AMENDMENT 2
PRIME HEALTHCARE
SUMMARY PLAN DESCRIPTION OF THE
VALUE MEDICAL AND PRESCRIPTION DRUG BENEFITS PLAN

Effective January 1, 2021, the Prime Healthcare Summary Plan Description of the Value Medical and Prescription Drug Benefits Plan (the "Plan"), dated January 1, 2020, is hereby amended as follows:

1. Immediately following the Table of Contents insert the following:

"**INTRODUCTION**

The Plan is designed to provide eligible Employees of Prime Healthcare Services, Inc. and their eligible Dependents with Covered Medical Expenses and Covered Prescription Drugs as described herein.

The Plan establishes the rules under which a Prime Healthcare Services, Inc. Employee becomes a Participant and receives Plan benefits. The Plan is also intended to explain to Participants and other Covered Persons how those Plan rules apply to them. Any questions regarding the Plan should be directed to the Claims Administrator.

If there is a conflict between this Plan Document/Summary Plan Description and any other communications concerning the Plan, the terms of this Plan Document/Summary Plan Description will prevail."

2. The Section entitled "**MEDICAL AND PRESCRIPTION DRUG BENEFITS**" is revised by updating existing language or inserting new language as follows:

   (a) "**Not Tier 1 or Tier 2** – Any services or charges from an individual or entity not described in Tier 1 or Tier 2 above are Non-Network Provider charges. Non-Network Provider charges are not covered by the Plan and do not qualify as Allowable Charges (see "Allowable Charges" in the **Definitions** section) subject to only the following limited exceptions:"

   (b) The following new language is inserted after the paragraph relating to "**Emergency Services Care.**"

   "**No Choice of Provider**—If, while receiving covered treatment in a Network Facility, a Covered Person receives Ancillary Services from a Non-Network Provider in a situation in which such person has no control over Provider selection (such as in the selection of an Emergency Room Physician, an Anesthesiologist or a Provider for emergent diagnostic services), such Non-Network Provider services will be covered at the Network Provider facility's benefit levels as shown in the Schedule of Medical Benefits. The Plan may be unable to protect Covered Persons from balance billing for the difference between the Provider's charge and the Allowable Charge."

   (c) At the end of this Section insert the following:

"**PAYMENT OF BENEFITS**

Payment to Providers
Benefits for services rendered by Network Providers will be paid directly to the provider of service. All other Plan payments, unless the Covered Person requests otherwise in writing, will be paid directly to the Participant.

Discharge
Any payment made by the Plan in accordance with the above provisions will fully discharge the obligations of the Plan to the extent of such payment.

Billing Errors and/or Overcharges
In the event that a claim submitted by a Network Provider or Non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan. However, balance billing is legal in many jurisdictions, and the Plan may be unable to protect Covered Persons from Non-Network Providers that engage in the practice of balance billing.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant is not responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan, and there should not be a balance bill for such difference. Again, the Plan has no control over any Non-Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of Copays, Coinsurances, deductible amounts and Out-Of-Pocket Maximum amounts and may be billed for any or all of these."

3. The Section entitled "**ELIGIBLE MEDICAL EXPENSES**" is hereby amended as follows:

   (a) Remove "**Chiropractic Care**" and replace with the following:

   "**Chiropractic Care**—Musculoskeletal manipulation provided by a Chiropractor to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain. Covered treatment is limited to 20 visits per Plan Year.

   NOTE: EXTRASPINAL MANIPULATION ALSO KNOWN AS EXTRASPINAL MANIPULATIVE THERAPY (EMT) IS NOT A COVERED BENEFIT."

   (b) Remove "**Dialysis, Acute**" and replace with the following:

   "**Dialysis** – Dialysis services and supplies, for the onset of kidney failure necessitating such services. The Plan covers a maximum of 39 treatments per Covered Person for that individual's lifetime."

4. The Section entitled "**PRESCRIPTION DRUG PROGRAM**" is hereby amended by inserting the following language to the end of that Section:

"CLAIMS AND APPEALS RIGHTS UNDER ERISA
INITIAL CLAIM REVIEW REQUEST

Covered Persons have the right to request that Prescription Drugs be covered or be covered at a higher benefit level (e.g. lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. For the initial coverage review, Express Scripts reviews both clinical and administrative coverage review requests.

Clinical Coverage Review (Prior Authorization). A clinical coverage review request is a request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan, for example, a medication that requires prior authorization. For an initial clinical coverage review (i.e. prior authorization), the prescribing Physician can use the electronic options found at www.express-scripts.com/PA.

Administrative Coverage Review. An administrative coverage review request is a request for coverage of a medication based on the Plan's benefit design. For example, whether a medication is in the formulary or whether a medication is covered. To request an initial administrative coverage review, the Covered Person or representative must submit the request in writing. A Benefit Coverage Request Form, used to submit the request, is obtained by calling the customer service phone number found on the back of the ID Card. Complete the form and mail or fax it to Express Scripts Attn: Benefit Coverage Review Department P.O. Box 66587 St. Louis, MO 63166-6587. Fax: (877) 328-9660.

Urgent Review. An "urgent" review is a request that, in the opinion of the attending Provider, the patient's health may be in serious jeopardy or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on review. If the patient or Provider believes the patient's situation is urgent, the expedited review must be requested by phone at (800) 753-2851.

- Supporting Information. For an initial coverage review request (prior authorization by Provider) or an administrative coverage administrative coverage request (Covered Person's request) supporting information must be submitted.
- Timeframes. The initial determination and notification to patient and Provider will be made within the specified timeframes indicated in the Section called "Claims and Appeals Procedures."

FIRST AND SECOND APPEALS OF DENIED INITIAL REVIEW

When an initial coverage review has been denied (in whole or in part), a request for appeal may be submitted by the Participant or authorized representative within 180 days from receipt of notice of the initial Adverse Benefit Determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical, administrative or urgent review requests:

- Name of Patient;
- Participant ID Card Number;
- Phone Number;
- The name of the drug for which benefit coverage has been denied;
- Brief description of why the Claimant disagrees with the initial Adverse Benefit Determination; and

- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents.

Appeals are subject to the requirements and timeframes as noted in the Section called "Claims and Appeals Procedures" and should be submitted as follows:

Clinical Review Requests (Prior Authorization):
Prime Healthcare Employee Benefits Plan
3480 East. Guasti Road
Ontario, CA91761
Attention: EHP

Administrative Review Requests:
Prime Healthcare Employee Benefits Plan
3480 East. Guasti Road
Ontario, CA91761
Attention: EHP

EXTERNAL REVIEW

The right to request an External Review in respect of a Final Adverse Benefit Determination is subject to, and described in, the Section entitled "Claims and Appeals Procedures" including the timeframes stated therein. The right to request an Expedited Review is subject to, and described in, the Section entitled "Claims and Appeals Procedures" including the timeframes stated therein.

To submit an External Review, the request must be mailed to:

Prime Healthcare Employee Benefits Plan
3480 East. Guasti Road
Ontario, CA91761
Attention: EHP"

5. The Section entitled "**ELIGIBILITY AND EFFECTIVE DATES**" is revised by removing the two paragraphs under "**EFFECTIVE DATE – EMPLOYEES**" and replacing them with the following:

"An Employee becomes eligible to participate in the Plan as described in the Prime Healthcare Employee Benefits Guide (which is hereby incorporated into and made part of the Plan).

If an Employee fails to enroll within thirty-one (31) days of the Employee's initial eligibility date, their coverage can become effective only in accordance with the "Open Enrollment" or "Special Enrollment Rights and Mid-Year Election Change Allowances" provisions below."

6. The Section entitled "**CLAIMS AND APPEALS PROCEDURES**" is revised by adding the "Notice of Claim" as the third paragraph on the first page of the section as follows:

"**NOTICE OF CLAIM**

Benefits under the Plan shall be allowed only if the claim is submitted within 1 year from the date on which Covered Medical Expenses were first Incurred, or within 90 days of the date of termination of the Plan, whichever comes first."

7. The Section entitled "**DEFINITIONS**" is revised by adding by revising the following definitions:

"**Active Service** - An Employee will be deemed in "Active Service" on each day that services are being performed for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided that the Employee was actively at work on the last preceding regular working day. An Employee will also be deemed in "Active Service" on any day on which the Employee is absent from work solely due to the Employee's own health status. An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on the first scheduled workday, the Employee will not be considered as having commenced active employment."

"**Ancillary Services** – Support services other than Room and Board, and medical and nursing services that are provided to Hospital patients in the course of care. They include such services as laboratory, radiology, Pharmacy, and Physical Therapy services."

"**Experimental and/or Investigational** – means treatments, procedures, therapies, devices or drugs which the Plan determines, in the exercise of its discretion, to be Experimental and/or Investigational, or done primarily for research including but not limited to any procedure, device, drug or medicine or the use thereof which falls within any of the following categories:

(a) It is considered by any government agency or subdivision including but not limited to the Food and Drug Administration, the Office of Health Technology Assessment, or HCFA Medicare Coverage Issues Manual to be:

- Experimental and/or Investigational;
- Not considered Reasonable and necessary; or
- Any similar finding;

(b) It is not covered under Medicare reimbursement laws, regulations or interpretations;

(c) It is not commonly and customarily recognized by the medical profession or appropriate for the condition being treated; or

(d) "Experimental and/or Investigational" does not include covered services for:

- Approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and
- Reliable evidence shows that the treatment, procedure, device or drug is the subject of ongoing Phase I, II, III or IV Clinical Trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or Clinical Trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.
- "Reliable evidence" shall include anything determined to be such by the Plan, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be

authoritative by the medical professional community in the United States, including the CMS Medicare Coverage Issues Manual."

"**Fiduciary** – A person who exercises any discretionary authority or discretionary control with respect to the management of the Plan or exercises any authority or control with respect to the management or disposition of its benefits or has any discretionary authority or discretionary responsibility in the administration of the Plan. For purposes of ERISA section 402 (a)(2) the "Named Fiduciary" of the Plan is the Plan Administrator."

"**Qualified Medical Child Support Order (QMCSO)** – A Medical Child Support Order that creates or recognizes the right of an alternate recipient to receive benefits for which a Covered Person is eligible under a group health plan and is recognized by the Plan as "qualified."

An eligible Dependent Child of an Employee will include a Child for whom the Employee is required to provide coverage due to a National Medical Support Notice (NMSN) which is determined by the Plan Administrator to be a Qualified Medical Child Support Order (QMCSO). QMCSO will also include a judgment, decree or order issued by a court of "competent jurisdiction" or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMCSO requirements of ERISA section 609(a).

Covered Persons may obtain a copy of the QMCSO procedures from the Plan Administrator without charge."

"**Usual, Customary, and Reasonable (UCR) –** For purposes of this Plan, the Usual, Customary, and Reasonable rate shall be a charge made by a provider that does not exceed the general level of charges made by other providers in the geographic area or community and takes into account the following criteria: (1) the provider's training, qualifications, and length of time in practice; (2) the nature of the services provided; (3) the fees usually charged by the provider; (4) prevailing provider rates charged in the general geographic area in which the services were rendered; (5) other aspects of the economics of the medical provider's practice that are relevant; and (6) any unusual circumstances in the case. The term "geographic area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

With regard to charges made by a provider of service participating in the Plan's Network program, Usual, Customary and Reasonable will mean the provider's negotiated rate - but not to exceed the actual charge or the non-Network Usual, Customary and Reasonable allowance unless such lesser amount is not permitted under the terms of the Network agreement."

8. A new Section entitled "**HIPAA STANDARDS FOR PRIVACY**" is hereby inserted after the Section entitled "**DEFINITIONS**" as follows:

"HIPAA STANDARDS FOR PRIVACY

The provisions of this Section comply with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued by the Department of Health and Human Services (HHS) pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

DEFINITIONS

Business Associate—a person who, on behalf of the Plan: (i) performs a function that involves the use or disclosure of Protected Health Information, including claims processing, data analysis, utilization review, quality assurance, patient safety activities listed at 42 C.F.R. §3.20, billing, benefit management, practice management, and repricing; or (ii) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services that involve the disclosure of Protected Health Information from the Plan, or from another Business Associate of the Plan, to the person.

Business Associate includes (i) a health information organization, e-prescribing gateway, or other person that provides data transmission services with respect to Protected Health Information to the Plan and that requires access on a routine basis to such Protected Health Information; (ii) a person that offers a personal health record to one or more individuals on behalf of the Plan; (iii) patient safety organizations and (iv) a subcontractor that creates, receives, maintains, or transmits Protected Health Information on behalf of the Business Associate.

Business Associate does not include (i) a Health Care Provider, with respect to disclosures by a Plan to the Health Care Provider concerning the treatment of the individual; (ii) the Plan Administrator, with respect to disclosures by the Plan to the Plan Sponsor, to the extent that the requirements of the "Disclosure To Plan Sponsor," Section 15.3, apply and are met; (iii) a government agency, with respect to determining eligibility for, or enrollment in, a government health plan that provides public benefits and is administered by another government agency, or collecting Protected Health Information for such purposes, to the extent such activities are authorized by law; or (iv) a Covered Entity participating in an organized health care arrangement that performs a function or activity as described in this definition for or on behalf of such organized health care arrangement, or that provides a service as described in this definition to or for such organized health care arrangement by virtue of such activities or services.

Breach—the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under this Article or the HHS Regulations which compromises the security of privacy of the protected health information.

The term "Breach" does not include any of the following:

(a) Any unintentional acquisition, access, or use of Protected Health Information by a workforce member or person acting under the authority of the Plan, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HHS Regulations.

(b) Any inadvertent disclosure by a person who is authorized to have access to Protected Health Information of the Plan to another person authorized to have access to Protected Health Information of the Plan, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HHS Regulations.

(c) A disclosure of Protected Health Information where the Plan has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Covered Entity—a health plan, health care clearinghouses and Health Care Providers who electronically transmit any Health Information in connection with transactions for which HHS as adopted standards.

Health Information—any information, including genetic information, whether oral or recorded, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future Payment for the provision of health care to an individual.

Health Care Operations—any of the following activities of the Plan: (i) conducting quality assessment and improvement activities; (ii) reviewing the competence or qualifications of Health Care Providers; (iii) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits (including stop-loss insurance); (iv) conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; (v) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan; and (vi) business management and general administrative activities of the Plan, including compliance with the requirements of this Article, and the provision of data analyses for the Plan Sponsor. However, the Plan will not use genetic information for underwriting purposes.

HHS Regulations—those regulations regarding security and privacy of Protected Health Information, as set forth in 45 C.F.R. Subtitle A, Subchapter C, as amended from time to time, and any subsequent laws and regulations relating to such subject matter.

Individually Identifiable Health Information—Health Information that either identifies the individual or provides a reasonable basis to believe it can be used to identify the individual.

Limited Data Set—Protected Health Information that excludes the direct identifiers of the individual or of relatives, employers, or household members of the individual.

Payment—the activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care, including: (i) determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims; (ii) billing, claims management, collection activities, and obtaining payment under a contract for reinsurance; (iii) review of health care services with respect to Medical Necessity, coverage under the Plan, appropriateness of care, or justification of charges; (iv) utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and (v) disclosure to consumer reporting agencies of Protected Health Information relating to collection of premiums or reimbursement.

Protected Health Information—Individually Identifiable Health Information other than employment records held by the Plan in its role as employer, education records covered by the Family Educational Rights and Privacy Act, as amended (20 U.S.C. 1232g), records described at 20 U.S.C. 1232g(a)(4)(B)(iv), and information regarding a person who has been deceased for more than 50 years.

Summary Health Information—information, which may be Individually Identifiable Health Information, that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the

Plan, but excludes the identifying information described at HHS Regulations § 164.514(b)(2)(i), except that the geographic information described in §164.514(b)(2)(i)(B) need only be aggregated to the level of five digit zip code.

Treatment—the provision, coordination, or management of health care and related services by one or more Health Care Providers, including the coordination or management of health care by a Health Care Provider with a third-party; consultation between Health Care Providers relating to a patient; or the referral of a patient for health care from one Health Care Provider to another.

Unsecured Protected Health Information—Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified on the Department of Health and Human Services Website.

DISCLOSURES TO BUSINESS ASSOCIATES

The Plan may disclose Protected Health Information to a Business Associate and may allow a Business Associate to create, receive, maintain, or transmit electronic Protected Health Information on its behalf, only if the Plan obtains satisfactory assurances, in accordance with provisions of this Article that the Business Associate will appropriately safeguard the information.

There shall be a contract between the Plan and a Business Associate. Such contract must:

(a) Establish the permitted and required uses and disclosures of Protected Health Information by the Business Associate. The contract may not authorize the Business Associate to use or further disclose the information in a manner that would violate the requirements of subpart E of the HHS Regulations (45 C.F.R. §§164.500 to 164.534) if done by the Plan, except that:

- the contract may permit the Business Associate to use and disclose Protected Health Information for the proper management and administration of the Business Associate; and
- the contract may permit the Business Associate to provide data aggregation services relating to the Health Care Operations of the Covered Entity.

(b) Provide that the Business Associate will:

- Not use or further disclose the information other than as permitted or required by the contract or as required by law;
- With respect to electronic Protected Health Information: (i) comply with the applicable requirements of 45 C.F.R. §§164.302 to 164.318 (including security standards, administrative safeguards, physical safeguards, technical safeguards, organizational requirements, and policies and procedures and documentation requirements; (ii) ensure that any subcontractors that create, receive, maintain, or transmit electronic Protected Health Information on behalf of the Business Associate agree to comply with the applicable requirements of 45 C.F.R. §§164.302 to 164.318 by entering into an appropriate contract or other arrangement; and (iii) report to the Plan any security incident of which it becomes aware, including Breaches of Unsecured Protected Health Information as required by 45 C.F.R. §164.410;

- Report to the Plan any use or disclosure of the information not provided for by its contract of which it becomes aware, including Breaches of Unsecured Protected Health Information as required by 45 C.F.R. §164.410;
- Ensure that any subcontractors that create or receive Protected Health Information on behalf of the Business Associate agree to the same restrictions and conditions that apply to the Business Associate with respect to such information in accordance with 45 C.F.R. §164.502(e)(1)(ii);
- Make available Protected Health Information in accordance with 45 C.F.R. §164.524;
- Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. §164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;
- To the extent the Business Associate is to carry out the Plan's obligation under subpart E of the HHS Regulations (45 C.F.R. §§164.500 to 164.534), comply with the requirements of subpart E of the HHS Regulations that apply to the Plan in the performance of such obligation;
- Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by, the Business Associate on behalf of the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with subpart E of the HHS Regulations (45 C.F.R.§§ 164.500 to 164.534); and
- At termination of the contract, if feasible, return or destroy all Protected Health Information received from, or created or received by, the Business Associate on behalf of the Plan that the Business Associate still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of the contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(c) Authorize termination of the contract by the Plan, if the Plan determines that the Business Associate has violated a material term of the contract.

(d) If the Plan knows of a pattern of activity or practice of the Business Associate that constitutes a material breach or violation of the Business Associate's obligation under the contract or other arrangement, the Plan shall take reasonable steps to cure the breach or end the violation, as applicable, and, if such steps were unsuccessful, terminate the contract or arrangement, if feasible.

DISCLOSURES TO PLAN SPONSOR

Subject to the paragraph below, the Plan may disclose the following to the Plan Sponsor:

(a) Summary Health Information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or modifying, amending, or terminating the Plan;

(b) Information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan Sponsor; and

(c) Information in accordance with an authorization described below.

The Plan will disclose Protected Health Information to the Plan Sponsor only upon receipt of a certification by the Plan Administrator that the Plan documents incorporate the following provisions and that the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by the Plan documents;
- Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available Protected Health Information in accordance with the Access, Amendment and Accounting provisions described below;
- Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HHS Regulations;
- If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation required in the paragraph below is established.

There shall be adequate separation between the Plan and the Plan Sponsor. Those persons under the control of the Plan Sponsor to be given access to Protected Health Information shall be set forth in the Plan's written policies or procedures. In the event no such persons are identified in such policies or procedures, such persons shall consist of the Employees of the Plan Sponsor's Human Resources Department, and any other person who receives Protected Health Information relating to Payment under, or Health Care Operation of, or other matters pertaining to the Plan in the ordinary course of business. The access to and use of Protected Health Information by such persons shall be restricted to the Plan administration functions that the Plan Sponsor performs for the Plan. The Plan Sponsor will provide an effective mechanism for resolving any noncompliance with the terms of this paragraph.

DISCLOSURES FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

Except with respect to uses or disclosures that require an authorization as described below, the Plan may use or disclose Protected Health Information: (i) for the Plan's Payment or Health Care Operations; (ii) for Treatment activities of a Health Care Provider; (iii) to another

Covered Entity or a Health Care Provider for the Payment activities of the entity that receives the information; or (iv) to another Covered Entity for Health Care Operations activities of the entity that receives the information if the disclosure is for health care fraud and abuse detection or compliance or for assessment or review of Health Care Providers.

DISCLOSURES REQUIRING AN AUTHORIZATION

Except as otherwise permitted or required by this Article, the Plan may not use or disclose Protected Health Information without an authorization that is valid under the disclosure provisions described herein.

The Plan must obtain an authorization for any use or disclosure of (i) psychotherapy notes (except to the extent set forth in HHS Regulation §164.508(a)(2)), or (ii) Protected Health Information for marketing (except to the extent set for in HHS Regulation §164.508(a)(3)). The Plan must obtain an authorization for any disclosure of Protected Health Information for which the disclosure is in exchange for direct or indirect remuneration from or on behalf of the recipient of the Protected Health Information (except to the extent set forth in HHS Regulation §164.508(a)(4)).

The Plan will not use or disclose Protected Health Information for marketing and will not sell Protected Health Information without a written authorization.

A written authorization is also required for any other use or disclosure not described in this Article.

A valid authorization under this provision must contain at least the following elements: (i) a specific and meaningful description of the information to be used or disclosed; (ii) the identification of the persons authorized to make the requested use or disclosure; (iii) the identification of the persons to whom the Plan may make the requested use or disclosure; (iv) a description of each purpose of the requested use or disclosure; (v) an expiration date or an expiration event for the use or disclosure; and (vi) signature of the individual, date and, if applicable, title. An authorization for use or disclosure of Protected Health Information may not be combined with any other document to create a compound authorization (except to the extent set for in HHS Regulation §164.508(b)(3)).

The authorization must contain statements adequate to place the individual on notice of all of the following: (i) the individual's right to revoke the authorization in writing, and the exceptions to the right to revoke; (ii) whether Treatment, Payment, enrollment or eligibility for benefits is conditioned on the individual signing the authorization; and (iii) the potential for the information disclosed to be subject to redisclosure by the recipient.

DISCLOSURES ALLOWING INDIVIDUAL TO AGREE OR OBJECT

The Plan may use or disclose Protected Health Information for the reasons listed below, provided that the individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the use or disclosure. The Plan may orally inform the individual of and obtain the individual's oral agreement or objection to a use or disclosure permitted by this paragraph.

The Plan may disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the Protected Health Information directly relevant to such person's involvement with the individual's care or Payment related to the individual's health care.

The Plan may use or disclose Protected Health Information to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition, or death.

If the individual is deceased, the Plan may disclose Protected Health Information of the individual to a family member, other relative, a close personal friend of the individual, or any other person identified by the individual who was involved in the individual's care or Payment for health care prior to the individual's death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the Plan.

DISCLOSURES NOT REQUIRING AUTHORIZATION OR AGREEMENT

The Plan may use or disclose Protected Health Information without the written authorization of the individual or the opportunity for the individual to agree or object, in the following situations, subject to the applicable requirements of HHS Regulations §164.512: (i) as required by law; (ii) for public health activities; (iii) regarding victims of abuse, neglect or domestic violence; (iv) for health oversight activities; (v) for judicial and administrative proceedings; (vi) for law enforcement purposes; (vii) regarding decedents; (viii) for cadaveric organ, eye or tissue donation purposes; (ix) for research purposes; (x) to avert a serious threat to health or safety; (xi) for specialized government functions; or (xii) for Workers' Compensation.

OTHER REQUIREMENTS

When using or disclosing Protected Health Information or when requesting Protected Health Information from another Covered Entity, the Plan must make reasonable efforts to limit Protected Health Information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request, except with respect to: (i) disclosures to or requests by a Health Care Provider for Treatment; (ii) uses or disclosures made to the individual to which they relate; (iii) uses or disclosures made pursuant to an authorization under the Disclosure provisions above and (iv) uses and disclosures that are required by law.

The Plan must identify: (i) those persons in its workforce who need access to Protected Health Information to carry out their duties; and (ii) for each such person, the categories of Protected Health Information to which access is needed and any conditions appropriate to such access. The Plan must make reasonable efforts to limit access to Protected Health Information consistent with the preceding sentence.

The Plan may use or disclose a Limited Data Set only for the purposes of research, public health, or Health Care Operations. The Plan may use or disclose a Limited Data Set only if the Plan obtains satisfactory assurance, in the form of a data use agreement that meets the requirements of HHS Regulation §164.514(e)(4), that the Limited Data Set recipient will only use or disclose the Protected Health Information limited purposes. If the Plan knows of a pattern of activity or practice of the Limited Data Set recipient that constitutes a material breach or violation of the data use agreement, the Plan must take reasonable steps to cure the breach or end the violation, as applicable, and, if such steps are unsuccessful: (i) discontinue disclosure of Protected Health Information to the recipient; and (ii) report the problem to the Secretary of Health and Human Services.

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices can be found at **Appendix C**.

ACCESS OF INDIVIDUALS TO PROTECTED HEALTH INFORMATION

Except as otherwise provided in HHS Regulation §164.524, an individual has a right of access to inspect and obtain a copy of Protected Health Information about the individual. The Plan must act on a request for access no later than 30 days after receipt of the request (60 days if the Protected Health Information is not accessible to the Plan on-site). The Plan may extend the time for such actions by no more than 30 days, provided that the Plan, within the time limit set forth above, provides the individual with a written statement of the reasons for the delay and the date by which the Plan will complete its action on the request. If the individual requests a copy of the Protected Health Information, the Plan may impose a reasonable, cost-base fee.

If the Plan denies access, in whole or in part, to Protected Health Information, the Plan must provide a timely, written denial to the individual in plain language that explains: (i) the basis for the denial; (ii) if applicable, a statement of the individual's review rights; and (iii) a description of how the individual may complain to the Plan or to the Secretary of Health and Human Services.

If the individual has requested a review of a denial that is subject to review under HHS Regulation §164.524, the Plan must promptly refer the request to a licensed health care professional, who was not directly involved in the denial, to review the decision to deny access. The designated reviewing official must determine, with a reasonable period of time, whether or not to deny the access requested. The Plan must promptly provide written notice to the individual of the determination of the designated reviewing official.

AMENDMENT OF PROTECTED HEALTH INFORMATION

An individual may submit a written request that the Plan amend the Protected Health Information maintained by the Plan. The Plan must act on the individual's request no later than 60 days after receipt of the request. If the Plan is unable to act on the request within such 60-day period, the Plan may extend the time for such action by no more than 30 days, provided that the Plan, within such 60-day period, provides the individual with a written statement of the reasons for the delay and the date by which the Plan will complete its action on the request.

If the Plan accepts the requested amendment, in whole or in part, the Plan must timely inform the individual that the amendment is accepted and obtain the individual's identification of an agreement to have the Plan notify the relevant persons with which the amendment needs to be shared. The Plan must make reasonable efforts to inform and provide the amendment within a reasonable time to: (i) persons identified by the individual as having received Protected Health Information needing the amendment; and (ii) persons, including Business Associates, that the Plan knows have the Protected Health Information and that may have relied, or could foreseeably rely, on such information to the detriment of the individual.

If the Plan denies the requested amendment, in whole or in part, the Plan must provide the individual with a timely, written denial that explains: (i) the basis for the denial; (ii) the individual's right to submit a written statement disagreeing with the denial; (iii) a statement that, if the individual does not submit a statement of disagreement, the individual may request that the Plan provide the individual's request for amendment and the denial with any future disclosures of the Protected Health Information; and (iv) a description of how the individual may complain to the Plan or to the Secretary of Health and Human Services. The Plan may prepare a written rebuttal to the individual's statement of disagreement. Whenever such a

rebuttal is prepared, the Plan must provide a copy to the individual who submitted the statement of disagreement. The Plan must, as appropriate, identify the Protected Health Information that is the subject of the disputed amendment and append or otherwise link the individual's request for an amendment, the Plan's denial of the request, the individual's statement of disagreement, if any, and the Plan's rebuttal, if any, to the information. The Plan must include such material, or an accurate summary, with any subsequent disclosure of the Protected Health Information to which the disagreement relates.

ACCOUNTING OF DISCLOSURES

An individual has a right to receive an accounting of disclosures of Protected Health Information made by the Plan in the six years prior to the date on which the accounting is requested, except for disclosures: (i) to carry out Treatment, Payment and Health Care Operations as provided above; (ii) to the individual; (iii) pursuant to an authorization described above; (iv) to persons involved in the individual's care or for other notification purposes as provided above; (v) for national security or intelligence purposes; (vi) to correctional institutions or law enforcement officials; or (v) as part of a Limited Data Set as provided above.

The Plan must provide an individual who submits a request for an accounting with a written accounting of disclosures by the Plan or Business Associates of the Plan that includes the following for each disclosure: (i) the date of the disclosure; (ii) the name of the person who received the Protected Health Information and, if known, the address of such person; (iii) a brief description of the Protected Health Information disclosed; and (iv) a brief statement of the purpose of the disclosure.

The Plan must act on the individual's request for an accounting within the time limits described above. The Plan must provide the first accounting to an individual in any 12-month period without charge. The Plan may impose a reasonable, cost-based fee for each subsequent request for an accounting by the same individual within the 12-month period, provided that the Plan informs the individual in advance of the fee and provides the individual with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

ADMINISTRATIVE REQUIREMENTS

The Plan must designate a privacy official who is responsible for the development and implementation of the policies and procedures of the Plan with respect to privacy of Protected Health Information. The Plan must also designate a contact person or office that is responsible for receiving complaints under this Article and who is able to provide further information about matters covered by the notice described above. These designations must be documented by the Plan.

The Plan must train all members of its workforce on the policies and procedures with respect to Protected Health Information required by this Article, as necessary and appropriate for the members of the workforce to carry out their function within the Plan. The Plan must document such training.

The Plan must have in place appropriate administrative, technical, and physical safeguards to protect the privacy of Protected Health Information.

The Plan must provide a process for individuals to make complaints concerning the Plan's policies and procedures required by this Article or its compliance with such policies and

procedures or the requirements of this Article. The Plan must document all complaints received, and their disposition, it any.

The Plan must have and apply appropriate sanctions against members of its workforce who fail to comply with the privacy policies and procedures of the Plan or the requirements of this Article. The Plan must document the sanctions imposed.

The Plan must mitigate, to the extent practicable, any harmful effect that is known to the Plan of a use or disclosure of Protected Health Information in violation of its policies and procedures or the requirements of this Article by the Plan or its Business Associates.

The Plan may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any person for the exercise by the person of any right under this Article or the HHS Regulations.

The Plan may not require individuals to waive their rights under this Article as a condition of the provision of Treatment, Payment, enrollment in the Plan, or eligibility for benefits.

The Plan must implement and document policies and procedures with respect to Protected Health Information that are designed to comply with the requirements of this Article. The Plan must retain the documentation required by this Article for six years from the date of its creation or the date when it last was in effect, whichever is later.

The Plan shall change its policies and procedures as necessary and appropriate to comply with changes in the law, including the standards, requirements, and implementation specifications of the HHS Regulations.

SECURITY RULE COMPLIANCE

In order to comply with the requirements of the HIPAA Security Rule as issued by the HHS, the Plan Administrator shall:

(a) Reasonably and appropriately safeguard electronic Protected Health Information created, received, maintained or transmitted to or by the Plan Administrator on behalf of the Plan;

(b) Implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of the Plan's electronic Protected Health Information;

(c) Ensure that adequate separation of the Plan and the Plan Sponsor is supported by reasonable and appropriate security measures;

(d) Ensure that any agents, including subcontractors, to whom it provides electronic Protected Health Information, agree to implement reasonable and appropriate safeguards to protect electronic Protected Health Information;

(e) Report to the Plan any security incident of which it becomes aware that may threaten the integrity and confidentiality of electronic Protected Health Information; and

(f) Make its policies and procedures and documentation relating to Security Rule safeguards available to HHS for purposes of determining the Plan's compliance therewith.

BREACH NOTIFICATION

The Plan shall, following the discovery of a Breach of Unsecured Protected Health Information, notify each individual whose Unsecured Protected Health Information has been, or is reasonably believed by the Plan to have been, accessed, acquired, used, or disclosed as a result of such Breach.

A Breach shall be treated as discovered by the Plan as of the first day on which such Breach is known to the Plan, or, by exercising reasonable diligence would have been known to the Plan. The Plan shall be deemed to have knowledge of a Breach if such Breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is a workforce member or agent of the Plan.

Except for the notices to the Secretary of Health and Human Services, as provided in subparagraph (d), below, the Plan shall provide the notification required by this Section without unreasonable delay and in no case later than 60 calendar days after discovery of a Breach.

(a) The notification required by this Section shall be written in plain language and shall include, to the extent possible:

- A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
- A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
- Any steps individuals should take to protect themselves from potential harm resulting from the Breach;
- A brief description of what the Plan is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches; and
- Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, web site, or postal address.

(b) The notification required by this Section shall be provided in the following form:

- Written notification by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available;
- If the Plan knows the individual is deceased and has the address of the next of kin or personal representative of the individual (as specified under §164.502(g)(4) of the HHS Regulations), written notification by first-class mail to either the next of kin or personal representative of the individual;
- In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual under subparagraph (a), a substitute form of notice reasonably calculated to reach the individual shall be provided. Substitute notice need not be provided in the case in which there is

insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual;

- In the case in which there is insufficient or out-of-date contact information for fewer than 10 individuals, then such substitute notice may be provided by an alternative form of written notice, telephone, or other means;
- In the case in which there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice shall: (i) be in the form of either a conspicuous posting for a period of 90 days on the home page of the website of the Plan, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the Breach likely reside; and (ii) include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual's Unsecured Protected Health Information may be included in the Breach; or
- In any case deemed by the Plan to require urgency because of possible imminent misuse of Unsecured Protected Health Information, the Plan may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under this paragraph.

(c) For a Breach of Unsecured Protected Health Information involving more than 500 residents of a state or jurisdiction, the Plan shall, following the discovery of the Breach, notify prominent media outlets serving the state or jurisdiction. Such notification shall be made without unreasonable delay and in no case later than 60 calendar days after discovery of the Breach, and shall be written in plain language and shall include the information described above and meet the requirements set forth herein.

(d) The Plan shall, following the discovery of a Breach of Unsecured Protected Health Information, notify the Secretary of Health and Human Services:

- For Breaches of Unsecured Protected Health Information involving 500 or more individuals, the Plan shall, except as provided in the subparagraph below, provide the notification required by the subparagraphs above contemporaneously with the notice required by the provisions of this Section and in the manner specified on Department of Health and Human Services website; and
- For Breaches of Unsecured Protected Health Information involving less than 500 individuals, the Plan shall maintain a log or other documentation of such Breaches and, not later than 60 days after the end of each Plan Year, provide the notification required by the subparagraph for Breaches occurring during the preceding Plan Year, in the manner specified on the Department of Health and Human Services website.

(e) If a law enforcement official states to the Plan that a notification, notice, or posting required under this Section would impede a criminal investigation or cause damage to national security, the Plan shall:

- If the statement is in writing and specifies the time for which a delay is required, delay such notification, notice, or posting for the time period specified by the official; and

- If the statement is made orally, document the statement, including the identity of the official making the statement, and delay the notification, notice, or posting temporarily and not longer than 30 days from the date of the oral statement, unless a written statement as described above, is submitted during that time."

9. Delete "**APPENDIX A – PREVENTIVE CARE SERVICES**" and replace with new **APPENDIX A** attached hereto.

10. The Plan is hereby amended by adding new "**APPENDIX C – NOTICE OF PRIVACY PRACTICES**" immediately after **APPENDIX B** as attached hereto.

Following the new Appendix C are Amendments to the Addendums.

APPENDIX A - 2021 PREVENTIVE CARE SERVICES

Preventive Care Services are based on recommendations of the U.S. Preventive Task Force, Centers for Disease Control and Prevention and the Health Resources and Services Administration. The extent and timing of such services are based on guidance from these organizations. To the extent not specified within these recommendations, Preventive Care Services will be available without cost sharing during the annual physical. Routine office visits for children may be Incurred more frequently if a recommendation requires services more than annually (e.g. a child's vaccination). The frequency, method, treatment or setting is based on reasonable medical management techniques. More information on Preventive Care Services for adults, women including pregnant women and children can be found at https://www.healthcare.gov/what-are-my-preventive-care-benefits/. The specific recommendations of the U.S. Preventive Services Task Force can be found at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.

- Other than as described in the Schedule of Benefits, Preventive Care Services are not covered on a Non-Network Provider basis. However, where a particular Preventive Care Service is not offered by a Network Provider, the item or service when performed by a Non-Network Provider will be covered with no cost-sharing.
- Other than as described in the Schedule of Benefits, Preventive Care Services that are billed separately from an office visit, will require an office visit Co-Pay.
- If Preventive Care Services are not billed separately from an office visit and the primary purpose of the office visit is the delivery of Preventive Care Services, then there is no Co-Pay with respect to the office visit.
- If Preventive Care Services are not billed separately from an office visit and the primary purpose of the office visit is not the delivery of Preventive Care Services, then the office visit is subject to a Co-Pay.

New Preventive Services

TOPIC	DESCRIPTION
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men ages 65 to 75 years who have ever smoked.
Alcohol and drug use: adolescents	Assessments for adolescents.
Alcohol use, unhealthy: adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.
Anemia	Iron supplements for children ages 6 to 12 months at risk for anemia.
Anemia	Routine screening for pregnant women.
Anxiety Screening	Adolescent and Adult Women, including those who are pregnant or postpartum based on clinical judgment.
Aspirin preventive medication: adults aged 50 to 59 years with a ≥10% 10-year cardiovascular risk	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.
Autism Screening	Screenings at 18 and 24 months.
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant persona.

TOPIC	DESCRIPTION
Blood Pressure Screening: adults	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.
Breast cancer preventive medication: Women at increased risk	The USPSTF recommends that clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.
Breastfeeding interventions	The Women's Preventive Services Initiative recommends comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and after birth to ensure the successful initiation and maintenance of breastfeeding
Cervical cancer screening	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Cholesterol Screening for abnormalities: men 35 and older	Screening men aged 35 and older, men under age 35 who have heart disease or risk factors for heart disease and women who have heart disease or risk factors for heart disease; every 5 years.
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults. The risks and benefits of these screening methods vary. Frequency depends on risk. Includes bowel preparation, required specialist consultation and pathology examination on any polyp biopsy
Contraceptive methods and counseling	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a health care Provider.
COVID-19	COVID-19 preventive services and vaccinations within 15 days after a recommendation from USPSTF or the CDC.
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
Depression screening: adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

TOPIC	DESCRIPTION
Depression screening: adults	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Developmental Screening for Children under 3	Developmental screenings for babies through age 3 for signs of speech or language display.
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
Folic acid supplementation	The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 μg) of folic acid.
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation and after pregnancy
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
Hearing screening: newborns	The CDC recommends hearing screening for all newborns.
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.
Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.
Hepatitis B screening: pregnant women	The USPSTF recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.
HIV preexposure prophylaxis for the prevention of HIV infection	The USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.

TOPIC	DESCRIPTION
Human papillomavirus DNA testing	High-risk human papillomavirus DNA testing in women with normal cytology results. Screening should begin at 30 years of age for women with normal cytology and should occur no more frequently than every 3 years.
Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.
Immunizations for Adults	Doses, recommended ages, and recommended populations vary and include: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella.
Immunizations for Children	Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary, including: Diphtheria, Tetanus, Pertussis, Haemophilus Influenza type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus. Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus and Varicella.
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence and provide or refer women who screen positive to ongoing services.
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Obesity screening and counseling: adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions, up to 26 sessions per year.
Obesity screening: children and adolescents	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.
Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.
Osteoporosis screening: postmenopausal women younger than 65 years at increased risk of osteoporosis	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older.
Osteoporosis screening: women 65 years and older	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.
Perinatal depression: counseling and intervention	The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.
Preeclampsia prevention: aspirin	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
Preeclampsia screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.

TOPIC	DESCRIPTION
Rh incompatibility screening: 24-28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Sexually transmitted infections behavioral counseling	The USPSTF recommends behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).
Skin cancer behavioral counseling	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.
Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.
Syphilis screening: nonpregnant persons	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.
Syphilis screening: pregnant women	The USPSTF recommends early screening for syphilis infection in all pregnant women.
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
Tuberculosis screening: adults	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.
Urinary Screening for Women	The Women's Preventive Services Initiative recommends screening women for urinary incontinence annually. Screening should ideally assess whether women experience urinary incontinence and whether it impacts their activities and quality of life. The Women's Preventive Services Initiative recommends referring women for further evaluation and treatment if indicated.
Vision screening: children	The USPSTF recommends vision screening at least once in all children ages 3 to 5 years to detect amblyopia or its risk factors.
Well baby and well child care	Includes behavioral assessments, screenings for blood pressure, dyslipidemia, hematocrit or hemoglobin, lead, measurements including height, weight and body mass index, medical history, oral health assessments, tuburcelin testing.

TOPIC	DESCRIPTION
Well woman care	Well-woman preventive care visit for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines. Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.

Rev. 20210125

Recommended Child and Adolescent Immunization Schedule
for ages 18 years or younger

UNITED STATES
2020

Vaccines in the Child and Adolescent Immunization Schedule*

Vaccines	Abbreviations	Trade names
Diphtheria, tetanus, and acellular pertussis vaccine	DTaP	Daptacel® Infanrix®
Diphtheria, tetanus vaccine	DT	No trade name
Haemophilus influenzae type b vaccine	Hib (PRP-T)	ActHIB® Hiberix® PedvaxHIB®
	Hib (PRP-OMP)	
Hepatitis A vaccine	HepA	Havrix® Vaqta®
Hepatitis B vaccine	HepB	Engerix-B® Recombivax HB®
Human papillomavirus vaccine	HPV	Gardasil 9®
Influenza vaccine (inactivated)	IIV	Multiple
Influenza vaccine (live, attenuated)	LAIV	FluMist® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R® II
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D	Menactra®
	MenACWY-CRM	Menveo®
Meningococcal serogroup B vaccine	MenB-4C	Bexsero®
	MenB-FHbp	Trumenba®
Pneumococcal 13-valent conjugate vaccine	PCV13	Prevnar 13®
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax® 23
Poliovirus vaccine (inactivated)	IPV	IPOL®
Rotavirus vaccine	RV1	Rotarix®
	RV5	RotaTeq®
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel® Boostrix®
Tetanus and diphtheria vaccine	Td	Tenivac® Tdvax™
Varicella vaccine	VAR	Varivax®
Combination vaccines *(use combination vaccines instead of separate injections when appropriate)*		
DTaP, hepatitis B, and inactivated poliovirus vaccine	DTaP-HepB-IPV	Pediarix®
DTaP, inactivated poliovirus, and *Haemophilus influenzae* type b vaccine	DTaP-IPV/Hib	Pentacel®
DTaP and inactivated poliovirus vaccine	DTaP-IPV	Kinrix® Quadracel®
Measles, mumps, rubella, and varicella vaccine	MMRV	ProQuad®

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

How to use the child/adolescent immunization schedule

1 Determine recommended vaccine by age **(Table 1)**

2 Determine recommended interval for catch-up vaccination **(Table 2)**

3 Assess need for additional recommended vaccines by medical condition and other indications **(Table 3)**

4 Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American Academy of Pediatrics (www.aap.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), and American College of Nurse-Midwives (www.midwife.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or 800-822-7967

Download the CDC Vaccine Schedules App for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html.

Helpful information

- Complete ACIP recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- General Best Practice Guidelines for Immunization: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Outbreak information (including case identification and outbreak response), see Manual for the Surveillance of Vaccine-Preventable Diseases: www.cdc.gov/vaccines/pubs/surv-manual

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS310020-A

Table 1 Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars. To determine minimum intervals between doses, see the catch-up schedule (Table 2). School entry and adolescent vaccine age groups are shaded in gray.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs
Hepatitis B (HepB)	1st dose	2nd dose			3rd dose												
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	See Notes												
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1st dose	2nd dose	3rd dose			4th dose				5th dose					
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See Notes		3rd or 4th dose, See Notes										
Pneumococcal conjugate (PCV13)			1st dose	2nd dose	3rd dose		4th dose										
Inactivated poliovirus (IPV <18 yrs)			1st dose	2nd dose	3rd dose							4th dose					
Influenza (IIV)					Annual vaccination 1 or 2 doses								Annual vaccination 1 dose only				
or													or				
Influenza (LAIV)											Annual vaccination 1 or 2 doses		Annual vaccination 1 dose only				
Measles, mumps, rubella (MMR)					See Notes		1st dose					2nd dose					
Varicella (VAR)							1st dose					2nd dose					
Hepatitis A (HepA)					See Notes		2-dose series, See Notes										
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)														Tdap			
Human papillomavirus (HPV)														See Notes			
													*				
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos)			See Notes											1st dose		2nd dose	
Meningococcal B														See Notes			
Pneumococcal polysaccharide (PPSV23)											See Notes						

Range of recommended ages for all children

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

Recommended based on shared clinical decision-making or *can be used in this age group

No recommendation/ not applicable

Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who are More than 1 month Behind, United States, 2020

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the notes that follow.**

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose.** Minimum age for the final dose is 24 weeks.		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days	**4 weeks**	**4 weeks** Maximum age for final dose is 8 months, 0 days.		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months**
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** If first dose was administered before the 1st birthday. **8 weeks (as final dose)** If first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older. **4 weeks** If current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months ***and*** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix) or unknown. **8 weeks *and* age 12 through 59 months (as final dose)** If current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; OR If current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose administered at younger than 15 months; OR If both doses were PRP-OMP (PedvaxHIB, Comvax) ***and*** were administered before the 1st birthday.	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older. **4 weeks** If first dose was administered before the 1st birthday. **8 weeks (as final dose for healthy children)** If first dose was administered at the 1st birthday or after.	**No further doses needed** for healthy children if previous dose administered at age 24 months or older. **4 weeks** If current age is younger than 12 months and previous dose was administered at <7 months old. **8 weeks (as final dose for healthy children)** If previous dose was administered between 7–11 months (wait until at least 12 months old); OR If current age is 12 months or older and at least 1 dose was given before age 12 months.	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus	6 weeks	**4 weeks** if current age is < 4 years. **6 months (as final dose)** if current age is 4 years or older.		**6 months** (minimum age 4 years for final dose).	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal ACWY	2 months MenACWY-CRM 9 months MenACWY-D	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**4 weeks**	**4 weeks** If first dose of DTaP/DT was administered before the 1st birthday. **6 months (as final dose)** If first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.	**6 months** if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose.**		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older.			

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2020

Always use this table in conjunction with Table 1 and the notes that follow.

VACCINE	INDICATION										
			HIV infection CD4+ count[1]								
	Pregnancy	Immunocompromised status (excluding HIV infection)	<15% and total CD4 cell count of <200/mm3	≥15% and total CD4 cell count of ≥200/mm3	Kidney failure, end-stage renal disease, or on hemodialysis	Heart disease or chronic lung disease	CSF leaks or cochlear implants	Asplenia or persistent complement component deficiencies	Chronic liver disease	Diabetes
Hepatitis B										
Rotavirus		SCID[2]								
Diphtheria, tetanus, & acellular pertussis (DTaP)										
Haemophilus influenzae type b										
Pneumococcal conjugate										
Inactivated poliovirus										
Influenza (IIV)										
or										
Influenza (LAIV)						Asthma, wheezing: 2–4yrs[3]				
Measles, mumps, rubella										
Varicella										
Hepatitis A										
Tetanus, diphtheria, & acellular pertussis (Tdap)										
Human papillomavirus										
Meningococcal ACWY										
Meningococcal B										
Pneumococcal polysaccharide										

- Vaccination according to the routine schedule recommended
- Recommended for persons with an additional risk factor for which the vaccine would be indicated
- Vaccination is recommended, and additional doses may be necessary based on medical condition. See Notes.
- Not recommended/ contraindicated—vaccine should not be administered
- Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction
- Delay vaccination until after pregnancy if vaccine indicated
- No recommendation/ not applicable

1 For additional information regarding HIV laboratory parameters and use of live vaccines, see the General Best Practice Guidelines for Immunization, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote D) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.
2 Severe Combined Immunodeficiency
3 LAIV contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months.

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020

For vaccine recommendations for persons 19 years of age or older, see the Recommended Adult Immunization Schedule.

Additional information

- Consult relevant ACIP statements for detailed recommendations at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For information on contraindications and precautions for the use of a vaccine, consult the General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html and relevant ACIP statements at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see Table 3-1, Recommended and minimum ages and intervals between vaccine doses, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccine requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2018 Report of the Committee on Infectious Diseases*. 31st ed. Itasca, IL: American Academy of Pediatrics; 2018:67–111).
- For information regarding vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information, see www.hrsa.gov/vaccinecompensation/index.html.

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination

- 5-dose series at 2, 4, 6, 15–18 months, 4–6 years
  - **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
  - **Retrospectively:** A 4th dose that was inadvertently administered as early as 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.
- For other catch-up guidance, see Table 2.

Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

Routine vaccination

- **ActHIB, Hiberix, or Pentacel:** 4-dose series at 2, 4, 6, 12–15 months
- **PedvaxHIB:** 3-dose series at 2, 4, 12–15 months

Catch-up vaccination

- **Dose 1 at 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before 12 months and dose 2 before 15 months:** Administer dose 3 (final dose) 8 weeks after dose 2.
- **2 doses of PedvaxHIB before 12 months:** Administer dose 3 (final dose) at 12–59 months and at least 8 weeks after dose 2.
- **Unvaccinated at 15–59 months:** 1 dose
- **Previously unvaccinated children age 60 months or older** who are not considered high risk do not require catch-up vaccination.
- For other catch-up guidance, see Table 2.

Special situations

- **Chemotherapy or radiation treatment:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT):**
  - 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history
- **Anatomic or functional asplenia (including sickle cell disease):**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated persons age 5 years or older*
  - 1 dose
- **Elective splenectomy:**
  Unvaccinated persons age 15 months or older*
  - 1 dose (preferably at least 14 days before procedure)
- **HIV infection:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated persons age 5–18 years*
  - 1 dose
- **Immunoglobulin deficiency, early component complement deficiency:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

**Unvaccinated* = Less than routine series (through 14 months) OR no doses (15 months or older)*

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020

Hepatitis A vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination
- 2-dose series (minimum interval: 6 months) beginning at age 12 months

Catch-up vaccination
- Unvaccinated persons through 18 years should complete a 2-dose series (minimum interval: 6 months).
- Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.
- Adolescents 18 years and older may receive the combined HepA and HepB vaccine, **Twinrix®**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (0, 7, and 21–30 days, followed by a dose at 12 months).

International travel
- Persons traveling to or working in countries with high or intermediate endemic hepatitis A (www.cdc.gov/travel/):
  - **Infants age 6–11 months**: 1 dose before departure; revaccinate with 2 doses, separated by at least 6 months, between 12 and 23 months of age
  - **Unvaccinated age 12 months and older**: Administer dose 1 as soon as travel is considered.

Hepatitis B vaccination (minimum age: birth)

Birth dose (monovalent HepB vaccine only)
- **Mother is HBsAg-negative:** 1 dose within 24 hours of birth for **all** medically stable infants ≥2,000 grams. Infants <2,000 grams: Administer 1 dose at chronological age 1 month or hospital discharge.
- **Mother is HBsAg-positive:**
  - Administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** (in separate limbs) within 12 hours of birth, regardless of birth weight. For infants <2,000 grams, administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
- **Mother's HBsAg status is unknown:**
  - Administer **HepB vaccine** within 12 hours of birth, regardless of birth weight.
  - For infants <2,000 grams, administer **HBIG** in addition to HepB vaccine (in separate limbs) within 12 hours of birth. Administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, administer **HBIG** to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

Routine series
- 3-dose series at 0, 1–2, 6–18 months (use monovalent HepB vaccine for doses administered before age 6 weeks)
- Infants who did not receive a birth dose should begin the series as soon as feasible (see Table 2).
- Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum age** for the final (3rd or 4th) dose: 24 weeks
- **Minimum intervals:** dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks (when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations)

Catch-up vaccination
- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months.
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB** only).
- Adolescents 18 years and older may receive a 2-dose series of HepB **(Heplisav-B®)** at least 4 weeks apart.
- Adolescents 18 years and older may receive the combined HepA and HepB vaccine, **Twinrix**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (0, 7, and 21–30 days, followed by a dose at 12 months).
- For other catch-up guidance, see Table 2.

Special situations
- Revaccination is not generally recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Revaccination** may be recommended for certain populations, including:
  - **Infants born to HBsAg-positive mothers**
  - **Hemodialysis patients**
  - **Other immunocompromised persons**
- For detailed revaccination recommendations, see www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html.

Human papillomavirus vaccination (minimum age: 9 years)

Routine and catch-up vaccination
- HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated
- 2- or 3-dose series depending on age at initial vaccination:
  - **Age 9 through 14 years at initial vaccination**: 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
  - **Age 15 years or older at initial vaccination**: 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
- If completed valid vaccination series with any HPV vaccine, no additional doses needed

Special situations
- **Immunocompromising conditions, including HIV infection:** 3-dose series as above
- **History of sexual abuse or assault:** Start at age 9 years.
- **Pregnancy:** HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

Influenza vaccination (minimum age: 6 months [IIV], 2 years [LAIV], 18 years [recombinant influenza vaccine, RIV])

Routine vaccination
- Use any influenza vaccine appropriate for age and health status annually:
  - 2 doses, separated by at least 4 weeks, for **children age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2019, or whose influenza vaccination history is unknown (administer dose 2 even if the child turns 9 between receipt of dose 1 and dose 2)
  - 1 dose for **children age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2019
  - 1 dose for **all persons age 9 years and older**
- For the 2020–21 season, see the 2020–21 ACIP influenza vaccine recommendations.

Special situations
- **Egg allergy, hives only**: Any influenza vaccine appropriate for age and health status annually
- **Egg allergy with symptoms other than hives** (e.g., angioedema, respiratory distress, need for emergency medical services or epinephrine): Any influenza vaccine appropriate for age and health status annually in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions
- **LAIV should not be used** in persons with the following conditions or situations:
  - History of severe allergic reaction to a previous dose of any influenza vaccine or to any vaccine component (excluding egg, see details above)
  - Receiving aspirin or salicylate-containing medications
  - Age 2–4 years with history of asthma or wheezing
  - Immunocompromised due to any cause (including medications and HIV infection)
  - Anatomic or functional asplenia
  - Cochlear implant
  - Cerebrospinal fluid-oropharyngeal communication
  - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
  - Pregnancy
  - Received influenza antiviral medications within the previous 48 hours

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020

Measles, mumps, and rubella vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination
- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 4 weeks after dose 1.

Catch-up vaccination
- Unvaccinated children and adolescents: 2-dose series at least 4 weeks apart
- The maximum age for use of MMRV is 12 years.

Special situations
International travel
- **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series with dose 1 at 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.
- **Unvaccinated children age 12 months and older:** 2-dose series at least 4 weeks apart before departure

Meningococcal serogroup A,C,W,Y vaccination (minimum age: 2 months [MenACWY-CRM, Menveo], 9 months [MenACWY-D, Menactra])

Routine vaccination
- 2-dose series at 11–12 years, 16 years

Catch-up vaccination
- Age 13–15 years: 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- Age 16–18 years: 1 dose

Special situations
Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:
- **Menveo**
  - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
  - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
- **Menactra**
  - **Persistent complement component deficiency or complement inhibitor use:**
    - Age 9–23 months: 2-dose series at least 12 weeks apart
    - Age 24 months or older: 2-dose series at least 8 weeks apart
  - **Anatomic or functional asplenia, sickle cell disease, or HIV infection:**
    - Age 9–23 months: Not recommended
    - Age 24 months or older: 2-dose series at least 8 weeks apart
    - **Menactra** must be administered at least 4 weeks after completion of PCV13 series.

Travel in countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (www.cdc.gov/travel/)**:**
- Children less than age 24 months:
  - **Menveo (age 2–23 months):**
    - Dose 1 at 8 weeks: 4-dose series at 2, 4, 6, 12 months
    - Dose 1 at 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - **Menactra (age 9–23 months):**
    - 2-dose series (dose 2 at least 12 weeks after dose 1; dose 2 may be administered as early as 8 weeks after dose 1 in travelers)
- Children age 2 years or older: 1 dose **Menveo** or **Menactra**

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:
- 1 dose **Menveo** or **Menactra**

Adolescent vaccination of children who received MenACWY prior to age 10 years:
- **Children for whom boosters are recommended** because of an ongoing increased risk of meningococcal disease (e.g., those with complement deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk (see below).
- **Children for whom boosters are not recommended** (e.g., those who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

Note: Menactra should be administered either before or at the same time as DTaP. For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and for additional meningococcal vaccination information, see www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

Meningococcal serogroup B vaccination (minimum age: 10 years [MenB-4C, Bexsero; MenB-FHbp, Trumenba])

Shared clinical decision-making
- **Adolescents not at increased risk** age 16–23 years (preferred age 16–18 years) based on shared clinical decision-making:
  - **Bexsero:** 2-dose series at least 1 month apart
  - **Trumenba:** 2-dose series at least 6 months apart; if dose 2 is administered earlier than 6 months, administer a 3rd dose at least 4 months after dose 2.

Special situations
Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:
- **Bexsero:** 2-dose series at least 1 month apart
- **Trumenba:** 3-dose series at 0, 1–2, 6 months

Bexsero and **Trumenba** are not interchangeable; the same product should be used for all doses in a series.
For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and for additional meningococcal vaccination information, see www.cdc.gov/vaccines/acip/recommendations.html and www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

Pneumococcal vaccination (minimum age: 6 weeks [PCV13], 2 years [PPSV23])

Routine vaccination with PCV13
- 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV13
- 1 dose for healthy children age 24–59 months with any incomplete* PCV13 series
- For other catch-up guidance, see Table 2.

Special situations
High-risk conditions below: When both PCV13 and PPSV23 are indicated, administer PCV13 first. PCV13 and PPSV23 should not be administered during the same visit.

Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure), chronic lung disease (including asthma treated with high-dose, oral corticosteroids), diabetes mellitus:

Age 2–5 years
- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Age 6–18 years
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Cerebrospinal fluid leak, cochlear implant:

Age 2–5 years
- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Age 6–18 years
- No history of either PCV13 or PPSV23: 1 dose PCV13, 1 dose PPSV23 at least 8 weeks later
- Any PCV13 but no PPSV23: 1 dose PPSV23 at least 8 weeks after the most recent dose of PCV13
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent dose of PPSV23

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020

Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:

Age 2–5 years

- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose) and a 2nd dose of PPSV23 5 years later

Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- Any PCV13 but no PPSV23: 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after the most recent dose of PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent PPSV23 dose and a 2nd dose of PPSV23 administered 5 years after dose 1 of PPSV23 and at least 8 weeks after a dose of PCV13

Chronic liver disease, alcoholism:

Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series. See Tables 8, 9, and 11 in the ACIP pneumococcal vaccine recommendations at www.cdc.gov/mmwr/pdf/rr/rr5911.pdf for complete schedule details.

Poliovirus vaccination (minimum age: 6 weeks)

Routine vaccination

- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose at or after age 4 years and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended at or after age 4 years and at least 6 months after the previous dose.

Catch-up vaccination

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- IPV is not routinely recommended for U.S. residents 18 years and older.

Series containing oral polio vaccine (OPV), either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
  - Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
  - Doses of OPV administered on or after April 1, 2016, should not be counted.
  - For guidance to assess doses documented as "OPV," see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Table 2.

Rotavirus vaccination (minimum age: 6 weeks)

Routine vaccination

- **Rotarix:** 2-dose series at 2 and 4 months
- **RotaTeq:** 3-dose series at 2, 4, and 6 months
- If any dose in the series is either **RotaTeq** or unknown, default to 3-dose series.

Catch-up vaccination

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Table 2.

Tetanus, diphtheria, and pertussis (Tdap) vaccination (minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination

- **Adolescents age 11–12 years:** 1 dose Tdap
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination

- **Adolescents age 13–18 years who have not received Tdap:** 1 dose Tdap, then Td or Tdap booster every 10 years
- **Persons age 7–18 years not fully vaccinated* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at 7–10 years:**
  - **Children age 7–9 years** who receive Tdap should receive the routine Tdap dose at age 11–12 years.
  - **Children age 10 years** who receive Tdap do not need to receive the routine Tdap dose at age 11–12 years.
- **DTaP inadvertently administered at or after age 7 years:**
  - **Children age 7–9 years:** DTaP may count as part of catch-up series. Routine Tdap dose at age 11–12 years should be administered.
  - **Children age 10–18 years:** Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Table 2.
- For information on use of Tdap or Td as tetanus prophylaxis in wound management, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

**Fully vaccinated* = 5 valid doses of DTaP OR 4 valid doses of DTaP if dose 4 was administered at age 4 years or older

Varicella vaccination (minimum age: 12 months)

Routine vaccination

- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 3 months after dose 1 (a dose administered after a 4-week interval may be counted).

Catch-up vaccination

- Ensure persons age 7–18 years without evidence of immunity (see www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2-dose series:
  - **Age 7–12 years:** routine interval: 3 months (a dose administered after a 4-week interval may be counted)
  - **Age 13 years and older:** routine interval: 4–8 weeks (minimum interval: 4 weeks)
  - The maximum age for use of MMRV is 12 years.

Recommended Adult Immunization Schedule
for ages 19 years or older

UNITED STATES
2020

How to use the adult immunization schedule

1 Determine recommended vaccinations by age **(Table 1)**

2 Assess need for additional recommended vaccinations by medical condition and other indications **(Table 2)**

3 Review vaccine types, frequencies, and intervals and considerations for special situations **(Notes)**

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American College of Physicians (www.acponline.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), and American College of Nurse-Midwives (www.midwife.org).

Vaccines in the Adult Immunization Schedule*

Vaccines	Abbreviations	Trade names
Haemophilus influenzae type b vaccine	Hib	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	HepA	Havrix® Vaqta®
Hepatitis A and hepatitis B vaccine	HepA-HepB	Twinrix®
Hepatitis B vaccine	HepB	Engerix-B® Recombivax HB® Heplisav-B®
Human papillomavirus vaccine	HPV vaccine	Gardasil 9®
Influenza vaccine (inactivated)	IIV	Many brands
Influenza vaccine (live, attenuated)	LAIV	FluMist® Quadrivalent
Influenza vaccine (recombinant)	RIV	Flublok® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R® II
Meningococcal serogroups A, C, W, Y vaccine	MenACWY	Menactra® Menveo®
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero® Trumenba®
Pneumococcal 13-valent conjugate vaccine	PCV13	Prevnar 13®
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax® 23
Tetanus and diphtheria toxoids	Td	Tenivac® Tdvax™
Tetanus and diphtheria toxoids and acellular pertussis vaccine	Tdap	Adacel® Boostrix®
Varicella vaccine	VAR	Varivax®
Zoster vaccine, recombinant	RZV	Shingrix
Zoster vaccine live	ZVL	Zostavax®

*Administer recommended vaccines if vaccination history is incomplete or unknown. Do not restart or add doses to vaccine series if there are extended intervals between doses. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

Report
- Suspected cases of reportable vaccine-preventable diseases or outbreaks to the local or state health department
- Clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System at www.vaers.hhs.gov or 800-822-7967

Injury claims
All vaccines included in the adult immunization schedule except pneumococcal 23-valent polysaccharide (PPSV23) and zoster (RZV, ZVL) vaccines are covered by the Vaccine Injury Compensation Program. Information on how to file a vaccine injury claim is available at www.hrsa.gov/vaccinecompensation.

Questions or comments
Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.

Download the CDC Vaccine Schedules App for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html.

Helpful information
- Complete ACIP recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- General Best Practice Guidelines for Immunization (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/vaccines/pubs/surv-manual
- Travel vaccine recommendations: www.cdc.gov/travel
- Recommended Child and Adolescent Immunization Schedule, United States, 2020: www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS310021-A

Table 1 Recommended Adult Immunization Schedule by Age Group, United States, 2020

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
Influenza inactivated (IIV) or **Influenza recombinant** (RIV)	1 dose annually			
or				
Influenza live, attenuated (LAIV)	1 dose annually			
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap, then Td or Tdap booster every 10 years			
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)			
Varicella (VAR)	2 doses (if born in 1980 or later)		2 doses	
Zoster recombinant (RZV) *(preferred)*			2 doses	
or				
Zoster live (ZVL)			1 dose	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
Pneumococcal conjugate (PCV13)	1 dose			65 years and older
Pneumococcal polysaccharide (PPSV23)	1 or 2 doses depending on indication			1 dose
Hepatitis A (HepA)	2 or 3 doses depending on vaccine			
Hepatitis B (HepB)	2 or 3 doses depending on vaccine			
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication, see notes for booster recommendations			
Meningococcal B (MenB)	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations			
	19 through 23 years			
***Haemophilus influenzae* type b** (Hib)	1 or 3 doses depending on indication			

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended vaccination for adults with an additional risk factor or another indication

Recommended vaccination based on shared clinical decision-making

No recommendation/ Not applicable

Table 2 Recommended Adult Immunization Schedule by Medical Condition and Other Indications, United States, 2020

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 count <200	HIV infection CD4 count ≥200	Asplenia, complement deficiencies	End-stage renal disease; or on hemodialysis	Heart or lung disease, alcoholism[1]	Chronic liver disease	Diabetes	Health care personnel[2]	Men who have sex with men
IIV or RIV or LAIV	1 dose annually									or 1 dose annually	
	NOT RECOMMENDED						PRECAUTION				
Tdap or Td	1 dose Tdap each pregnancy	1 dose Tdap, then Td or Tdap booster every 10 years									
MMR	NOT RECOMMENDED	1 or 2 doses depending on indication									
VAR	NOT RECOMMENDED	2 doses									
RZV (preferred) or ZVL	DELAY				2 doses at age ≥50 years or 1 dose at age ≥60 years						
	NOT RECOMMENDED										
HPV	DELAY	3 doses through age 26 years			2 or 3 doses through age 26 years						
PCV13		1 dose									
PPSV23		1, 2, or 3 doses depending on age and indication									
HepA					2 or 3 doses depending on vaccine						
HepB							2 or 3 doses depending on vaccine				
Men ACWY	1 or 2 doses depending on indication, see notes for booster recommendations										
MenB	PRECAUTION	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations									
Hib		3 doses HSCT[3] recipients only			1 dose						

- Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection
- Recommended vaccination for adults with an additional risk factor or another indication
- Precaution—vaccination might be indicated if benefit of protection outweighs risk of adverse reaction
- Delay vaccination until after pregnancy if vaccine is indicated
- Not recommended/ contraindicated—vaccine should not be administered
- No recommendation/ Not applicable

1. Precaution for LAIV does not apply to alcoholism. 2. See notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations. 3. Hematopoietic stem cell transplant.

Notes

Recommended Adult Immunization Schedule, United States, 2020

***Haemophilus influenzae* type b vaccination**

Special situations

- **Anatomical or functional asplenia (including sickle cell disease):** 1 dose if previously did not receive Hib; if elective splenectomy, 1 dose, preferably at least 14 days before splenectomy
- **Hematopoietic stem cell transplant** (HSCT): 3-dose series 4 weeks apart starting 6–12 months after successful transplant, regardless of Hib vaccination history
- **Pregnancy** if at risk for infection or severe outcome from infection during pregnancy
- **Settings for exposure, including** health care settings targeting services to injection or noninjection drug users or group homes and nonresidential day care facilities for developmentally disabled persons (individual risk factor screening not required)

Hepatitis A vaccination

Routine vaccination

- **Not at risk but want protection from hepatitis A** (identification of risk factor not required): 2-dose series HepA (Havrix 6–12 months apart or Vaqta 6–18 months apart [minimum interval: 6 months]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: 4 weeks between doses 1 and 2/5 months between doses 2 and 3])

Special situations

- **At risk for hepatitis A virus infection:** 2-dose series HepA or 3-dose series HepA-HepB as above
  - **Chronic liver disease** (e.g., persons with hepatitis B, hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice the upper limit of normal)
  - **HIV infection**
  - **Men who have sex with men**
  - **Injection or noninjection drug use**
  - **Persons experiencing homelessness**
  - **Work with hepatitis A virus** in research laboratory or with nonhuman primates with hepatitis A virus infection
  - **Travel in countries with high or intermediate endemic hepatitis A**
  - **Close, personal contact with international adoptee** (e.g., household or regular babysitting) in first 60 days after arrival from country with high or intermediate endemic hepatitis A (administer dose 1 as soon as adoption is planned, at least 2 weeks before adoptee's arrival)

Hepatitis B vaccination

Routine vaccination

- **Not at risk but want protection from hepatitis B** (identification of risk factor not required): 2- or 3-dose series (2-dose series Heplisav-B at least 4 weeks apart [2-dose series Hepb only applies when 2 doses of Heplisav-B are used at least 4 weeks apart] or 3-dose series Engerix-B or Recombivax HB at 0, 1, 6 months [minimum intervals: 4 weeks between doses 1 and 2/8 weeks between doses 2 and 3/16 weeks between doses 1 and 3]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: 4 weeks between doses 1 and 2/5 months between doses 2 and 3])

Special situations

- **At risk for hepatitis B virus infection:** 2-dose (Heplisav-B) or 3-dose (Engerix-B, Recombivax HB) series or 3-dose series HepA-HepB (Twinrix) as above
  - **Chronic liver disease** (e.g., persons with hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice upper limit of normal)
  - **HIV infection**
  - **Sexual exposure risk** (e.g., sex partners of hepatitis B surface antigen [HBsAg]-positive persons; sexually active persons not in mutually monogamous relationships; persons seeking evaluation or treatment for a sexually transmitted infection; men who have sex with men)
  - **Current or recent injection drug use**
  - **Percutaneous or mucosal risk for exposure to blood** (e.g., household contacts of HBsAg-positive persons; residents and staff of facilities for developmentally disabled persons; health care and public safety personnel with reasonably anticipated risk for exposure to blood or blood-contaminated body fluids; hemodialysis, peritoneal dialysis, home dialysis, and predialysis patients; persons with diabetes mellitus age younger than 60 years and, at discretion of treating clinician, those age 60 years or older)
  - **Incarcerated persons**
  - **Travel in countries with high or intermediate endemic hepatitis B**
  - **Pregnancy** if at risk for infection or severe outcome from infection during pregnancy (Heplisav-B not currently recommended due to lack of safety data in pregnant women)

Human papillomavirus vaccination

Routine vaccination

- **HPV vaccination recommended for all adults through age 26 years:** 2- or 3-dose series depending on age at initial vaccination or condition:
  - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2, 6 months (minimum intervals: 4 weeks between doses 1 and 2/12 weeks between doses 2 and 3/5 months between doses 1 and 3; repeat dose if administered too soon)
  - **Age 9 through 14 years at initial vaccination and received 1 dose or 2 doses less than 5 months apart:** 1 dose
  - **Age 9 through 14 years at initial vaccination and received 2 doses at least 5 months apart:** HPV vaccination complete, no additional dose needed.
- **If completed valid vaccination series with any HPV vaccine, no additional doses needed**

Shared clinical decision-making

- **Age 27 through 45 years based on shared clinical decision-making:**
  - 2- or 3-dose series as above

Special situations

- **Pregnancy through age 26 years:** HPV vaccination is not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

Notes Recommended Adult Immunization Schedule, United States, 2020

Influenza vaccination

Routine vaccination

- **Persons age 6 months or older**: 1 dose any influenza vaccine appropriate for age and health status annually
- For additional guidance, see www.cdc.gov/flu/professionals/index.htm

Special situations

- **Egg allergy, hives only**: 1 dose any influenza vaccine appropriate for age and health status annually
- **Egg allergy more severe than hives** (e.g., angioedema, respiratory distress): 1 dose any influenza vaccine appropriate for age and health status annually in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions
- **LAIV should not be used** in persons with the following conditions or situations:
  - History of severe allergic reaction to any vaccine component (excluding egg) or to a previous dose of any influenza vaccine
  - Immunocompromised due to any cause (including medications and HIV infection)
  - Anatomic or functional asplenia
  - Cochlear implant
  - Cerebrospinal fluid-oropharyngeal communication
  - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
  - Pregnancy
  - Received influenza antiviral medications within the previous 48 hours
- **History of Guillain-Barré syndrome within 6 weeks of previous dose of influenza vaccine**: Generally should not be vaccinated unless vaccination benefits outweigh risks for those at higher risk for severe complications from influenza

Measles, mumps, and rubella vaccination

Routine vaccination

- **No evidence of immunity to measles, mumps, or rubella**: 1 dose
  - **Evidence of immunity**: Born before 1957 (health care personnel, see below), documentation of receipt of MMR vaccine, laboratory evidence of immunity or disease (diagnosis of disease without laboratory confirmation is not evidence of immunity)

Special situations

- **Pregnancy with no evidence of immunity to rubella**: MMR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose
- **Nonpregnant women of childbearing age with no evidence of immunity to rubella**: 1 dose
- **HIV infection with CD4 count ≥200 cells/µL for at least 6 months and no evidence of immunity to measles, mumps, or rubella**: 2-dose series at least 4 weeks apart; MMR contraindicated in HIV infection with CD4 count <200 cells/µL
- **Severe immunocompromising conditions**: MMR contraindicated
- **Students in postsecondary educational institutions, international travelers, and household or close, personal contacts of immunocompromised persons with no evidence of immunity to measles, mumps, or rubella**: 2-dose series at least 4 weeks apart if previously did not receive any doses of MMR or 1 dose if previously received 1 dose MMR
- **Health care personnel**:
  - **Born in 1957 or later with no evidence of immunity to measles, mumps, or rubella**: 2-dose series at least 4 weeks apart for measles or mumps or at least 1 dose for rubella
  - **Born before 1957 with no evidence of immunity to measles, mumps, or rubella**: Consider 2-dose series at least 4 weeks apart for measles or mumps or 1 dose for rubella

Meningococcal vaccination

Special situations for MenACWY

- **Anatomical or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use**: 2-dose series MenACWY (Menactra, Menveo) at least 8 weeks apart and revaccinate every 5 years if risk remains
- **Travel in countries with hyperendemic or epidemic meningococcal disease, microbiologists routinely exposed to *Neisseria meningitidis***: 1 dose MenACWY (Menactra, Menveo) and revaccinate every 5 years if risk remains
- **First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) and military recruits**: 1 dose MenACWY (Menactra, Menveo)

Shared clinical decision-making for MenB

- **Adolescents and young adults age 16 through 23 years (age 16 through 18 years preferred) not at increased risk for meningococcal disease**: Based on shared clinical decision-making, 2-dose series MenB-4C at least 1 month apart or 2-dose series MenB-FHbp at 0, 6 months (if dose 2 was administered less than 6 months after dose 1, administer dose 3 at least 4 months after dose 2); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series)

Special situations for MenB

- **Anatomical or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use, microbiologists routinely exposed to *Neisseria meningitidis***: 2-dose primary series MenB-4C (Bexsero) at least 1 month apart or 3-dose primary series MenB-FHbp (Trumenba) at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series); 1 dose MenB booster 1 year after primary series and revaccinate every 2–3 years if risk remains
- **Pregnancy**: Delay MenB until after pregnancy unless at increased risk and vaccination benefits outweigh potential risks

Notes Recommended Adult Immunization Schedule, United States, 2020

Pneumococcal vaccination

Routine vaccination

- **Age 65 years or older** (immunocompetent–see www.cdc.gov/mmwr/volumes/68/wr/mm6846a5.htm?s_cid=mm6846a5_w): 1 dose PPSV23
  - If PPSV23 was administered prior to age 65 years, administer 1 dose PPSV23 at least 5 years after previous dose

Shared clinical decision-making

- **Age 65 years and older** (immunocompetent): 1 dose PCV13 based on **shared clinical decision-making**
  - If both PCV13 and PPSV23 are to be administered, PCV13 should be administered first
  - PCV13 and PPSV23 should be administered at least 1 year apart
  - PCV13 and PPSV23 should not be administered during the same visit

Special situations

(see www.cdc.gov/mmwr/volumes/68/wr/mm6846a5.htm?s_cid=mm6846a5_w)

- **Age 19 through 64 years with chronic medical conditions (chronic heart [excluding hypertension], lung, or liver disease, diabetes), alcoholism, or cigarette smoking**: 1 dose PPSV23
- **Age 19 years or older with immunocompromising conditions (congenital or acquired immunodeficiency [including B- and T-lymphocyte deficiency, complement deficiencies, phagocytic disorders, HIV infection], chronic renal failure, nephrotic syndrome, leukemia, lymphoma, Hodgkin disease, generalized malignancy, iatrogenic immunosuppression [e.g., drug or radiation therapy], solid organ transplant, multiple myeloma) or anatomical or functional asplenia (including sickle cell disease and other hemoglobinopathies)**: 1 dose PCV13 followed by 1 dose PPSV23 at least 8 weeks later, then another dose PPSV23 at least 5 years after previous PPSV23; at age 65 years or older, administer 1 dose PPSV23 at least 5 years after most recent PPSV23 (note: only 1 dose PPSV23 recommended at age 65 years or older)
- **Age 19 years or older with cerebrospinal fluid leak or cochlear implant**: 1 dose PCV13 followed by 1 dose PPSV23 at least 8 weeks later; at age 65 years or older, administer another dose PPSV23 at least 5 years after PPSV23 (note: only 1 dose PPSV23 recommended at age 65 years or older)

Tetanus, diphtheria, and pertussis vaccination

Routine vaccination

- **Previously did not receive Tdap at or after age 11 years**: 1 dose Tdap, then Td or Tdap every 10 years

Special situations

- **Previously did not receive primary vaccination series for tetanus, diphtheria, or pertussis**: At least 1 dose Tdap followed by 1 dose Td or Tdap at least 4 weeks after Tdap and another dose Td or Tdap 6–12 months after last Td or Tdap (Tdap can be substituted for any Td dose, but preferred as first dose); Td or Tdap every 10 years thereafter
- **Pregnancy**: 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- For information on use of Td or Tdap as tetanus prophylaxis in wound management, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm

Varicella vaccination

Routine vaccination

- **No evidence of immunity to varicella**: 2-dose series 4–8 weeks apart if previously did not receive varicella-containing vaccine (VAR or MMRV [measles-mumps-rubella-varicella vaccine] for children); if previously received 1 dose varicella-containing vaccine, 1 dose at least 4 weeks after first dose
  - Evidence of immunity: U.S.-born before 1980 (except for pregnant women and health care personnel [see below]), documentation of 2 doses varicella-containing vaccine at least 4 weeks apart, diagnosis or verification of history of varicella or herpes zoster by a health care provider, laboratory evidence of immunity or disease

Special situations

- **Pregnancy with no evidence of immunity to varicella**: VAR contraindicated during pregnancy; after pregnancy (before discharge from health care facility) 1 dose if previously received 1 dose varicella-containing vaccine or dose 1 of 2-dose series (dose 2: 4–8 weeks later) if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **Health care personnel with no evidence of immunity to varicella**: 1 dose if previously received 1 dose varicella-containing vaccine; 2-dose series 4–8 weeks apart if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **HIV infection with CD4 count ≥200 cells/µL with no evidence of immunity**: Vaccination may be considered (2 doses, administered 3 months apart); VAR contraindicated in HIV infection with CD4 count <200 cells/µL
- **Severe immunocompromising conditions**: VAR contraindicated

Zoster vaccination

Routine vaccination

- **Age 50 years or older**: 2-dose series RZV (Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon), regardless of previous herpes zoster or history of ZVL (Zostavax) vaccination (administer RZV at least 2 months after ZVL)
- **Age 60 years or older**: 2-dose series RZV 2–6 months apart (minimum interval: 4 weeks; repeat if administered too soon) or 1 dose ZVL if not previously vaccinated. RZV preferred over ZVL (if previously received ZVL, administer RZV at least 2 months after ZVL)

Special situations

- **Pregnancy**: ZVL contraindicated; consider delaying RZV until after pregnancy if RZV is otherwise indicated
- **Severe immunocompromising conditions (including HIV infection with CD4 count <200 cells/µL)**: ZVL contraindicated; recommended use of RZV under review

"APPENDIX C
NOTICE OF PRIVACY PRACTICES

Prime Healthcare	***3480 E. Guasti Road, Ontario, CA 91761*** ***Clay Wombacker, Chief Compliance Officer*** ***cwombacher@phprimehealthcare.com*** ***(909) 638-0092***

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This Section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	▪ You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. ▪ We will provide a copy of a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	▪ You can ask us to correct your health and claims records if you think we are incorrect or incomplete. Ask us how to do this. ▪ We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	▪ You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. ▪ We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	▪ You can ask us not to use or share certain health information for treatment, payment, or our operations. ▪ We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	▪ You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. ▪ We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

YOUR RIGHTS *CONTINUED*

Get a copy of this privacy notice	▪ You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	▪ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. ▪ We will make sure the person has this authority and can act for you before we take action.
File a complaint if you feel your rights are violated	▪ You can complain if you feel we have violated your rights by contacting us using the information on page 1. ▪ You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. ▪ We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	▪ Share information with your family, close friends, or others involved in payment for your care ▪ Share information in a disaster relief situation ▪ Contact you for fundraising efforts ▪ If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases, we never share your information unless you give us written permission:	▪ Marketing purposes ▪ Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	▪ We can use your health information and share it with professionals who are treating you.	Example: A doctor sends us information about your diagnosis and treatment plan, so we can arrange additional services.
Run our organization	▪ We can use and disclose your information to run our organization and contact you when necessary. ▪ We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	Example: We use health information about you to develop better services for you.
Pay for your health services	▪ We can use and disclose your health information as we pay for your health services.	Example: We share information about you with your dental plan to coordinate payment for your dental work.
Administer your plan	▪ We may disclose your health information to your health plan sponsor for plan administration.	Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues	▪ We can share health information about you for certain situations such as:
	  ▪ Preventing disease
	  ▪ Helping with product recalls
	  ▪ Reporting adverse reactions to medications
	  ▪ Reporting suspected abuse neglect, or domestic violence
	  ▪ Preventing or reducing a serious threat to anyone's health or safety

Do research	▪ We can use or share your information for health research.

OUR USES AND DISCLOSURES *CONTINUED*

Comply with the law	▪ We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	▪ We can share health information about you with organ procurement organizations. ▪ We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	▪ We can use or share health information about you: ▪ For workers' compensation claims ▪ For law enforcement purposes or with a law enforcement official ▪ With health oversight agencies for activities authorized by law ▪ For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	▪ We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date of Notice: January 1, 2021.

Clay Wombacker, Chief Compliance Officer
cwombacher@phprimehealthcare.com
(909) 638-0092

Prime Healthcare Value Plan 2021 – 2nd Amendment to Addendum 101 changes effective January 1, 2021 are as follows:

1. The first Section entitled "Prime Healthcare entities included in the following schedule of medical benefits are:" is hereby amended by listing out the facilites included for clarity:

- Alvarado Hospital Medical Center
- Bio-Med Services, Inc.
- Centinela Hospital Medical Center
- Chino Valley Medical Center
- Coshocton Regional Medical Center
- CPCN Physicians Service
- Dallas Medical Center
- Dallas Medical Physician Group
- Dallas Regional Medical Center
- Desert Valley Hospital
- Desert Valley Medical Group
- East Liverpool City Hospital
- Encino Hospital Medical Center
- Gadsden Physician Management
- Garden City Hospital
- Prime Garden City Medical Group
- Garden Grove Hospital Medical Center
- Glendora Oaks Behavioral Health Hospital
- Harlingen Medical Center
- Huntington Beach Hospital
- Knapp Medical Center
- Knapp Medical Group
- Lake Huron Medical Center
- Lake Huron Medical Group
- La Palma Intercommunity Hospital
- Lehigh Regional Medical Center
- Lower Bucks Hospital
- Mission Regional Medical Center
- Monroe Hospital
- Montclair Hospital Medical Center
- North Vista Hospital
- North Vista Medical Group
- Ohio Valley Home Health Services
- Pampa Regional Medical Center
- Paradise Valley Hospital
- Paradise Valley Medical Group
- Prime Healthcare Management, Inc.
- Providence Medical Center
- Riverview Regional Medical Center
- River Valley Physicians
- Roxborough Memorial Hospital
- Saint Clare's Behavioral Health
- Saint Clare's Denville Hospital
- Saint Clare's Dover Hospital
- Saint John Hospital
- St. Joseph Medical Center
- Saint Mary's General Hospital
- St. Mary's Medical Center
- Saint Mary's Medical Group
- Saint Mary's Regional Medical Center
- Saint Michael's Medical Center
- San Dimas Community Hospital
- Shasta Regional Medical Center
- Shasta Regional Medical Group
- Sherman Oaks Hospital
- Southern Regional Medical Center
- Suburban Community Hospital
- Suburban Medical Group
- Summit Surgery Center at Saint Mary's Galena
- United Home Health Services
- West Anaheim Medical Center

2. Add the following after the second paragraph on page 1:

"Eligible Dependent: A current spouse or other Partner may be eligible to be a Dependent if they are eligible for coverage under another group medical plan that provides minimum value as described in section 36B(c)(2)(C)(ii) of the IRS Code (See the Dependent Eligibility Charts and requirements in the Prime Employee Benefits Guide)."

3. The section under "**Tier 2 Blue Shield of CA Network / BCBS BlueCard Network**" is hereby amended by updating the Annual Out-of-Pocket Maximum as follows:

Tier 2 Blue Shield of CA Network / BCBS BlueCard Network	
Annual Out-of-Pocket Maximum	$5,550 Individual / $11,100 Family

4. The second Section is hereby amended by changing the line item in Tier 1 and Tier 2 "Acute Dialysis" as follows:

Tier 1 Prime Healthcare Network	
Dialysis[1]: 39 lifetime visits	20% coinsurance, No Deductible

[1] Visit limits are combined with Tier 1 Prime Healthcare Network and Tier 2 Blue Shield of CA / BCBS BlueCard Network.

Tier 2 Blue Shield of CA Network / BCBS BlueCard Network	
Dialysis[1]: 39 lifetime visits	Deductible plus 60% coinsurance

[1] Visit limits are combined with Tier 1 Prime Healthcare Network and Tier 2 Blue Shield of CA / BCBS BlueCard Network.

5. The Section entitled "**SCHEDULE OF PRECRIPTION COPAYS**" is amended by adding an "Annual Out-of-Pocket Maximum" as follows:

Express Scripts	Prime Pharmacy	Retail
Annual Out-of-Pocket Maximum	**Combined with Medical Tier 2 OOP Maximum**	