Product(s) – *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The Adams County Government Choice Plus Health Benefit Plan.

Plan Administrator - Adams County Government or its designee.

Plan Sponsor - Adams County Government, references to "we", "us" and "our" refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- 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.

Recognized Amount – the amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.

- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee - an Employee under the age of 65 who meets the retirement eligibility rules as defined by Adams County policy guidelines. Retirees over 65 years of age actively enrolled in Medicare are not eligible for coverage.

Secretary – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

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.

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.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

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 Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, 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 stable and safe housing and the opportunity to learn how to manage 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 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 14 - OUTPATIENT PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drug Products.
- How to utilize the retail and mail order service for obtaining Prescription Drug Products.
- Any Benefit limitations and exclusions that exist for Prescription Drug Products.
- Definitions of terms used throughout this section related to the Prescription Drug Product Plan.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List (PDL) the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

What You Must Pay

Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Coinsurance described in the *Payment Information - Outpatient Prescription Drugs* table or *Schedule of Benefits - Outpatient Prescription Drugs*.

Payment Terms and Features - Outpatient Prescription Drugs

Prescription Drug Product Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug Product coverage. It includes Coinsurance amounts that apply when you have a prescription filled at a Network or non-Network Pharmacy after you meet the Annual Deductible. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Note: The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 5, *Additional Coverage Details*. The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 5, *Additional Coverage Details*.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change. As a result, your Coinsurance may change. You will pay the Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare or its designee. The reason for notifying UnitedHealthcare or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 13, *Glossary*.

The Plan may also require you to notify UnitedHealthcare or its designee so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying UnitedHealthcare.

Non-Network Pharmacy Notification

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician, are responsible for notifying UnitedHealthcare as required.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Drug Product order or refill. You will be required to pay for the Prescription Drug Product at the time of purchase. The Prescription Drug Products requiring notification are subject to UnitedHealthcare's periodic review and modification. You may determine whether a particular Prescription Drug Product requires notification through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, you can ask UnitedHealthcare to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. UnitedHealthcare contracted pharmacy reimbursement rates (UnitedHealthcare's Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from the Plan as described in Section 8, *Claims Procedures*.

When you submit a claim on this basis, you may pay more because you did not notify UnitedHealthcare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Coinsurance and any deductible that applies.

To determine if a Prescription Drug Product requires notification, either visit **www.myuhc.com** or call the number on your ID card. The Prescription Drug Products requiring notification are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after UnitedHealthcare reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require notification for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable notification, participation or activation requirements associated with such programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Schedule of Benefits - Outpatient Prescription Drugs

Benefit Information for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy

Covered Health Services[1,2,3,4]	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Out-of-Network Reimbursement Rate Payable by the Plan:
	Network	Non-Network
Retail - up to a 31-day supply		
■ Tier-1	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Tier-2	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
■ Tier-3	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Specialty Prescription Drug Products - As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.		
■ Tier-1	80% after you meet the Annual Deductible	Not Covered

Covered Health Services[1,2,3,4]	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Out-of-Network Reimbursement Rate Payable by the Plan:
	Network	**Non-Network**
■ Tier-2	80% after you meet the Annual Deductible	Not Covered
■ Tier-3	80% after you meet the Annual Deductible	Not Covered
Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a non-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.		
Mail order - up to a 90-day supply		
■ Tier-1	80% after you meet the Annual Deductible	Not Covered
■ Tier-2	80% after you meet the Annual Deductible	Not Covered
■ Tier-3	80% after you meet the Annual Deductible	Not Covered

[1]Please notify UnitedHealthcare before receiving Prescription Drug Products, as described in *Payment Terms and Features*, under *Prior Authorization Requirements* in this section.

[2]The Plan pays Benefits for Specialty Prescription Drug Products as described in this table.

[3]You are not responsible for paying a Coinsurance for Preventive Care Medications. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

[4]Covered Persons cost share on covered insulin products cannot exceed $100 per 31 day supply or $300 per 90 day supply per perscription.

Note: The Coordination of Benefits provision described in Section 9, *Coordination of Benefits (COB)* does not apply to covered Prescription Drug Products as described in this section, except that Benefits for Prescription Drug Products will be coordinated with prescription drug benefits provided under Medicare Parts B and D.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by UnitedHealthcare during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

You may seek reimbursement from the Plan as described in Section 8, *Claims Procedures*, under the heading, *If Your Provider Does Not File Your Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Coinsurance, and any deductible that applies.

Submit your claim to:

Optum Rx
PO Box 29077
Hot Spring, AR 71903

Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drug Products.

All Prescription Drug Products covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the number on your ID card for the most current information.

Each tier is assigned a Coinsurance, which is the amount you pay after you have met the Annual Deductible, when you visit the pharmacy or order your medications through mail order. Your Coinsurance will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Coinsurance option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Coinsurance option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Coinsurance option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

Coinsurance for a Prescription Drug at a Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug at a non-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of:

- The applicable Coinsurance.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug.
- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- The applicable Coinsurance.
- The Prescription Drug Charge for that particular Prescription Drug.

Retail

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy. The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the number on your ID card or by logging onto **www.myuhc.com**.

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy. If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with UnitedHealthcare, as described in your SPD, *Section 8, Claims Procedures*. The Plan will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. The Plan will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Coinsurance, after meeting the Annual Deductible. The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Coinsurance for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Coinsurance that applies will reflect the number of days dispensed.

If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The mail order service may allow you to purchase up to a 90-day supply of a covered Prescription Drug Product through the mail.

To use the mail order service, all you need to do is complete a patient profile and enclose your Prescription Order or Refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the number on your ID card.

The following supply limits apply: As written by the provider, up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged the mail order Coinsurance for any Prescription Order or Refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined, in this section, under *Glossary - Prescription Drug Products*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the number on your ID card.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom UnitedHealthcare has an arrangement to provide those Specialty Prescription Drug Products. You may fill a prescription for Specialty Prescription Drug Products up to two times at any Pharmacy. However, after that you will be directed to a Designated Pharmacy.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.

Please see *Glossary - Outpatient Prescription Drugs*, for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Please see *Glossary - Outpatient Prescription Drugs*, in this section for definitions of Specialty Prescription Drug Product and Designated Pharmacy.

Want to lower your out-of-pocket Prescription Drug Product costs?
Consider tier-1 Prescription Drug Products, if you and your Physician decide they are appropriate.

Assigning Prescription Drug Products to the Prescription Drug List (PDL)

UnitedHealthcare's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on UnitedHealthcare's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access **www.myuhc.com** through the Internet or call the number on your ID card for the most up-to-date tier status.

Prescription Drug Product, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)
The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Benefit.

Prescription Drug Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 8, *Claims Procedures*.

Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, UnitedHealthcare may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits that are stated in the table under the heading *Prescription Drug Product Coverage Highlights*. For a single Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing, through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Special Programs

Adams County Government and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on 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 Adams County Government may, at times, receive rebates for certain drugs included on the PDL, including those drugs that you purchase prior to meeting any applicable deductible. As determined by UnitedHealthcare, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Coinsurance.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug* section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 7, *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 14, *Outpatient Prescription Drugs*) portion of the Plan.

   This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. Available over-the-counter medications that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

5. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned

to Tier 3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product.

6. Prescription Drug Products dispensed outside of the United States, except in an Emergency.

7. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *SPD*. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

8. Certain Prescription Drug Products for tobacco cessation.

9. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

10. The amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

11. The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

12. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

13. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee.

14. Prescribed, dispensed or intended for use during an Inpatient Stay.

15. Prescribed, dispensed for appetite suppression, and other weight loss products.

16. Prescribed to treat infertility.

17. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that UnitedHealthcare determines do not meet the definition of a Covered Health Service.

18. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

19. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

20. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain unit dose packaging or repackagers of Prescription Drug Products.

22. Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Adams County Government have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 13, *Glossary*.

23. Used for cosmetic purposes

24. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

25. General vitamins, except for the following which require a Prescription Order or Refill:

    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.

26. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury.

27. A Prescription Drug Product that contains marijuana, including medical marijuana.

28. 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.

29. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

30. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Glossary - Outpatient Prescription Drugs

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that UnitedHealthcare identifies as a Brand-name product, based on available data resources including, but not limited to, medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that UnitedHealthcare identifies as a Generic product based on available data resources including, but not limited to, medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with UnitedHealthcare or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by UnitedHealthcare as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by UnitedHealthcare's Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

Out-of-Network Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax.

Prescription Drug Charge - the rate the Plan has agreed to pay UnitedHealthcare on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration*. This list is subject to UnitedHealthcare's periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting UnitedHealthcare at the number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Glucose meters including continuous glucose monitors.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- Certain injectable medications administered in a Network Pharmacy.

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 (PPACA Zero Cost Share) - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Coinsurance or 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.

For the purposes of this definition PPACA means Patient Protection and Affordable Care Act of 2010.

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 15 - 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 SAVINGS ACCOUNT

What this attachment includes:

- About Health Savings Accounts.
- Who is eligible and how to enroll.
- Contributions.
- Additional medical expense coverage available with your Health Savings Account.
- Using the HSA for Non-Qualified Expenses.
- Rolling over funds in your HSA.

Introduction

This attachment to the Summary Plan Description (SPD) describes some key features of the Health Savings Account (HSA) that you could establish to complement the Adams County Government health benefit Plan, which is a high deductible medical plan. In particular, and except as otherwise indicated, this attachment will address the Health Savings Account, and not the high deductible health plan that is associated with the "HSA".

Adams County Government has entered into an agreement with United Healthcare Services, Inc., Minnetonka, MN, ("UnitedHealthcare") under which UnitedHealthcare will provide certain administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this attachment. Further, note that it is the Plan's intention to comply with *Department of Labor* guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

The HSA described in this section is not an arrangement that is established and maintained by Adams County Government. Rather, the HSA is established and maintained by the HSA trustee. However, for administrative convenience, a description of the HSA is provided in this section.

About Health Savings Accounts

You gain choice and control over your health care decisions and expenditures when you establish your HSA to complement the high deductible medical plan described in the SPD.

An HSA is an account funded by you, your employer, or any other person on your behalf. The HSA can help you to cover, on a tax free basis, medical plan expenses that require you to pay out-of-pocket, such as Deductibles, Copayments or Coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses, however, these amounts are subject to income tax and may be subject to 20% penalty.

You have three tools you can use to meet your health care needs:

- Adams County Government health benefit Plan, a high deductible medical plan which is discussed in your Summary Plan Description.
- An HSA you establish.
- Health information, tools and support.

Benefits available under your medical plan are described in your medical plan Summary Plan Description (SPD).

What is an HSA?
An HSA is a tax-advantaged account Participants can use to pay for qualified health expenses they or their eligible dependents incur, while covered under a high deductible medical plan. HSA contributions:

- Accumulate over time with interest or investment earnings.
- Are portable after employment.
- Can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

Who Is Eligible And How To Enroll

Eligibility to participate in the Health Savings Account is described in the SPD for your high deductible medical plan. You must be covered under a high deductible medical plan in order to participate in the HSA. In addition, you:

- Must not be covered by any high deductible medical plan considered non-qualified by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.)
- Must not participate in a full health care Flexible Spending Account (FSA).
- Must not be entitled to Benefits under Medicare (i.e., enrolled in Medicare).
- Must not be claimed as a dependent on another person's tax return.

Contributions

Contributions to your HSA can be made by you, by your employer or by any other individual. All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee.

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum.

Note that if coverage under a qualified high deductible health plan terminates, no further contributions may be made to the HSA.

The contribution maximum is the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds monthly to their HSA up to the maximum allowed by federal regulations. The maximum limits set by federal regulations may be found on the IRS website at www.irs.gov.

If you enroll in your HSA within the year (not on January 1) you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and HSA until the end of the 12th month from your initial enrollment or you will be subject to tax implications and an additional tax of 10%.

Note: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year.

Reimbursable Expenses

The funds in your HSA will be available to help you pay your or your eligible dependents' out-of-pocket costs under the medical plan, including Annual Deductibles, Copayments and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". Please see the description of *Additional Medical Expense Coverage Available With Your Health Savings Account* below, for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the medical expenses of you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

HSA funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

Additional Medical Expense Coverage Available with Your Health Savings Account

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services and you have funds in your HSA, you may use the funds in your HSA to pay for the medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your Annual Deductible or Out-of-Pocket Maximum.

Using the HSA for Non-Qualified Expenses

You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for COBRA premiums and Medicare premiums.

Rollover Feature

If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will roll-over. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the accompanying high deductible health plan, as described in your medical plan SPD.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

Important
Be sure to keep your receipts and medical records. If these records verify that you paid qualified health expenses using your HSA, you can deduct these expenses from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. Adams County Government and UnitedHealthcare will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. Adams County Government and the Claims Administrator are not responsible or liable for the misuse by Participants of HSA funds by, or for the use by Participants of HSA funds for non-qualified health expenses.

Additional Information About the HSA

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, UnitedHealthcare and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will UnitedHealthcare provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this

information disclosed, you must notify the Claims Administrator and the financial institution in writing.

You can obtain additional information on your HSA online at www.irs.gov. You may also contact your tax advisor. Please note that additional rules may apply to a Dependent's intent to opening an HSA.

ATTACHMENT II – 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.

You 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 III – 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 স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏯ ᏰᎵ ᏧᏟᏃᏢᏗ ᏧᏎᏍᏗ ᏥᎪᏪᎳ ᎥᏋ ᏣᏤᎵ ᏙᎯ ᏰᏒ ᏗᏗᎪᏙᏗ ᎠᏟᏍᏙᏗ ᏆᎾᏂᏍᏗᎢ, ᏅᏐᏅᏍᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, ૦ દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	နအိဉ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘဉ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒဉ်နဝဲလၢတလိဉ်ဟ့ဉ်အပှ့ၤဘဉ်နူဉ်လီၤ.လၢတၢ်ကယ့န့ၢ်ပှၤကတိၤကျိးထံတၢ်တဂၤအဂီၢ်ကိးဘဉ်လီတဲစိအကျိၤလၢကရၢဖိအတလိဉ်ဟ့ဉ်အပှ့ၤလၢအအိဉ်လၢနတၢ်အိဉ်ဆူဉ်အိဉ်ချ့အတၢ်ရဲဉ်တၢ်ကျ အကးအလိၤဒီးဆိဉ်လီၤနီၢ်ဂံၢ် 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,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ąh '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

Language	Translated Taglines
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟੋਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-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

Language	Translated Taglines
	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	ܐܢܬܘܢ ܐܝܬܠܘܟܘܢ ܢܡܘܣܘܬܐ ܕܡܩܒܠܝܬܘܢ ܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܓܢܢܐܝܬ ܠܡܫܟܚܬܐ ܕܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܡܓܢܢܐ ܕܐܝܬܠܗ ܥܠ ܒܛܩܐ ܐܝܟ ܦܬܩܐ ܕܣܘܠܚܢܐ ܘܟܒܘܫ 0. TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు స మాచార పొందడానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta'etotongi ma'ae kau memipa 'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non

Language	Translated Taglines
	kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן קארטל , דרוקט 0. TTY 711 ID
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Approving a Memorandum of Understanding between Adams County and Colorado Coalition for the Homeless
FROM: Jenni Hall, Community & Economic Development Director
AGENCY/DEPARTMENT: Community & Economic Development
HEARD AT STUDY SESSION ON: September 13, 2022
RECOMMENDED ACTION: That the Board of County Commissioners approve the attached Memorandum of Understanding between Adams County and Colorado Coalition for the Homeless

BACKGROUND:
Colorado Coalition for the Homeless (CCH) approached Adams County with interest in applying for Adams County's American Rescue Plan Act (ARPA) State and Local Fiscal Recovery Funds (SLFRF) for the acquisition and rehabilitation of the Clarion hotel, located at 200 West 48th Avenue, Denver, CO 80216, for transitional and permanent supportive housing. The project was discussed at a high level with the Board of County Commissioners at the September 13, 2022, Study Session. The Board agreed to allow for CCH to formally apply for Adams County's ARPA SLFRF. The attached Memorandum of Understanding (MOU) provides CCH the opportunity to apply for ARPA SLFRF and to be formally considered for funds through the County's review process. Further, staff is seeking authorization for the Chair to execute the attached MOU.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
County Attorney's Office
Community Safety & Well-Being

ATTACHED DOCUMENTS:
Resolution
Memorandum of Understanding Between Colorado Coalition for the Homeless and Adams County

FISCAL IMPACT:
No

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING A MEMORANDUM OF UNDERSTANDING BETWEEN ADAMS COUNTY AND COLORADO COALITION FOR THE HOMELESS

Resolution 2022-

WHEREAS, the Board of County Commissioners has adopted goals to strengthen quality of life and community enrichment for Adams County residents; and,

WHEREAS, the County has a stated priority to address the need for housing opportunities and homelessness services and prevention and to increase support through funding contributions; and,

WHEREAS, on March 11, 2021, the American Rescue Plan Act ("ARPA") was signed into law and established the Coronavirus State and Local Fiscal Recovery Funds ("SLFRF"); and,

WHEREAS, the County received an allocation of SLFRF from the United States Treasury to support recovery efforts including the ability to provide funding to subrecipients to spend on eligible expenditures under ARPA; and,

WHEREAS, Colorado Coalition for the Homeless ("CCH") seeks to obtain funding for a project to expand transitional housing shelter beds and permanent supportive housing for the Adams County homeless population; and,

WHEREAS, the Board of County Commissioners will allow for CCH to formally apply for ARPA SLFRF for the consideration of a formal commitment through the County's application and review process as outlined in the Memorandum of Understanding.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the Memorandum of Understanding between Adams County and Colorado Coalition for the Homeless be approved.

BE IT FURTHER RESOLVED, that the Chair is authorized to sign the Memorandum of Understanding, upon approval from the County Attorney's Office.

Memorandum of Understanding

THIS MEMORANDUM OF UNDERSTANDING ("MOU") is entered this 22nd day of September, 2022, between Adams County, 4430 S. Adams County Parkway, Brighton, CO 80601, hereinafter referred to as "County," and Colorado Coalition for the Homeless, 2111 Champa Street, Denver, CO 80205, hereinafter referred to as "CCH," collectively referred to as "the Parties."

Recitals

WHEREAS, the Board of County Commissioners have adopted goals to strengthen quality of life and community enrichment for Adams County residents; and,

WHEREAS, the County has a stated priority to address the need for housing and homelessness services and prevention and to increase opportunities to provide homelessness services and housing opportunities through funding contributions; and,

WHEREAS, on March 11, 2021, the American Rescue Plan Act ("ARPA") was signed into law and established the Coronavirus State and Local Fiscal Recovery Funds ("SLFRF"); and,

WHEREAS, the County received an allocation of SLFRF from the United States Treasury to support recovery efforts including the ability to provide funding to subrecipients to spend on eligible expenditures under ARPA; and,

WHEREAS, CCH seeks to obtain funding for a project to expand transitional housing shelter beds and permanent supportive housing for the Adams County homeless population.

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

Terms of the Understanding

1. CCH is working on a project to acquire and rehabilitate the Clarion Hotel (the "Project") located at 200 West 48th Avenue, Denver, CO 80216, with the intent to convert the 215 units at the property for permanent supportive housing and transitional bridge housing to provide a continuum of housing solutions for the community. Although physically located in the City and County of Denver, the Project is expected to serve Adams County residents.
2. The County is supportive of the goals of the Project.
3. CCH will submit an application for ARPA SLFRF to Adams County outlining the details of the Project. The funding amount sought will be $3.8 million.
4. The County will review the ARPA application of CCH in accordance with its usual process.

4. The County will review the ARPA application of CCH in accordance with its usual process. The County will determine whether to provide any amount up to $3.8 million in ARPA SLFRF to CCH for the Project.
5. Should the County decide to award CCH SLFRF, a subrecipient agreement will be required. CCH will be required to follow the federal rules of the SLFRF funding, County policies and procedures, and the subgrantee agreement.
6. This MOU does not constitute an award of funds of any kind and creates no rights or obligations between the Parties.

IN WITNESS WHEREOF, the Parties have caused this MOU to be duly executed on the day, month, and year below.

ADAMS COUNTY:

_____ _____

Chair, Board of County Commissioners Date

Attest:

_____

Deputy Clerk

Approved to Form:

_____

County Attorney's Office

COLORADO COALITION FOR THE HOMELESS

John Parvensky, President & CEO

9-22-22
Date

NOTARIZATION OF SIGNATURE:

COUNTY OF DENVER)

STATE OF COLORADO)SS.

Signed and sworn to before me this 22 day of September, 2022, by John Parvensky, President & CEO of Colorado Coalition for the Homeless.

YVES NATH
Notary Public
State of Colorado
Notary ID # 20224034122
My Commission Expires 08-30-2026

YVES NATH
Notary Public

My commission expires on: August 30, 2026

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Appointing Erika Manuel to the Workforce Development Board as a Business Sector/Healthcare Representative
FROM: Erica Hannah
AGENCY/DEPARTMENT: County Manager's Office
HEARD AT STUDY SESSION ON: September 20, 2022
RECOMMENDED ACTION: That the Board of County Commissioners approves the resolutions for the boards and commissions appointments.

BACKGROUND:
The attached resolutions are to formally approve the appointments to the boards and commissions accordingly.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
None

ATTACHED DOCUMENTS:
Resolution

FISCAL IMPACT:
No

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPOINTING ERIKA MANUEL TO THE WORKFORCE DEVELOPMENT BOARD AS A BUSINESS SECTOR/HEALTHCARE REPRESENTATIVE

WHEREAS, a vacancy currently exists for a member for the Workforce Development Board; and,

WHEREAS, Erika Manuel has expressed an interest in serving on the Workforce Development Board; and,

WHEREAS, the Board of County Commissioners have reviewed all candidates deemed qualified; and,

WHEREAS, the Board of County Commissioners selected Erika Manuel to fill this vacancy as the Business Sector/Healthcare Representative.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Erika Manuel is hereby appointed as a member of the Workforce Development Board as a Business Sector/Healthcare Representative for the term as listed below:

	Term Expires
Erika Manuel	July 1, 2024

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Approving Amendment Three to the Agreement between Adams County and GMCO Corporation, in the Amount of $5,892.19, for Fugitive Dust Chloride Abatement
FROM: Bethany Frank
AGENCY/DEPARTMENT: Finance
HEARD AT STUDY SESSION ON:
RECOMMENDED ACTION: That the Board of County Commissioners approves Amendment Three to the Agreement with GMCO Corporation for fuel surcharges for the chloride dust abatement program.

BACKGROUND:

Chloride for fugitive dust control is specified for County maintained gravel roads when average daily traffic (ADT) exceeds 200 vehicles per day. Controlling fugitive dust generated by vehicular traffic on gravel roads reduces environmental and safety liabilities. Dust from unpaved roads is not only a nuisance but creates a safety and health hazard. The County's Fugitive Dust Control Plan has been developed pursuant to United States Environmental Protection Agency, guidance for Serious PM10 Nonattainment Areas. This plan includes the use and application of chemical (80% magnesium chloride 20% sugar blend) and is formulated to control dust. Controlling fugitive dust will not prevent all emissions but will substantially reduce emissions. Adams County entered into an Agreement with GMCO Corporation (GMCO) in March of 2022 to provide the chloride dust abatement program services. Due to unanticipated fuel price increases that have affected the delivery of material, GMCO instituted a fuel surcharge that was added to each gallon of dust abatement material that was delivered in 2022. This fuel surcharge was reviewed and agreed upon by both the Adams County Finance Department and the Public Works Operations division. The Agreement breaks down as follows:

Original Contract Amount	Approved 3/10/2020	$ 256,080.00
Amendment One	Approved 2/9/2021	$ 349,950.05
Amendment Two	Approved 3/8/2022	$ 368,683.41
Amendment Three		$ 5,892.19
New Total Contract Value		$ 980,605.65

The recommendation is to approve Amendment Three to the Agreement with GMCO Corporation for fuel surcharges in the amount of $5,892.19, for a total not to exceed agreement amount of $980,605.65.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
Public Works Department

ATTACHED DOCUMENTS:
Resolution

FISCAL IMPACT:
Yes

Fund:	13			
Cost Center:	3031			
		Object Account:	**Subledger:**	**Amount:**
Current Budgeted Revenue:				
Additional Revenue not included in Current Budget:				
Total Revenues:				
		Object Account:	**Subledger:**	**Amount:**
Current Budgeted Operating Expenditure:		7415		$450,000.00
Add'l Operating Expenditure not included in Current Budget:				
Current Budgeted Capital Expenditure:				
Add'l Capital Expenditure not included in Current Budget:				
Total Expenditures:				$450,000.00
New FTEs requested:	**No**			
Future Amendment Needed:	**No**			

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING AMENDMENT THREE TO THE AGREEMENT BETWEEN ADAMS COUNTY AND GMCO CORPORATION, IN THE AMOUNT OF $5,892.19, FOR FUGITIVE DUST CHLORIDE ABATEMENT

WHEREAS, GMCO Corporation was awarded an Agreement March 10, 2020, to provide fugitive dust chloride abatement; and,

WHEREAS, the County would like to amend the Agreement to add fuel surcharges to the Fugitive Dust Chloride Abatement Project; and,

WHEREAS, GMCO agrees to amend the Agreement to add fuel surcharges for the 2022 Fugitive Dust Chloride Abatement Project in the amount of $5,892.19, for a total not to exceed Agreement amount of $980,605.65.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Amendment Three to the Agreement between Adams County and GMCO Corporation, in the amount of $5,892.19, for fuel surcharges; is hereby approved.

BE IT FURTHER RESOLVED, that the Chair is hereby authorized to sign Amendment Three to the Agreement with GMCO Corporation on behalf of Adams County, after negotiation and approval as to form is completed by the County Attorney's Office.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Approving Change Order One (Amendment One) to the Agreement between Adams County and A-1 Chipseal Company in the Amount of $19,594.40, for the 2022 Seal Program
FROM: Bethany Frank
AGENCY/DEPARTMENT: Finance
HEARD AT STUDY SESSION ON:
RECOMMENDED ACTION: That the Board of County Commissioners approves Change Order One (Amendment One) to the Agreement with A-1 Chipseal Company for the 2022 Pavement Seal Program.

BACKGROUND:
The 2022 Seal Program is an annual street maintenance program. The County provides slurry seal on different streets in unincorporated Adams County with approximately 44 lane miles in various areas in unincorporated Adams County. On April 5, 2022, the Board of County Commissioners awarded an Agreement to A-1 Chipseal Company to provide services for the 2022 Pavement Seal Program. During the initial bid process, the asphalt patching quantities could not be accurately quantified. During the construction process, the asphalt patching quantity overran and must be accurately accounted for. Change Order One (Amendment One) is necessary to account for the additional patching overruns. The Agreement breaks down as follows:

Original Agreement	Approved 04/25/2022	$987,736.52
Change Order One (Amendment One)		$19,594.40
Total Agreement Amount:		$1,007,330.92

The recommendation is to approve Change Order One (Amendment One) to the Agreement with A-1 Chipseal Company in the amount of $19,594.40, for a total not to exceed Agreement amount of $1,007,330.92.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
Public Works Department

ATTACHED DOCUMENTS:
Resolution

FISCAL IMPACT:
Yes

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:		7822		$800,000.00
Add'l Operating Expenditure not included in Current Budget:				
Current Budgeted Capital Expenditure:				
Add'l Capital Expenditure not included in Current Budget:				
Total Expenditures:				$800,000.00
New FTEs requested:	**No**			
Future Amendment Needed:	**No**			

Additional Note:
The additional operating expenditure is anticipated to be covered by savings in other accounts.

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING CHANGE ORDER ONE (AMENDMENT ONE) TO THE AGREEMENT BETWEEN ADAMS COUNTY AND A-1 CHIPSEAL COMPANY IN THE AMOUNT OF $19,594.40, FOR THE 2022 SEAL PROGRAM

WHEREAS, On April 5, 2022, the Board of County Commissioners awarded an Agreement to A-1 Chipseal Company to provide services for the 2022 Pavement Seal Program; and,

WHEREAS, the County would like to amend the Agreement to account for asphalt overruns; and,

WHEREAS, A-1 Chipseal Company agrees to provide asphalt overruns for the 2022 Seal Program in the amount of $19,594.40, for a total not to exceed Agreement amount of $1,007,330.92.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Change Order one (Amendment One) to the Agreement between Adams County and A-1 Chipseal Company in the amount of $19,594.40, for the 2022 Seal Program; is hereby approved.

BE IT FURTHER RESOLVED, that the Chair is hereby authorized to sign Change Order One (Amendment One) to the Agreement with A-1 Chipseal Company on behalf of Adams County, after negotiation and approval as to form is completed by the County Attorney's Office.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Approving Amendment Two to the Agreement between Adams County and Growing Home in the Amount of $1,194,839.65, for Housing and Homeless Prevention Services
FROM: Sarah Fix
AGENCY/DEPARTMENT: Finance
HEARD AT STUDY SESSION ON:
RECOMMENDED ACTION: The recommendation is to approve Amendment Two to the Agreement with Growing Home for Housing and Homeless Prevention Services, in the amount of $1,194,839.65 for a total not to exceed agreement amount of $2,034,959.75.

BACKGROUND:
Adams County Human Services Department (HSD) receives Federal Temporary Assistance for Needy Families (TANF) Block Grant funds, allocated by the State to assist with the goals of the HSD Workforce and Business Center (WBC) TANF program. These home services provide homelessness prevention, rent, utility assistance and other related services for eligible Adams County families who are in danger of homelessness.

In April of 2021, the Board of County Commissioners approved an Agreement with Growing Home to provide Housing and Homeless Prevention Services for the TANF program. Amendment One was approved by the Board on March 8, 2022.

On September 13, 2022, the Board of County Commissioners approved Amendment One to the Agreement with Growing Home. This Amendment was incorrectly titled. The Amendment approved on September 13, 2022, was labeled Amendment One and should have been labeled Amendment Two.

The Agreement breaks down as follows:

Agreement	Approval Date	Amount	Cumulative Amount
Original Agreement	8/24/2021	$740,120.10	$740,120.10
Amendment One	3/8/2022	$100,000.00	$840,120.10

Amendment Two		$1,194,839.65	$2,034,959.75

The recommendation is to approve Amendment Two to the Agreement with Growing Home for Housing and Homeless Prevention Services, in the amount of $1,194,839.65 for a total not to exceed agreement amount of $2,034,959.75.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Human Services Department Workforce and Business Center, Temporary Assistance for Needy Families (TANF)

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
Adams County Human Services Department Workforce and Business Center, Temporary Assistance for Needy Families (TANF)

ATTACHED DOCUMENTS:

FISCAL IMPACT:
No

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING AMENDMENT TWO TO THE AGREEMENT BETWEEN ADAMS COUNTY AND GROWING HOME IN THE AMOUNT OF $1,194,839.65, FOR HOUSING AND HOMELESS PREVENTION SERVICES

WHEREAS, on August 24, 2021, the Board of County Commissioners approved an Agreement with Growing Home to provide Housing and Homeless Prevention Services for the Human Services Department, Temporary Assistance for Needy Families (TANF); and,

WHEREAS, on September 13, 2022, the Board of County Commissioners approved Amendment One which should have been titled Amendment Two with Growing Home to provide Housing and Homeless Prevention Services for the Human Services Department, Temporary Assistance for Needy Families (TANF); and,

WHEREAS, Growing Home agrees to provide Housing and Homeless Prevention Services in Amendment Two for $1,194,839.65 for a not to exceed amount of $2,034,959.75.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Amendment Two to the Agreement between Adams County and Growing Home in the amount of $1,194,839.65, to provide Housing and Homeless Prevention Services; is hereby approved.

BE IT FURTHER RESOLVED that the Chair is hereby authorized to sign Amendment Two to the Agreement with Growing Home on behalf of Adams County, after negotiation and approval as to form is completed by the County Attorney's Office.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: County Manager's Recommended 2023 Adams County Budget
FROM: Nancy Duncan
AGENCY/DEPARTMENT: Budget
HEARD AT STUDY SESSION ON:
RECOMMENDED ACTION: That the Board of County Commissioners considers the 2023 Proposed Adams County Budget being recommended by the County Manager.

BACKGROUND:
As a political subdivision of the State of Colorado, Adams County prepares an annual budget as required by Colorado State Statutes (CRS 29-1-103). As part of the 2023 annual budget development process, the 2023 Proposed Budget is being proposed during Public Hearing on October 11, 2022. In addition to this Public Hearing, the Board of County Commissioners will review the 2023 Proposed Budget at working sessions in September, October, and November 2022, as needed.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
Budget & Finance Department and County Manager's Office

ATTACHED DOCUMENTS:
PowerPoint Presentation

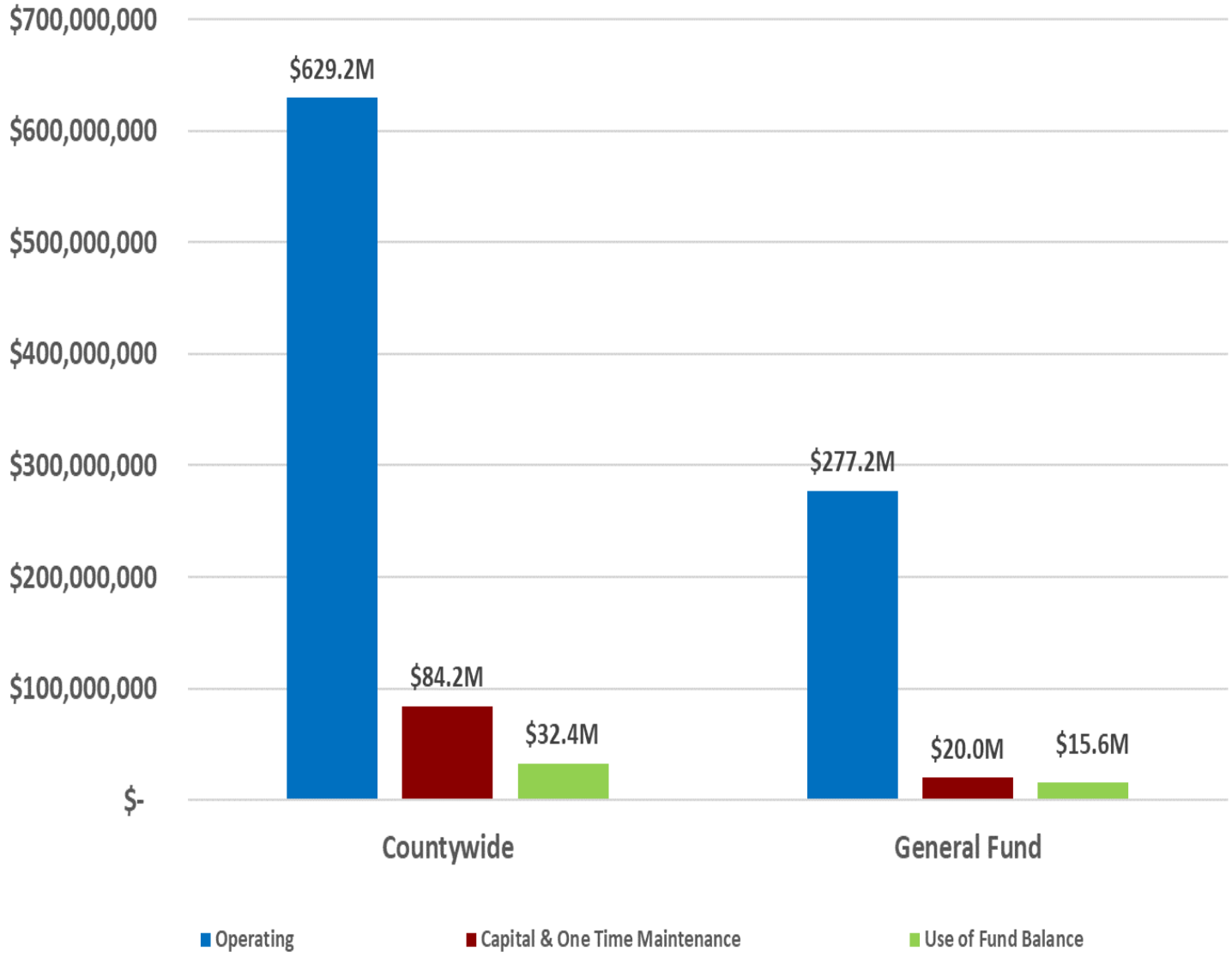
FISCAL IMPACT:
No

Additional Note:

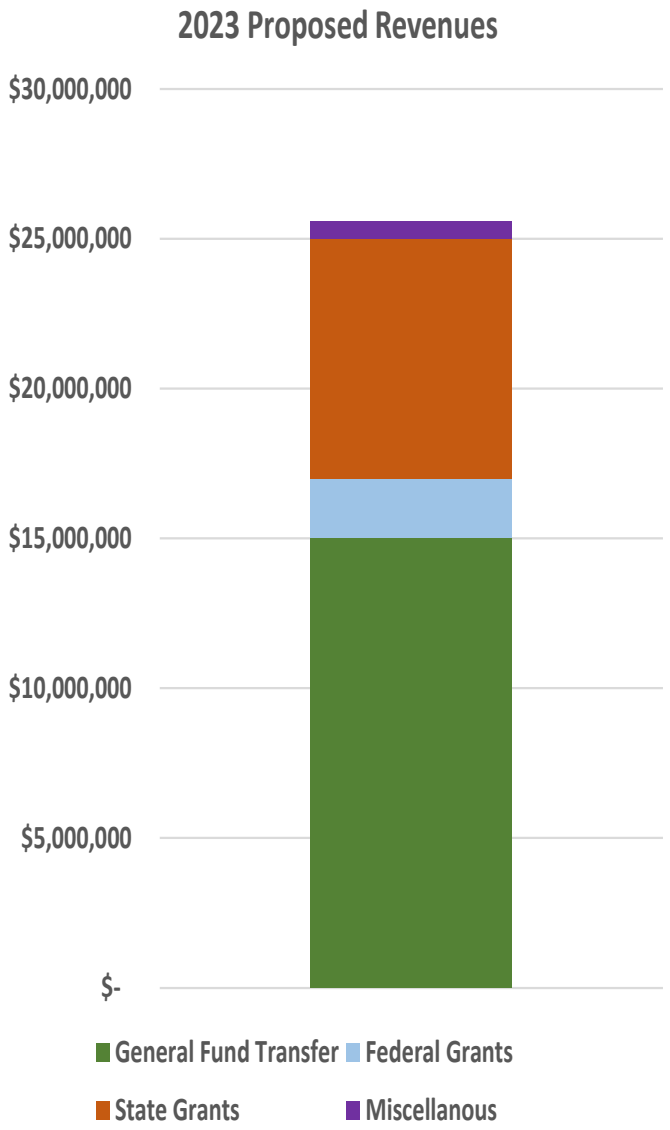
Adams County 2023 Budget Development - Proposed Budget

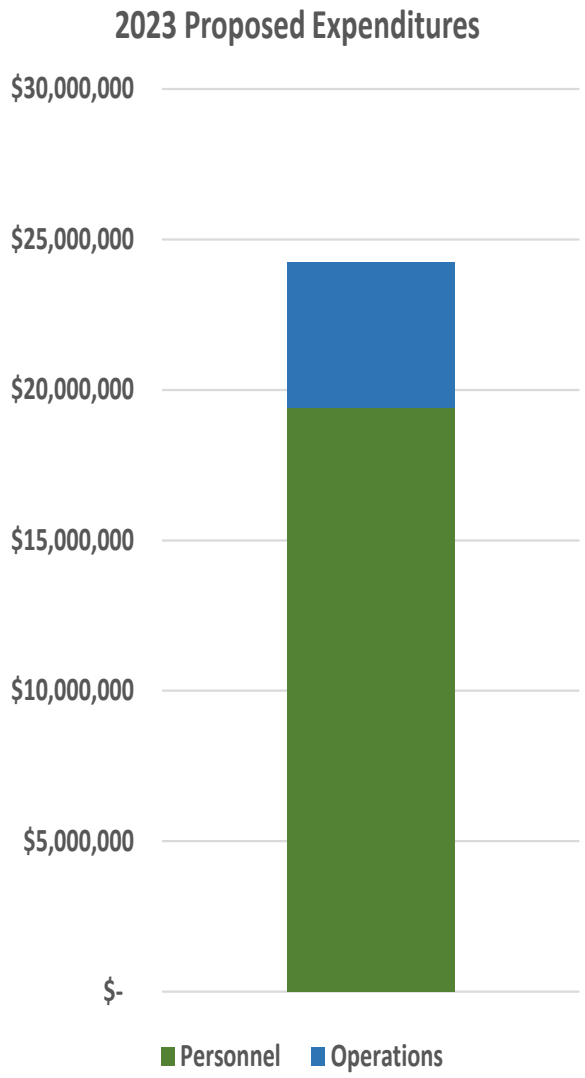
October 11, 2022

2023 Proposed Operating Expenditures, Capital, and Use of Fund Balance



2023 Proposed Budget - Adams County Public Health Department





2023 Budget Adoption Timeline

- October & November Planning Sessions with the BoCC.
- November 1, 2022 - First Reading of the Proposed Budget.
- November 15, 2022 – Second Reading and Adoption of the 2023 Adams County Budget.

- The 2023 Proposed Adams County Budget will be posted online at adcogov.org today, October 11, 2022.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Authorizing the Creation of a Public Health Department Fund to Account for Revenues and Expenditures for the Adams County Health Department
FROM: Marc Osborne
AGENCY/DEPARTMENT: Budget
HEARD AT STUDY SESSION ON:
RECOMMENDED ACTION: Approve the resolution to create a new Public Health Department Fund.

BACKGROUND:
C.R. S. § 25-1-511(b)(2) requires the county to create a separate Public Health Department Fund.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
County Attorney's Office, Budget & Finance, Adams County Health Department

ATTACHED DOCUMENTS:

FISCAL IMPACT:
No

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION AUTHORIZING THE CREATION OF A PUBLIC HEALTH DEPARTMENT FUND TO ACCOUNT FOR REVENUES AND EXPENDITURES FOR THE ADAMS COUNTY HEALTH DEPARTMENT

Resolution

WHEREAS, C.R. S. § 25-1-511(b)(2) requires the county to create a separate Public Health Department Fund to collect fees, grants and other revenues generated by the Adams County Health Department programs and account for the funding of operating and capital expenditures related to Public Health activities; and,

WHEREAS, the County intends to set up a separate fund known as the Public Health Department Fund into which shall be deposited revenues derived from Adams County Health Department activities, including fees, grants and other revenues and interest earned from those sources, and from which Adams County Health Department operating and capital expenses may be paid as determined by the Public Health Director and the Adams County Board of Health; and,

WHEREAS, the creation of this fund is needed for the accounting and financial reporting of the Adams County Health Department.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the Director of Budget & Finance and the Adams County Treasurer are authorized to establish the Public Health Department Fund, which will also be known as Fund 49 and which shall be used for the purposes stated above.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Approving an Agreement between Adams County and Shiloh Home Inc., in the Amount Not to Exceed $652, 323.00, for Guaranteed Beds
FROM: Jen Tierney
AGENCY/DEPARTMENT: Finance
HEARD AT STUDY SESSION ON:
RECOMMENDED ACTION: That the Board of County Commissioners approves an Agreement with Shiloh Home Inc., to provide Guaranteed Beds.

BACKGROUND:

BACKGROUND: Shiloh Home Inc., provides guaranteed beds, shelter and residential care of children and youth within Adams County. Shiloh Home Inc., also provides emergency shelter for children in crisis as well as a residential facility for children needing long-term treatment. Shiloh Home Inc., has been approved as a single source provider for providing guaranteed beds per the provisions of County Purchasing Policy #1080 Single Source and the approved Appendix F form for Single/Sole Source and Emergency Procurements. This Agreement is funded 80/20 under the Child Welfare Block Allocation Program, 80% is paid by the State with a 20% County match. In order to align with the Child Welfare Block Allocation Program, the Agreement will be a total of 22 months. The Agreement will breakdown as follows:

Agreement/Amendment	Requested Amount	Total Yearly Amount	Cumulative Agreement Amount
Year 1	$311,251.26	$311,251.26	$311,251.26
Year 2	$341,071.74	$341,071.74	$652,323.00

The recommendation is to approve an Agreement with Shiloh Home Inc., to provide guaranteed beds for a total not to exceed Agreement amount of $652,323.00.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:

Adams County Human Services Department, Division of Children & Family Services

ATTACHED DOCUMENTS:

Resolution

FISCAL IMPACT:
Yes

Fund:	15		
Cost Center:	99915, Various		
	Object Account:	**Subledger:**	**Amount:**
Current Budgeted Revenue:	99915.5755		$54,214,095
Additional Revenue not included in Current Budget:			
Total Revenues:			$54,214,095
	Object Account:	**Subledger:**	**Amount:**
Current Budgeted Operating Expenditure:	Various, 7645		$9,652,600
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			$9,652,600

New FTEs requested: **No**

Future Amendment Needed: **No**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING AN AGREEMENT BETWEEN ADAMS COUNTY AND SHILOH HOME INC., IN THE AMOUNT NOT TO EXCEED $652,323.00, FOR GUARANTEED BEDS

WHEREAS, in 2016, Board of County Commissioners approved a sole source agreement with Shiloh Home Inc. to provide guaranteed beds, shelter care and residential care for Adams County youth; and,

WHEREAS, Shiloh Home Inc., agrees to provide the guaranteed beds for over the next twenty-two months in the not to exceed Agreement amount $652,323.00.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that the Agreement between Adams County and Shiloh Home Inc., in the amount not to exceed $652,323.00, for Guaranteed Beds; is hereby approved.

BE IT FURTHER RESOLVED, that the Chair is hereby authorized to sign the Agreement with Shiloh Home Inc., on behalf of Adams County, after negotiation and approval as to form is completed by the County Attorney's Office.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Approving Amendment Two to an Agreement between Adams County and the Brendle Group, Inc., in the Amount of $220,000.00, for Sustainability Planning Services
FROM: Anna Forristall
AGENCY/DEPARTMENT: Finance
HEARD AT STUDY SESSION ON: n/a
RECOMMENDED ACTION: That the Board of County Commissioners approves the Amendment Two to an Agreement between Adams County and the Brendle Group, Inc., in the Amount of $220,000.00, for Sustainability Planning Services.

BACKGROUND:
In August 2020, The Brendle Group, Inc., was awarded an agreement to provide Sustainability Planning Services for Adams County. This firm reviewed the County's 2030 Sustainability Plan (Plan) and worked with departments to create goals to strategically guide the Plan into a relevant, actionable document.

In 2021, The Brendle Group, Inc., conducted monthly meetings with representatives from departments to learn essential objectives and roadblocks that are present to help move the County's sustainability targets forward.

In 2022, the firm created a focused department tracking and reporting table with specific expectations and measurement goals. The table listed potential tasks The Brendle Group, Inc. could support to substantially advance the implementation of the 2030 Sustainability Plan.

Highlights of the table include:
• The opportunity to advance organizational sustainability, water goals, and transportation goals such as to reduced vehicle idling.
• Parks and Open Space improved waste collection at County events including the County Fair.
• Increase County Employee Sustainability Awareness
• Strategic Electric Vehicle long-range planning

Agreement Description:

Agreement	Description	Signature Date	Amount
Original Agreement	Review 2030 Sustainability Plan	October 15, 2020	$95,000.00
Amendment One	Review Goals & Roadblocks	September 28, 2021	$100,000.00
Amendment Two	Provide Guidelines to Meet Goals		$220,000.00

The recommendation is to approve Amendment Two to the Agreement with The Brendle Group, Inc., for Sustainability Planning Services, in the amount of $220,000.00 for a total not to exceed agreement amount of $415,000.00.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
Facilities and Fleet Management Department

ATTACHED DOCUMENTS:
Resolution

FISCAL IMPACT:
Yes

Fund:	01		
Cost Center:	1091		
	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:	7635	10912004	75,000.00
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			75,000.00

New FTEs requested:

Future Amendment Needed:

Additional Note:
Part funding will come from 2022 budget, the majority will come out of 2023 budget.

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING AMENDMENT TWO TO AN AGREEMENT BETWEEN ADAMS COUNTY AND THE BRENDLE GROUP, INC., IN THE AMOUNT OF $220,000.00, FOR SUSTAINABILITY PLANNING SERVICES

WHEREAS, The Brendle Group, Inc., submitted a proposal on July 16, 2020, to provide Sustainability Planning Services; and,

WHEREAS, The Brendle Group, Inc., agrees to provide Sustainability Planning Services in Amendment Two for $220,000.00 for a total not to exceed agreement amount of $415,000.00.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that Amendment Two to the Agreement between Adams County and The Brendle Group, Inc., in the amount of $220,000.00, for Sustainability Planning Services; is hereby approved.

BE IT FURTHER RESOLVED that the Chair is hereby authorized to sign Amendment Two with The Brendle Group, Inc., on behalf of Adams County, after negotiation and approval as to form is completed by the County Attorney's Office.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: Resolution Approving an Agreement between Adams County and Epic Aviation, LLC in the Amount of $4,992,761.80, to Provide Aviation Fuel (Jet A) And Avgas (100LL)
FROM: Joe Lachermeier
AGENCY/DEPARTMENT: Finance
HEARD AT STUDY SESSION ON:
RECOMMENDED ACTION: That the Board of County Commissioners approves an Agreement with Epic Aviation, LLC to provide Aviation Fuel (Jet A) and Avgas (100LL) for the Colorado Air and Space Port.

BACKGROUND:
Colorado Air and Space Port (CASP) is the County's owned and operated General Aviation Airport and only licensed Spaceport in Colorado. Users of the Air and Space Port range from large corporate turbine aircraft down to small single engine piston aircraft. CASP manages the single Fixed Based Operator (FBO) located at the airport. This FBO is responsible for the fueling, storage and tugging of aircraft, in addition to numerous other services to support both based and transient aircraft and their users. The annual aviation fuel usage for 2022 is approximately 229,489 gallons of jet A which is the fuel used by jet and turbine aircraft, and 187,058 gallons of Avgas (100LL) for piston type aircraft. Contracted Jet A fuel is estimated to make up 89,087 gallons of the total Jet A annually, and the Retail Jet A is estimated to make up 140,402 gallons of the total for Jet-A.

Earlier this year, CASP identified several deficiencies regarding the self-service 100LL fuel system, the primary fuel farm and the current aviation fuel truck fleet. The 100LL self-service point of sale system is beyond the end of its usable life and requires immediate replacement. CASP's aviation fuel trucks are beyond the end of their usable life spans. a A new federal requirement requires new automatic shut-off devices at the primary fuel farm. To correct these deficiencies, the Colorado Air and Space Port is seeking the services of an aviation fuel provider to correct the above issues and increase marketing efforts, provide up to date training to the line service personnel, fuel quality training, customer service training, signage, leasing of fuel trucks, uniform support, credit card processing, annual inspections, quality assurance assistance, technical support and parts support as part of their services.

A formal Request for Proposal was posted on Bidnet for the supply and delivery of Aviation Fuel (Jet A) and Avgas (100LL). Proposals were opened on June 15, 2022. Five companies submitted proposals. An evaluation team made up of the Colorado Air and Spare Port and Facilities individually scored each proposal based on the following criteria:

- Professionalism
- Understanding of the project
- General project experience
- Similar project experience
- General items
- Fee proposal

After a thorough evaluation it was determined that Epic Aviation LLC, provides the best overall value for the County.

For the initial three-year term, the aviation fuel purchases are estimate as follows, based on annual budget approvals; the Agreement will break down as follows

Year 1	2023-2024	$ 1,392,751.07
Year 2	2024-2025	$ 1,627,708.18
Year 3	2025-2026	$ 1,902,302.55
	Total	$ 4,922,761.80

The recommendation is to approve an Agreement with Epic Aviation, LLC to provide Aviation Fuel (Jet A) and Avgas (100LL) for the Colorado Air and Space Port in the not to exceed Agreement amount of $4,922,761.80.

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
Colorado Air and Space Port

ATTACHED DOCUMENTS:

FISCAL IMPACT:
Yes

Fund:	43			
Cost Center:	4303			
		Object Account:	**Subledger:**	**Amount:**
Current Budgeted Revenue:		6410		$2,050,750.00
Additional Revenue not included in Current Budget:				
Total Revenues:				$2,050,750.00
		Object Account:	**Subledger:**	**Amount:**

Current Budgeted Operating Expenditure:	7442	01 & 02	$1,206,00.00
Add'l Operating Expenditure not included in Current Budget:			
Current Budgeted Capital Expenditure:			
Add'l Capital Expenditure not included in Current Budget:			
Total Expenditures:			$1,206,00.00

New FTEs requested: **undefined**

Future Amendment Needed: **undefined**

Additional Note:

BOARD OF COUNTY COMMISSIONERS FOR
ADAMS COUNTY, STATE OF COLORADO

RESOLUTION APPROVING AN AGREEMENT BETWEEN ADAMS COUNTY AND EPIC AVIATION, LLC IN THE AMOUNT OF $4,992,761.80, TO PROVIDE AVIATION FUEL (JET A) AND AVGAS (100LL)

WHEREAS, Epic Aviation, LLC submitted a proposal on June 15, 2022 to provide aviation fuel (Jet A) and Avgas (100LL) for the Colorado Air and Space Port; and,

WHEREAS, after a thorough evaluation it was deemed that Epic Aviation, LLC was the most responsive and responsible proposer; and,

WHEREAS, Epic Aviation, LLC agrees to provide aviation fuel (Jet A) and Avgas (100LL) to Colorado Air and Space Port in the following amounts; year one $1,392,751.07, year two $ 1,627,708.18 and year three $1,902,302.55, for a total not to exceed amount of $4,992,761.80.

NOW, THEREFORE, BE IT RESOLVED, by the Board of County Commissioners, County of Adams, State of Colorado, that an Agreement between Adams County and Epic Aviation, LLC in the amount of $4,992,761.80 to provide Aviation Fuel (Jet A) and Avgas (100LL); is hereby approved.

BE IT FURTHER RESOLVED, that the Chair is hereby authorized to sign the Agreement with Epic Aviation, LLC, on behalf of Adams County, after negotiation and approval as to form is completed by the County Attorney's Office.

PUBLIC HEARING AGENDA ITEM

DATE OF PUBLIC HEARING: October 11, 2022
SUBJECT/TITLE: PRC2021-00006 Ascent Drive Resort - Continuance
FROM: Nick Eagleson, Senior Strategic Planner
AGENCY/DEPARTMENT: Community & Economic Development
HEARD AT STUDY SESSION ON: N/A
RECOMMENDED ACTION: Continuance to the October 25, 2022 Board of County Commissioners meeting.

BACKGROUND:
1. Conditional Use Permit for a Racing Facility in the Agricultural-3 (A-3) Zone District
2. Right-of-Way Vacation for a portion of 96th Avenue

AGENCIES, DEPARTMENTS OR OTHER OFFICES INVOLVED:
Community and Economic Development

ATTACHED DOCUMENTS:
Continuance Memo

FISCAL IMPACT:
No

Additional Note:

Community & Economic
Development Department
www.adcogov.org

ADAMS COUNTY
COLORADO

4430 South Adams County Parkway
1st Floor, Suite W2000B
Brighton, CO 80601-8218
PHONE 720.523.6880
FAX 720.523.6967
EMAIL: epermitcenter@adcogov.org

To: Adams County Board of County Commissioners
From: Nick Eagleson, Senior Strategic Planner
Subject: Ascent Drive Resort (PRC2021-00006)
Date: October 11, 2022

An application for a Conditional Use Permit to allow a racing facility and a Vaction request to vacate a portion of 96th Avenue is scheduled for public hearing on October 11, 2022. Due to an error in noticing for this hearing, staff is recommending a continuance to the October 25, 2022 Board of County Commissioners meeting.