PRIME HEALTHCARE

SUMMARY PLAN DESCRIPTION

OF THE

UNIFIED EPO PLAN AND PRESCRIPTION DRUG BENEFITS

JANUARY 1, 2022

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INTRODUCTION

The Plan is designed to provide eligible Employees of Prime Healthcare Services, Inc., Prime Healthcare Foundation, 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., Prime Healthcare Foundation, 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.

UTILIZATION MANAGEMENT PROGRAM

WARNING: THE EPO MEDICAL PLAN AND PRESCRIPTION DRUG BENEFITS PLAN (THE "PLAN") PROVIDES COVERAGE ONLY WHEN CERTAIN PROVIDERS AND FACILITIES ARE USED. PLEASE READ THE FOLLOWING INFORMATION TO KNOW HOW TO OBTAIN COVERED SERVICES. ALL PLAN REQUIREMENTS AND BENEFITS ARE SUBJECT TO VARIATION BASED ON THE PRIME HEALTHCARE ENTITY THROUGH WHICH THE COVERED PERSON RECEIVES BENEFITS. ENTITIES WITH COLLECTIVE BARGAINING AGREEMENTS MAY HAVE VARIATIONS. PLEASE READ THE ADDENDUM FOR THE APPLICABLE PRIME HEALTHCARE ENTITY TO CONFIRM ANY SUCH VARIATION.

For quality of review and continuity of medical care, the Plan includes a **Utilization Management Program** as described below.

PRE-SERVICE REVIEW: Pre-service review and approval is required for all Non-Emergency Services, with only limited exceptions set forth directly below. If the pre-service review requirements are not completed and approved, benefits will not be payable under the Plan. Any additional share of expenses that becomes the Covered Person's responsibility for failure to comply with these requirements will not be considered Eligible Expenses and thus will not apply to any Coinsurance or Out-of-Pocket Maximums of the Plan.

- **Pre-Service Review Not Required for Office Visits to Prime Healthcare Network Primary Care Provider -** Office visits with a Primary Care Provider in the Prime Healthcare Network are not subject to the pre-service review requirements. However, all other Plan provisions continue to apply. For example, the office testing covered under the Plan is limited to the services included on the Prime Utilization Management Auto-Authorization List.

- **Pre-Service Review Not Required for Office Visits to Prime Healthcare Network Mental Health or Substance Use Disorder Provider -** Office visits with a Mental Health or Substance Use Disorder Provider in the Prime Healthcare Network are not subject to the pre-service review requirements. However, all other Plan provisions continue to apply. For example, the office testing covered under the Plan is limited to the services included on the Prime Healthcare Utilization Management Auto-Authorization List.

- **Pre-Service Review Not Required for Annual Well Woman Exam with Primary Care Provider -** Annual Well Woman Exam visits with a Primary Care Network Provider or a Network Provider who specializes in Obstetrics or Gynecology are not subject to the pre-service review requirements. The Network Provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For assistance on how to locate participating Network Providers who specialize in obstetrics or gynecology, contact Prime Healthcare Customer Service at (877) 234-5227, email EHP@primehealthcare.com or reference the Tier 1 Prime Provider Directory at www.primehealthcare.com/EHP or your local hospital website. See the **Mandatory Selection of a Primary Care Physician** section for more details.

- **Childbirth -** The Plan will pay for benefits for a hospital stay in connection with childbirth for the mother or newborn child up to at least 48 hours following a vaginal delivery, or 96 hours following a cesarean section delivery. However, if/when the

Pregnancy confinement for the mother or newborn is expected to exceed these limits, prior authorization for such extended confinement is required.

HOW TO OBTAIN PRE-SERVICE REVIEWS

It is the Covered Person's responsibility to confirm that the pre-service review requirements have been satisfied. For instructions on how to request pre-service review, contact Prime Healthcare Customer Service Department at (877) 234-5227.

The following rules apply to Pre-Service Reviews:

- For all elective services that are subject to utilization review, a Covered Person or their Physician must initiate the pre-service review when notified that an elective service is needed or at least 14 calendar days prior to when a Covered Person is scheduled to receive services.
- The Covered Person must receive the authorized service within 90 Calendar days of the certification or a new pre-service review must be obtained.
- The Prime Healthcare Utilization Management Department will determine if services are Medically Necessary and appropriate under the terms of the Plan.
- Pre-authorization for a specialty Physician referral covers only the initial consultation.

NOTE: A determination of Medical Necessity does not guarantee that the services are covered under the Plan.

MORE INFORMATION ABOUT PRE-SERVICE REVIEW

To minimize the risk of non-compliance, the Employee or other Covered Person should contact the Prime Healthcare Utilization Management Department to make certain that the facility or attending Physician has initiated the necessary processes.

Pre-service review and authorization is **not a guarantee of coverage**. The **Utilization Management Program** is designed ONLY to determine whether a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the **Utilization Management Program** will increase benefits to cover any confinement or service that is not Medically Necessary or that is otherwise not covered under the Plan.

See "Pre-Service Claims" in the **Claims and Appeals Procedures** section for more information, including information on appealing an adverse decision (i.e., a benefit denial) under this program.

SERVICES NOT AVAILABLE IN THE PRIME HEALTHCARE NETWORK: If a Prime Healthcare Network Physician or service is not available, a Covered Person may request pre-service review from the Prime Healthcare Utilization Management Department to determine if a BCBS BlueCard/Blue Shield of CA Network Provider may be available and approved under the Plan. If a Prime Healthcare Network Physician is available or the services can be provided safely at a Prime Healthcare Network facility, however, the services will not be covered under the Plan if provided elsewhere.

EMERGENCY SERVICES: The Prime Healthcare Utilization Management Department must be immediately notified upon the presentment of a Covered Person in a non-Prime Healthcare

Network Emergency Department of a Hospital or Independent Freestanding Emergency Department, and no later than 24 hours from presentment. It is the Covered Person's responsibility to make certain that the non-Prime Healthcare Network facility immediately calls the Prime Healthcare Utilization Management Department. Subject to the provisions of the No Surprises Act, services from a non-Prime Healthcare Network facility to a Covered Person after the Covered Person's condition is Stabilized may not be covered by the Plan unless the Prime Healthcare Utilization Management Department is notified.

The following rules apply to Emergency Services at non-Prime Healthcare Network facilities:

- **Stability for Transfer** – Once the Covered Person's condition has been Stabilized to the point they can be Transferred, subject to the provisions of the No Surprises Act, the Covered Person must be Transferred to a Prime Healthcare Network facility or benefits under the Plan may cease. Subject to the provisions of the No Surprises Act, it is both the Non-Prime Healthcare Network Provider's and the Covered Person's responsibility to request to be Transferred to the closest Prime Healthcare Network facility and the Non-Prime Healthcare Network Provider must make all reasonable efforts to repatriate the Covered Person to such Prime Healthcare Network facility.
- **Post-Stabilization Services Notice** – Subject to the provisions of the No Surprises Act, the Prime Healthcare Utilization Management Department must be notified of post-stabilization services at a Non-Prime Healthcare Network Provider every 24 hours for the services to continue being covered by the Plan.
- **Inpatient Admissions** – Subject to the provisions of the No Surprises Act, all Inpatient admissions require the patient's attending Physician or Treating Provider to contact the Prime Healthcare Utilization Management Department every 24 hours during the admission to be covered by the Plan.

EFFECTIVE JANUARY 1, 2022 THROUGH MARCH 31, 2022

REFERRAL AND AUTHORIZATION PROCESS:

Pre-service review and authorization are not required if the Covered Person is referred to a Prime Hospital or Facility for covered Inpatient and/or Outpatient services, laboratory tests and radiology procedures.

If the Covered Person is referred to a Specialist by a Primary Care Provider, the Covered Person must receive a pre-service review and authorization from the Prime Healthcare Utilization Management Department. A referral from a Tier 1 Prime Healthcare Provider to a Tier 1 Prime Healthcare Specialist does not require pre-service review and authorization for initial consultation. A referral to any other specialist or any visits beyond initial consultation requires pre-service review and authorization. Any authorization only covers the services specified. Certain pre-approved services performed during the initial consultation are covered without need for prior authorization. For a list of those services, please call Prime Healthcare Customer Service at (877) 234-5227, or email EHP@primehealthcare.com.

After the initial consultation, all Covered Persons must obtain pre-service review and authorization from the Prime Healthcare Utilization Management Department if additional care is requested by a Tier 1 Prime Healthcare Network Specialist or a Tier 2 BCBS BlueCard/Blue Shield of CA Network Specialist. The Prime Healthcare Utilization

Management Department will communicate its determination to the referring Provider and mail a copy of its determination to the Covered Person's home address.

If the Covered Person is referred to a Tier 2 BCBS BlueCard/Blue Shield of CA Network Provider, the referring Provider is required to submit a completed referral form to the Prime Healthcare Utilization Management Department. The Covered Person will be re-directed to a Tier 1 Prime Healthcare Network Provider if the necessary service is available within a fifty (50) mile radius of the applicable Employee's place of employment. The Prime Healthcare Utilization Management Department will review the requested treatment and communicate its determination to the referring Provider and mail a copy of its determination to the Covered Person's home address.

EFFECTIVE APRIL 1, 2022

REFERRAL AND AUTHORIZATION PROCESS:

A referral from a Tier 1 Prime Healthcare Primary Care Provider to a Tier 1 Prime Healthcare Specialist does not require prior authorization for Office Visits, services included on the Prime Healthcare Utilization Management Auto-Authorization list and US Prevention Task Force Preventive Screening services. All other specialty services require prior authorization.

If the Covered Person is referred to a Tier 2 BCBS BlueCard/Blue Shield of CA Network Specialist, the referring Provider must submit an authorization request to the Prime Healthcare Utilization Management Department. Once an authorization is obtained for the initial specialty office consult and 1.5 Benefits are applied, the Covered Person is allowed 3 follow-up visits within 365 days following the initial approved authorization date. A new authorization is required for specialty follow-up visits after 365 days of the initial approved authorization. All other specialty services require prior authorization for each follow-up visit. For a list of those services, refer to our website at www.primehealthcare.com/EHP.

For the status of a referral, please contact Prime Customer Service at (877) 234-5227 or email EHP@primehealthcare.com.

CONTINUITY OF CARE:
If a Network Provider is no longer a member of the Network (other than for fraud or failure to meet applicable quality standards), a Continuing Care Patient may request and elect to continue to have benefits provided under the Plan under the same terms and conditions as they would have been covered had no change occurred. Continuity of Care Services start on the date a notice of right to elect Continuity of Care is provided to the Covered Person and ends either 90 days later or the date on which the patient is no longer a Continuing Care Patient.

MEDICAL AND PRESCRIPTION DRUG BENEFITS

MANDATORY SELECTION OF A PRIMARY CARE PHYSICIAN

At the time of enrollment, each Covered Person must select a Primary Care Physician (PCP) from the Tier 1 Prime Provider Directory of Network Providers. The Tier 1 Prime Provider Directory can be found on www.primehealthcare.com/EHP or by contacting Prime Customer Service at (877) 234-5227. You have the right to designate any Primary Care Provider listed in the Tier 1 Prime Provider Directory and who is available to accept you or your family members. If a Covered Person is a minor or otherwise incapable of selecting a PCP, the Employee should select a PCP on the minor's behalf. For General Pediatrics, a Tier 2 BCBS BlueCard/Blue Shield of CA Network Primary Care Provider is also allowed. For information on how to select a Primary Care Provider, contact the Prime Healthcare Utilization Management Department at (877) 234-5227, or reference the Tier 1 Prime Provider Directory at www.primehealthcare.com/EHP or your local hospital website.

Women may designate an OB/GYN as their Primary Care Provider and children may designate a Pediatrician as their Primary Care Provider.

If a Prime Healthcare Network Physician is not available, a Covered Person may contact the Prime Healthcare Customer Service Department for instructions on how to request pre-service review to determine if a BCBS BlueCard/Blue Shield of CA Network Provider may be available and approved under the Plan. Covered Persons affiliated with certain Prime Hospitals and Facilities with limited Tier 1 Prime Healthcare Primary Care providers, may also select a Tier 2 BCBS BlueCard/BlueShield of CA Network Primary Care Provider without prior approval from the Prime Healthcare Utilization Management Department. Please see your applicable addendum to see if this special rule applies to your coverage. Office visit Copay is subject to the network Tier utilized.

If a Covered Person requires Hospital services or supplies, they will be referred to a Prime Healthcare Network Hospital. If services are not available at that Prime Healthcare Network facility, the Covered Person must contact the Prime Healthcare Utilization Management Department. See the **Utilization Management Program** section for details on seeking pre-service review.

COVERAGE FOR NETWORK PROVIDERS

The Plan Administrator has contracted with organizations or "networks" of Providers. Network Providers have agreed to provide services to Covered Persons at negotiated rates. Except in limited situations that are described herein, ALL HEALTH CARE must be authorized by the Prime Healthcare Utilization Management Department through pre-service review and be provided or ordered by Network Providers to be covered by the Plan.

If a Prime Healthcare Network Provider is not available and the Covered Person requests pre-service review from the Prime Healthcare Utilization Management Department, services from a BCBS BlueCard/Blue Shield of CA Network Provider may be approved under the Plan. In this case, though, the level of coverage of a Provider's services under the Plan will depend

upon the Tier of the Provider as described below. See the attached addendum for details on coverage amounts.

Tier 1 Prime Healthcare – Facilities, Physicians and non-Physician Licensed Network Providers who have agreements with Prime Healthcare to participate in its Provider Network.

Tier 2 BCBS BlueCard/Blue Shield of CA Network Providers – Facilities, Physicians and non-Physician Licensed Network Providers who have signed agreements to participate in the BCBS BlueCard/Blue Shield of CA Network.

The Plan Sponsor will automatically provide a Covered Person with information about how they can access directories of Network Providers.

1.5 Benefit – Generally, a Covered Person's Copay, Coinsurance and Deductible for services performed by Tier 1 Prime Healthcare Providers are lower than the Copay, Coinsurance and Deductible for services provided by Tier 2 BCBS BlueCard/Blue Shield of CA Network Providers.

If a Tier 1 Prime Healthcare Provider is not available, services performed by Tier 2 BCBS BlueCard/Blue Shield of CA Network Providers may be available to the Covered Person at Tier 1 cost levels, provided certain requirements are met and Prime Healthcare Utilization Management provides prior authorization for the 1.5 Benefit. This level of Plan benefit is referred to as the 1.5 Benefit and is available to an eligible Covered Person provided the applicable requirements are met.

The following eligibility requirements shall apply to the 1.5 Benefit:

- Employees and Dependents shall be actively enrolled in Prime (EPO) plan; and
- Specialty service is not available in Prime (EPO) Network (Tier 1) or within a radius of the employee place of employment as specified in the relevant addendum or as defined by the Plan; or
- Pediatric services Inpatient and PCP office visits. (excludes Labor Delivery Recovery Postpartum (LDRP), Neonatal Intensive Care Unit (NICU) and Newborn Nursery when service is available in Prime Healthcare Network (Tier 1)); or
- Tier 2 admission from a Prime Healthcare hospital.
- Tier 2 Emergency Services when transported by Emergency Medical System (EMS).

For example, a Covered Person may be eligible for the 1.5 Benefit if the requested service is not offered by a Tier 1 Prime Healthcare Provider within a radius of the covered Employee's place of employment as specified in the relevant addendum.

1.5 Benefits are only available if pre-authorization from the Prime Healthcare Utilization Management Department is obtained prior to receiving services. However, retro-authorization may be considered on appeal on a case-by-case basis.

1.5 Benefits do not apply to all services. 1.5 Benefits are not available for Dependents who reside in a state without any Tier 1 Prime Healthcare Facilities or Providers. Tier 2 Copayment, Coinsurance and Deductible costs still apply for the following services: Skilled

Nursing Facility Admissions, Dialysis Services, Urgent Care, Durable Medical Equipment, Inpatient Mental Health or Substance Use Disorder Services, Bariatric Services, Transplant Services and Sleep Studies.

Not Tier 1, 1.5 or Tier 2 – Any services or charges from an individual or entity not described in Tier 1, 1.5, 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:

Emergency Services Care – If a Covered Person requires items or services for an Emergency Medical Condition and must use the services of a Non-Network Provider, any such covered expenses will be paid as an Allowable Charge as described in the section entitled **Definitions**. See the **Utilization Management Program** section for details on Emergency Services coverage; and

Non-Network Provider Services at Network Facility Non-Emergency Visit (No Choice Provider) – Covered items or services received from a Non-Network Provider during a Non-Emergency Visit at a Network Provider Health Care Facility that have been the subject of pre-service review and have been authorized will be paid as an Allowable Charge as described in the section entitled **Definitions**.

The Plan may be unable to protect Covered Persons from Balance Billing for the difference between the Provider's charge and the Allowable Charge if the Provider (i) has received consent from the Covered Person in accordance with State and Federal law as described in 45 CFR 149.420(c) through (h) and (ii) has timely notified the Plan by providing the Plan with a copy of the signed written notice and consent document as described in 45 CFR 149.420(i).

The notice and consent requirements do not apply to certain items and services. A Covered Person cannot waive items and services with respect to (i) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; (ii) items and services provided by assistant surgeons, hospitalists, and intensivists; (iii) diagnostic services, including radiology and laboratory services; and (iv) items and services provided by a Non-Network Provider if there is no Network Provider who can furnish such item or service at such facility.

The notice and consent requirements do not apply to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Network Provider satisfied the notice and consent criteria of 45 CFR 149.420(c) through (i).

SPECIAL PROVISIONS RELATED TO TIER 2 PROVIDERS

This section applies to the use of Tier 2 Providers only. The rest of the Plan provisions continue to apply. The Plan has a variety of relationships with other Blue Shield and/or Blue Shield Plan Licensees. Generally, these relationships are called Inter-Plan Arrangements and they work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive Services outside of California, the claims for these services may be processed through one of these Inter-Plan Arrangements described below.

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands (BlueCard® Service Area), you will

receive the care from one of two kinds of Providers. Participating Providers contract with the local Blue Cross and/or Blue Shield. Licensees in that other geographic area referred to as the Host Blue. Non-participating Providers don't contract with the Host Blue. The Plan's payment practices for both kinds of Providers are described below.

INTER-PLAN ARRANGEMENTS

BlueCard Program

Under the BlueCard® Program, benefits will be provided for covered services received outside of California, but within the BlueCard Service Area (the United States, Puerto Rico, and U.S. Virgin Islands). When you receive covered services within the geographic area served by a Host Blue, the Plan will remain responsible for doing what we agreed to under the Plan. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers, including direct payment to the Provider.

The BlueCard Program enables you to obtain covered services outside of California, as defined, from a healthcare Provider participating with a Host Blue, where available. The participating healthcare Provider will automatically file a claim for the covered services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member Copay, Coinsurance and deductible amounts, if any, as stated in this Plan.

The Plan calculates the individual's share of cost either as a percentage of the Allowable Charges or a dollar Copay, as defined in this booklet. Whenever you receive covered services outside of California, within the BlueCard Service Area, and the claim is processed through the BlueCard Program, the amount you pay for covered services, if not a flat dollar Copay, is calculated based on the lower of:

1) The billed charges for covered services; or

2) The negotiated price that the Host Blue makes available to the Plan.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims as noted above. However, such adjustments will not affect the price the Plan used for your claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

To find participating BlueCard Providers you can call BlueCard Access® at 1-800-810-BLUE (2583) or go online at www.bcbs.com and select "Find a Doctor."

Prior authorization may be required for Non-Emergency Services. To receive prior authorization from the Plan, the out-of-area Provider should call the customer service number noted on the back of your identification card.

Non-participating Providers Outside of California

When covered services are provided outside of California and within the BlueCard Service Area by non-participating Providers, the amount you pay for such services will normally be based on either the Host Blue's non-participating Provider local payment, the Allowable Charges the Plan pays a Non-Participating Provider in California if the Host Blue has no non-participating Provider allowance, or the pricing arrangements required by applicable state law. In these situations, you will be responsible for any difference between the amount that the non-participating Provider bills and the payment the Plan will make for covered services as set forth in this paragraph.

If you do not see a participating Provider through the BlueCard Program, you will have to pay the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to the Plan for reimbursement. The Plan will review your claim and notify you of its coverage determination within 30 days after receipt of the claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of cost is higher when you see a non-participating Provider.

Federal or state law, as applicable, will govern payments for Out-Of-Network Emergency Services. The Plan pays claims for covered Emergency Services based on the Allowable Charges as defined in this Plan.

Prior authorization is not required for Emergency Services. In an emergency, go directly to the nearest hospital or Independent Freestanding Emergency Department. Please notify the Plan of your emergency admission within 24 hours or as soon as it is reasonably possible following medical stabilization.

Blue Shield Global® Core

Care for Covered Services Outside the BlueCard Service Area

If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is unlike the BlueCard Program available within the BlueCard Service Area in certain ways. For instance, although Blue Shield Global Core assists you with accessing a network of Inpatient, Outpatient, and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard Service Area, you will typically have to pay the Provider and submit the claim yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard Service Area you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. Provider information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global Core."

Submitting a Blue Shield Global Core Claim

When you pay directly for services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global Core claim form and send the claim form along with the Provider's itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the claim

form will help ensure timely processing of your claim. The claim form is available online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

SPECIAL CASES: VALUE-BASED PROGRAMS

Claims Administrator Value-Based Programs

You may have access to covered services from Providers that participate in a Value-Based Program. Claims Administrator Value-Based Programs include, but are not limited to, Accountable Care Organizations, Episode Based Payments, Patient Centered Medical Homes and Shared Savings arrangements.

BlueCard® Program

If you receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Shield through average pricing or fee schedule adjustments.

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 Person 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.

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions that are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined (e.g., Copay requirements and benefit sharing percentages).

Except as otherwise noted below or in the **Medical Benefit Summary**, Eligible Medical Expenses are the Allowable Charges for the items listed below and that are incurred by a Covered Person – subject to the **Definitions**, **Limitations and Exclusions** and all other provisions of the Plan. All eligible medical expenses are subject to the pre-service review requirement of the Utilization Management Program, except for a referral from a Tier 1 Prime Healthcare Provider to a Tier 1 Prime Healthcare Network Specialist for initial consultation only and Emergency Services pursuant to the No Surprises Act. In addition, the Plan will not cover any eligible medical expense that is not Medically Necessary for the care and treatment of a covered Illness, Injury, Pregnancy or other covered health care condition. The Plan Administrator reserves the right to determine coverage under the Plan for all claims from any source in accordance with the standards and requirements as set forth in this Summary Plan Description and any additional Plan documents, which are hereby incorporated herein by reference in their entirety and may be made available upon request, free of charge.

For benefit purposes, medical expenses will be deemed to be incurred on:

- The date a purchase is contracted; or
- The actual date a service is rendered.

3D Mammograms – 3D mammograms performed at a Tier 1 Prime Healthcare Network Facility, whether as Preventive Care or part of a treatment plan, will be automatically approved by the Prime Healthcare Utilization Management Department. 3D mammograms performed at a Tier 2 BCBS BlueCard/Blue Shield of CA Network Facility are subject to pre-service review and authorization from the Prime Healthcare Utilization Management Department.

Alcoholism – see "Substance Use Disorder Care."

Allergy Testing and Treatment – Allergy testing and treatment, including allergy injections.

Ambulance – Medically Necessary Ground or Air Ambulance transportation provided by a professional ambulance service or Provider of Air Ambulance Services.

Ambulatory Surgical Center – Services and supplies provided by an Ambulatory Surgical Center (see **Definitions**) in connection with a covered Outpatient surgery.

Anesthesia – Anesthetics and services of a Physician and/or Certified Registered Nurse Anesthetist for the administration of anesthesia. The payable scale for these services is Base units plus time units multiplied by the conversion factor equals the Allowable Charge.

Attention Deficit Disorder ("ADD") and Attention Deficit Hyperactivity Disorder ("ADHD") – Care, services or treatments for ADD or ADHD.

Autism and Asperger's Syndrome – The Plan will cover the Medically Necessary treatment for behavior modification, family therapy, or other forms of psychotherapy, that are clinically appropriate in terms of type, frequency, extent, site and duration, for management of

behavioral symptoms related to Autism, Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder and Pervasive Developmental Disorder not otherwise specified (NOS). These treatments are considered Medically Necessary when required for the management of behaviors, especially where there is the potential for individuals to harm themselves or others.

Psycho-pharmacotherapy for management of target symptoms or co-morbidities related to Autism, Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder and Pervasive Developmental Disorder not otherwise specified (NOS) is considered Medically Necessary.

Bariatric Surgical Procedures – The Plan will cover certain gastric bypass procedures such as gastric bypass, vertical sleeve gastrectomy, gastric banding, and duodenal switch procedures when Medically Necessary for the treatment of morbid obesity. The Plan will not cover any other bariatric procedure.

For these purposes, "morbid obesity" means a body mass index (BMI) ≥ 35 kg/m2, at least two uncontrolled obesity-related co-morbid conditions including:

- uncontrolled diabetes mellitus; **or**
- cardiovascular disease; **or**
- hypertension.

This benefit requires a documented cumulative history of 1 year previously unsuccessful medical treatment for obesity. Bariatric Surgical Procedures are limited to one per lifetime. This benefit excludes the following:

- post-operative adjustments if not in compliance with the program;
- procedure(s) after weight loss (ex: panniculectomy, breast lift);
- complications due to prior bariatric procedures; and
- Roux-en-Y procedures.

Birthing Center – Services and supplies provided by a Birthing Center (see **Definitions**) in connection with a covered Pregnancy.

Blood – Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

Processing, storage and administration charges for autologous blood (a patient's own blood) when a Covered Person is scheduled for a covered surgery that can reasonably be expected to require blood.

Cardiac Rehabilitation – A monitored exercise program directed at restoring both physiological and psychological well-being to an individual with heart disease. The program must be:

- Under the supervision of a Physician;
- In connection with a myocardial infarction, coronary occlusion or coronary bypass surgery, stable angina, PCI, valvular repair and replacement;
- Initiated within twelve (12) weeks after treatment for the medical condition ends;
- Provided in a covered medical care facility as defined by the Plan; and
- With a limit of 36 visits per incident.

NOTE: MAINTENANCE CARE IS NOT COVERED.

Chemical Dependency – see "Substance Use Disorder Care."

Chemotherapy and Radiation Therapy – Services and supplies related to the administration of chemical agents in the treatment or control of an Illness.

Radium and radioactive isotope therapy when provided for treatment or control of an Illness.

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.

Circumcision – Expenses incurred for circumcision of a child under age one. Expenses for circumcision over age one are covered when Medically Necessary.

Clinical Trials – Testing, treatment, and any other services provided in conjunction with an approved Clinical Trial are covered only if the Clinical Trial protocols and documents are submitted and pre-approved by the Prime Healthcare Utilization Management Department.

The following items, devices and/or services provided in conjunction with an approved Clinical Trial are not covered under the Plan: (1) items and services not required for clinical management; and (2) services not consistent with evidence-based guidelines or widely accepted and established standards of care for the particular diagnosis.

Complex Imaging Services – see "Diagnostic Lab and X-ray, Outpatient" below.

Continuity of Care Services – Covered services received by a Continuing Care Patient for a period of up to 90 days.

Contraception – Subject to reasonable medical management techniques, 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 Network Provider.

The administration of contraceptives by a Network Provider in a medical setting, such as sterilization services to place/remove/inject a contraceptive method will be covered under the Medical Benefit. For example, when performed by a Network Provider, the following contraceptive procedures and devices are covered as Preventive Care under the Medical Benefit and not the **Prescription Drug Program** without cost-sharing:

- Intrauterine devices (IUD) including insertion and removal;
- Diaphragms (covered under the pharmacy benefit if purchased by prescription at a participating pharmacy);
- Services to place/remove/inject covered FDA-approved contraceptive methods;
- Sterilization procedures for women, such as tubal ligations;
- Implantable contraceptive rods.

NOTE: ANY CONTRACEPTIVE THAT CAN BE OBTAINED THROUGH THE **PRESCRIPTION DRUG PROGRAM** (SEE **PRESCRIPTION DRUG PROGRAM** SECTION), MUST BE OBTAINED THROUGH THAT PROGRAM.

Contraceptive methods that are generally available over-the-counter are only included if the method is both FDA-approved and prescribed for a woman by her Network Provider.

Dental Care – Facility services and supplies, including general anesthesia, when provided in connection with a dental procedure where Hospital services or use of the Outpatient services of a Hospital or Ambulatory Surgical Center is required because of an underlying medical condition or clinical status of a Covered Person who: (1) is under the age of seven years; (2) is developmentally disabled, regardless of age; or (3) has impaired health and general anesthesia is Medically Necessary. Prior authorization by the Prime Healthcare Utilization Management Department is required for services to be covered under the Plan.

Diabetes Education – Charges for services of a Physician or other professionals who are knowledgeable about the treatment of diabetes (such as a Registered Nurse, registered pharmacist or registered dietitian) for the purpose of enabling a diabetic and their family to understand and practice daily management of diabetes.

Diagnostic Lab, X-ray, and Radiology, Outpatient – Laboratory, X-ray, radiology, and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

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.

Durable Medical Equipment – Rental of Durable Medical Equipment (but not to exceed the fair market purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician.

Repair of purchased equipment when necessary to maintain its usability. Replacement of equipment but only if: (1) needed due to a change in the Covered Person's physical condition, or (2) it is likely to cost less to buy a replacement than to repair existing equipment or rent like equipment.

"Durable Medical Equipment" includes items such as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment that: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Illness or Injury, and (4) are appropriate for use in the home.

For Insulin and Diabetic Supplies – see the "**Prescription Drug Program**" for additional information.

NOTE: COVERAGE IS LIMITED TO THE LEAST EXPENSIVE ITEM THAT IS ADEQUATE FOR THE COVERED PERSON'S NEEDS. DUPLICATE EQUIPMENT, SUPPORT EQUIPMENT (SUCH AS RACKS AND LIFTS) AND EXCESS CHARGES FOR DELUXE EQUIPMENT OR DEVICES ARE NOT COVERED.

Emergency Medical Condition – see "Definitions"

Emergency Services – see "Definitions"

Gender Dysphoria – Services and treatment related to Gender Dysphoria including surgical services, hormone replacement therapy and Mental Health therapy.

Hearing Examinations – Benefits will be provided for hearing examinations for the purpose of diagnosing a medical condition. In addition, routine hearing examinations will be covered when billed as routine and included as a part of the annual well visit.

NOTE: BENEFITS ARE NOT PROVIDED FOR HEARING AIDS OR THE EXAMINATIONS FOR THE PRESCRIPTION OR FITTING OF HEARING AIDS.

Home Health Care – Services and supplies that are furnished to a Covered Person by a Home Health Care Agency and in accordance with a written Home Health Care plan. The Home Health Care plan must be established by the Covered Person's attending Physician and must be monitored by the Physician during the period of Home Health Care. Also, the attending Physician in conjunction with the Prime Healthcare Utilization Management Department must certify that the condition would require Inpatient confinement in a Hospital or Skilled Nursing Facility in the absence of Home Health Care.

Covered Home Health Care services and supplies include, but are not limited to:

- Intermittent services of a Registered Nurse or services by a Licensed Vocational Nurse if a Registered Nurse is not available;
- Intermittent services of Physical, Occupational and Speech Therapists;
- Intermittent services of home health aides;
- Medical supplies, drugs and medicines prescribed by a Physician and laboratory services.

NOTE: COVERED HOME HEALTH CARE EXPENSES WILL NOT INCLUDE FOOD, FOOD SUPPLEMENTS, HOME DELIVERED MEALS, TRANSPORTATION, HOUSEKEEPING SERVICES OR OTHER SERVICES THAT ARE CUSTODIAL IN NATURE AND COULD BE RENDERED BY NON-PROFESSIONALS.

Hormone Therapy—Continuous hormone replacement therapy related to Gender Dysphoria. Oral and self-injected hormones from a Network Pharmacy are covered as Outpatient Prescription Drug Benefits.

Note: Hormones injected by a Health Care Provider (for example hormones injected during an office visit) are covered Medical Expenses.

Hospice Care – Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less) who has been admitted to a formal program of Hospice care. Eligible Expenses include, but are not limited to, Hospice program charges for:

Inpatient care in a Hospice facility, a Hospital or a Skilled Nursing Facility Center for pain control and other acute and chronic symptom management;

Outpatient services and supplies, including: medical social services under the direction of a Physician including: (1) assessment of the person's social, emotional and medical needs and

the home and family situation, and (2) identification of the community resources that are available and assisting the person to obtain those resources.

NOTE: HOSPICE CARE COVERAGE DOES NOT INCLUDE EXPENSES FOR BEREAVEMENT COUNSELING, FUNERAL ARRANGEMENTS, PASTORAL COUNSELING, FINANCIAL OR LEGAL COUNSELING, HOMEMAKER OR CARETAKER SERVICES, OR RESPITE CARE.

Hospital Services – Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and Ancillary Services and supplies.

Injectables – Injectables that are not available through the **Prescription Drug Program** and professional services for their administration.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit – Treatment for critically and seriously ill or injured patients requiring constant observation as prescribed by the attending Physician, including room and board.

Maternity Services – Includes global charges such as routine antepartum care, delivery (including routine newborn Hospital care) and mother's postpartum care.

Medical Supplies, Disposable – Disposable medical supplies such as surgical dressings, catheters, colostomy bags and related supplies.

Medicines – Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit or as part of a Home Health Care or Hospice care program. See the **Prescription Drug Program** for pharmacy drugs.

Mental Health Care – Eligible Expenses for the Medically Necessary treatment of Mental Health Conditions as follows:

- Inpatient Hospital and Residential Treatment Facility services as described herein;
- Physician visits during a covered Inpatient stay;
- Physician visits for Outpatient psychotherapy or psychological testing or Outpatient rehabilitative care at a Day Treatment Center for the treatment of Mental Health Conditions; and
- Inpatient Covered Prescription Drugs.

Treatment of mental health conditions in the following categories:

- Diagnosis and Medically Necessary treatment of "severe mental disorders"; and
- Diagnosis and Medically Necessary treatment of "other covered mental health conditions."

Severe mental disorders - For these purposes, a "severe mental disorder" means:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive Illness)
- Major depressive disorder
- Panic disorder
- Obsessive-compulsive disorder (OCD)
- Pervasive developmental disorder (except as excluded in Medical Limitations and Exclusions)
- Anorexia nervosa
- Bulimia nervosa

- Paranoia and other psychotic disorders
- Serious emotional disturbances of a child (i.e., a child who has one or more mental disorders as identified in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (other than a primary Substance Use Disorder or developmental disorder), that: (1) result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code that states that such persons shall meet one or more of the following criteria:
  a) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from the home or has already been removed from the home, or the mental disorder and impairments have been present for more than six months or, without treatment, are likely to continue for more than one year;
  b) The child displays one of the following: psychotic features: risk of suicide or risk of violence due to a mental disorder.
- Treatment of severe mental disorders may be provided through Outpatient services, Inpatient Hospital services and prescription drugs.
- Other Covered Mental Health Conditions - For these purposes, "other covered mental health conditions" will include conditions that affect thinking and the ability to figure things out, perception, mood and behavior - but not those conditions that are expressly included in the list of severe mental disorders (above) or that are excluded in the list of **Medical Limitations and Exclusions**.

Midwife – Services of a Certified or Registered Nurse Midwife when provided in conjunction with a covered Pregnancy – see "Pregnancy Care" below.

Newborn Care – Medically Necessary services and supplies, as listed herein, for a covered newborn who is Ill or Injured.

Also see "Pregnancy Care" for newborn expenses.

Nursing Services – Nursing services by a Registered Nurse or a nursing agency when Medically Necessary and prescribed and certified in writing by the attending Physician or surgeon in conjunction with the Prime Healthcare Utilization Management Department specifically as to duration and type.

Occupational Therapy – see "Therapy, Outpatient/Short-Term."

Orthotics – Orthopedic (non-dental) braces, casts, splints, trusses and other orthotics that are prescribed by a Physician and that are required for support of a body part due to a congenital condition or an Injury.

Special footwear when needed due to foot disfigurements including disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes and foot disfigurement caused by Injury or developmental disability.

Orthopedic Shoes – Orthopedic shoes, but only if they are an integral part of a leg brace.

Repair or replacement of an orthotic. However, replacement of an orthotic will only be covered if:

- There is a change in the Covered Person's physical condition;
- Replacement is necessary due to normal growth or wear and tear;
- It is likely to cost less to buy a new device than to repair the existing one; or
- The existing device cannot be made serviceable.

NOTE: EXPENSES RELATED TO THE REPAIR AND REPLACEMENT OF AN ORTHOTIC DUE TO MISUSE OR LOSS ARE NOT COVERED.

Oxygen – see "Durable Medical Equipment."

Physical Therapy – see "Therapy, Outpatient/Short-Term."

Physician Services – Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations.

Pregnancy Care – Pregnancy-related expenses of a covered Employee or a covered Dependent (including spouse, Partner or Dependent children) are covered. Eligible Pregnancy-related expenses are covered in the same manner as expenses for an Illness and include the following, and may include other care that is deemed to be Medically Necessary by the patient's attending Physician:

- Pre-natal visits and routine pre-natal and post-partum care;
- Expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of Pregnancy;
- Genetic testing or counseling when deemed Medically Necessary;
- Newborn Hospital services provided during the Employee's, spouse's, or Partner's confinement for delivery, but not to exceed the minimum requirements of the Newborns' and Mothers' Health Protection Act (see below). This will not apply, however, if the newborn is a Covered Person and the charges are covered as the newborn's own claim. Expenses of a Covered Person's daughter's newborn child are not eligible.

Home Births for routine antenatal, delivery and postpartum care only.
Home Births coverage will not include:

- Additional prenatal counseling sessions or prenatal evaluation/management services specifically related to home birth.
- Any equipment, supplies including emergency kits, and/or services specifically due to home birth;
- Charges related to prolonged personal attendance;
- Home modifications;
- Standby Services such as: supplies, equipment, support personnel, or ambulance.
- Member transfer to facility for delivery:
- Home birth provider will be paid for attending at labor in the home prior to transfer but not for attendance in the ambulance; and
- Delivery services will be paid only to the provider who delivers the child; and

- If during attendance at labor it is determined that the patient must be transferred to a facility and another clinician performs the delivery service, BCBS will cover up to one E/M service in the home and up to 3 additional hours of prolonged services with direct care if provided.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. Early discharge is permitted if the decision is made between the attending Physician and the mother.

NOTE: PREGNANCY COVERAGE WILL NOT INCLUDE: (1) LAMAZE AND OTHER CHARGES FOR EDUCATION RELATED TO PRE-NATAL CARE AND BIRTHING PROCEDURES, (2) ADOPTION EXPENSES, OR (3) EXPENSES OF A PAID SURROGATE MOTHER.

The Plan shall have full discretion to place a lien on any compensation paid to or in respect of a surrogate mother for such services and who is a Covered Person who has entered into an Assisted Reproduction Agreement under California Family Code Sections 7960 – 7962, or other similar applicable state law.

Prescription Drugs – Medicines that are dispensed and administered to a Covered Person during Inpatient services, during a Physician's office visit, or as part of a Home Health Care or Hospice care program.

Other Outpatient drugs (i.e., pharmacy purchases) are covered through a separate program. See the **Prescription Drug Program** for additional information.

Preventive Care Service – Preventive Care Services required by the ACA to be provided without Cost Sharing as described in **Appendix A**.

Prosthetics – External prosthetics such as artificial limbs, eyes or other appliances to replace natural body parts, including the fitting and adjustment of such appliances.

- Internally implanted prosthetics such as pacemakers and hip and knee joint replacements.
- A device and the installation of accessories to restore a method of speaking for a Covered Person following a laryngectomy.
- Post-mastectomy breast prostheses as required by the Women's Health and Cancer Rights Act.

NOTE: PROSTHETICS COVERAGE DOES NOT INCLUDE:

- Dental prosthetics, except as expressly included under "Dental Care" in the **Medical Limitations and Exclusions** section;
- Eyeglasses, vision aids or hearing aids;
- Communications aids, except as expressly included above;
- Repair or replacement of a prosthetic device except for: (1) replacement that is necessary due to a change in the Covered Person's physical condition, (2) repair or replacement that is necessary due to normal wear and tear, or (3) replacement when it is likely to cost less to buy a new prosthetic than to repair the existing one or when the existing prosthetic cannot be made serviceable.

Radiation Therapy – see "Chemotherapy and Radiation Therapy."

Rehabilitation Center – see "Skilled Nursing Facility."

Respiratory/Inhalation Therapy – Professional services of a licensed respiratory or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

Second Surgical Opinion – Charges for second surgical opinion, when Medically Necessary.

Semi-Private Room Accommodations – The standard charge by a facility for a Semi-Private Room and board accommodation (2 or more beds), or the average of such charges where the facility has more than one established level of such charges, or up to 90% of the lowest charge by the facility for a single-bed room and board accommodation where the facility does not provide any semi-private accommodations.

Skilled Nursing Facility – Inpatient care in a Skilled Nursing Facility or Rehabilitation Center, but only when the admission to the facility/center is Medically Necessary and is ordered by a Physician in lieu of Hospital confinement. Coverage shall be limited to 90 days per incident.

Sleep Study Testing – Testing and treatment for diagnosis of sleep disorders when Medically Necessary based on current evidence-based guidelines, including the treatment or supplies (i.e., CPAP machines, etc.). Home Sleep Studies for OSA (Obstructive Sleep Apnea) must be ordered by a Prime Healthcare Tier 1 Pulmonologist.

Speech Therapy – see "Therapy, Outpatient/Short-Term."

Sterilization Procedures – A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

NOTE: RECONSTRUCTION (REVERSAL) OF A PRIOR ELECTIVE STERILIZATION PROCEDURE IS NOT COVERED.

Substance Use Disorder Care – Medically Necessary treatment of Substance Use Disorders including (i) Inpatient Hospital services and services from a Residential Treatment Facility; (ii) partial hospitalization programs and visits to a day treatment center; and (iii) Outpatient services such as counseling and drug therapy monitoring and medical treatment for withdrawal symptoms.

Surgery – Surgical operations and procedures, unless otherwise specifically excluded under the Plan.

Therapy, Outpatient/Short-Term – The following therapy services when provided on an Outpatient basis, when such therapy is expected to result in the improvement of a body function (including the restoration of a speech function) that has been lost or impaired due to Injury, Illness or congenital defect, and when such therapy is expected to result in significant improvement of the person's condition within thirty (30) days from the date the therapy begins:

- Occupational therapy
- Physical therapy
- Speech therapy

For therapy services provided in the patient's home, see "Home Health Care."

Trauma Services – Medical services at a Trauma Center for Emergency Services. The Plan does not cover trauma activation fees when the services are for minor injuries not warranting Trauma Center care. Trauma activation and medical services provided at a Trauma Center for Non-Emergency Services will not be covered under the Plan unless otherwise authorized under the **Utilization Management Program**.

Transplant-Related Expenses – Eligible Expenses incurred by a Covered Person who is the recipient of a listed organ or tissue transplant that is not Experimental and/or Investigational in nature:

- bone marrow transplant
- heart transplant
- heart/lung transplant
- kidney transplant
- kidney/pancreas transplant
- liver transplant
- lung transplant
- pancreas transplant

A transplant must be ordered by a Network Physician and services must be performed at a facility designated by the Prime Healthcare Utilization Management Department.

Eligible Expenses for the Medically Necessary medical and surgical expenses of a live donor are covered only if the donor is not covered for such services by another plan or program and the services for the donor are provided at a facility designated by the Prime Healthcare Utilization Management Department.

Donor workup tests needed to determine if a person is a candidate for donation are NOT COVERED.

Evaluation, maintenance, and follow-up services that can be performed at a Prime Healthcare Network Facility will be directed and approved within the Prime Healthcare Network or a facility designated by the Prime Healthcare Utilization Management Department. Such services will not be covered unless they are obtained at Prime Healthcare Network Facilities or at facilities designated by the Prime Healthcare Utilization Management Department.

NOTE: TRANSPLANT-RELATED EXPENSES WILL NOT INCLUDE ANY EXPENSES INCURRED FOR TRAVEL, LODGING, OR MEALS FOR THE PATIENT OR FOR ANY COMPANION(S) TRAVELING WITH THE PATIENT.

Urgent Care – Services rendered for a sudden, serious or unexpected Illness, Injury or condition, which is not an Emergency Medical Condition but requires immediate care for the relief of pain or diagnosis and treatment of such condition.

MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for:

Abortion – see "Family Planning" below.

Acupuncture – Acupuncture treatment.

Air Purification Units, Etc. – Air conditioners, air-purification units, humidifiers and electric heating units.

Alcohol – Expenses incurred by the Covered Person's driving a motor vehicle with a blood alcohol concentration of .08 or higher or otherwise in violation.

Alcohol/Illegal Drugs or Medications – To a Covered Person, expenses for an injury arising from taking part in any activity made illegal due to the use of alcohol (e.g. driving with a blood alcohol concentration of .08 or more) or voluntary taking of, or being under the influence of, any controlled substance, drug, hallucinogen, narcotic or similar substance not administered on the advice of a Physician and not illegal under State and Federal law. Expenses will be covered for injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol, controlled or illegal substances, and expenses may be covered for Substance Use Disorder treatment as specified in this Plan, if applicable. This exclusion does not apply to: (a) injuries resulting from being the victim of an act of domestic violence, or (b) a Covered Person's expenses resulting from a medical condition (including both physical and mental health conditions).

Biofeedback, Etc. – Biofeedback, recreational, or educational therapy.

Carbon Dioxide Therapy

Chiropractic Care – Extraspinal manipulation also known as Extraspinal Manipulative Therapy (EMT) is not a covered benefit.

Complications of Non-Covered Treatment and Services

Cosmetic and Reconstructive Surgery, Etc. – Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly. This applies whether or not the service or supply is for psychological or emotional reasons unless the surgery is breast reduction covered in connection with surgery for Gender Dysphoria.

However, this exclusion will not apply to surgery intended to improve the function of a body part that is malformed (but is not a tooth or a structure that supports the teeth), when such surgery:

- Is to correct a congenital abnormality (severe birth defect) including cleft lip, webbed fingers or toes;
- Is performed to treat a Sickness, Injury, or complication resulting from non-covered treatment or service;
- Is required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of

all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as is determined by the attending Physician in consultation with the patient.

Counseling – Family, marriage, child, career, social adjustment, pastoral or financial counseling or other forms of self-care or self-help training or any related diagnostic testing.

Criminal Activities/Illegal Acts – see "General Exclusions."

Custodial and Maintenance Care – Care that does not restore health or care confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training.

Any type of maintenance care which is not reasonably expected to improve the patient's condition, except as may be included as part of a formal Hospice care program.

Dental, Mouth and Jaw Care – Care or treatment on or to the teeth, jaws, jaw joints, gingival tissue, or for malocclusion, except for:

- Surgery to treat a fracture, dislocation or wound;
- Removal of partially or fully-impacted teeth, removal of teeth that will not erupt through the gum, or removal of other teeth that cannot be removed without cutting into bone;
- Removal of the roots of a tooth without removing the entire tooth;
- Removal of cysts, tumors or other diseased tissues;
- Cutting into the gums and tissues of the mouth when not done in connection with the removal, replacement or repair of teeth;
- Repair or prosthetic replacement of sound natural teeth that are damaged in an Injury;
- Nonsurgical treatment of infections or diseases that are not related to the teeth;
- Dental work, surgery and orthodontic treatment when needed to remove, repair, replace, restore or reposition natural teeth damaged, lost or removed, or other body tissues of the mouth that are fractured or cut due to Injury. Any such teeth must have been free from decay or in good repair and firmly attached to the jaw bone at the time of the accident. If crown, denture or bridgework or in-mouth appliances are installed due to such Injury, Eligible Expenses will only include charges for: (1) the first denture or fixed bridge to replace lost teeth, (2) the first crown needed to repair each damaged tooth, and (2) an in-mouth appliance used in the first course of orthodontia treatment after the Injury.

Diagnostic Hospital Admissions – Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

Ecological or Environmental Medicine – Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin that are not specifically approved by the FDA as effective for treatment.

Environmental change, including Hospital or Physician expenses incurred in connection with prescribing an environmental change.

Educational or Vocational Testing or Training – Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation.

Training of a Covered Person for the development of skills needed to cope with an Injury or Illness, except as may be expressly included.

Enhanced External Counterpulsation Therapy (EECP)

Exercise Equipment/Health Clubs – Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.

Family Planning – Family planning-related services or supplies including:

- Infertility testing, treatment, or the use of advanced reproductive technologies (e.g., in vitro fertilization (IVF or egg donation);
- Reversal of a sterilization procedure;
- Elective abortion, except when the mother's life is in immediate danger; and
- When complications arise out of an abortion.

Foot Care, Routine – Routine and non-surgical foot care services and supplies including, but not limited to:

- Trimming or treatment of toenails, excluding excision of the nail and matrix;
- Foot massage;
- Treatment of corns, calluses, metatarsalgia or bunions;
- Treatment of weak, strained, flat, unstable or unbalanced feet, excluding 3 steroid injections for plantar fasciitis;
- Orthopedic shoes (except when permanently attached to braces) or other appliances for support of the feet except as expressly allowed (see "Orthotics" in the **Eligible Medical Expenses** section).

NOTE: THIS EXCLUSION DOES NOT APPLY TO THE INITIAL PHYSICIAN VISIT AND RELATED DIAGNOSTIC PROCEDURES TO ESTABLISH THE DIAGNOSIS AND MEDICALLY NECESSARY TREATMENT OF THE FEET (E.G., THE REMOVAL OF NAIL ROOTS, OTHER PODIATRY SURGERIES, OR FOOT CARE SERVICES NECESSARY DUE TO A METABOLIC OR PERIPHERAL-VASCULAR DISEASE) OR COVERED FOOT CARE AS DEFINED UNDER MEDICARE (CMS) PODIATRY SERVICES GUIDELINES. SEE CMS PODIATRY SERVICES GUIDELINES FOR A DESCRIPTION OF COVERED SERVICES.

Genetic Counseling or Testing – Counseling or testing concerning inherited (genetic) disorders. However, this limitation does not apply when such services are determined by a Physician to be Medically Necessary and pre-authorized by Prime Healthcare UMO during the course of a covered Pregnancy or are Preventive Care Services.

Hair Restoration – Any surgeries, treatments, drugs, services or supplies relating to baldness or hair loss, whether or not prescribed by a Physician.

Hair Pieces – Wigs, artificial hair pieces, human or artificial hair transplants, or any drug, Prescription Drug or otherwise, used to eliminate baldness.

Hearing Aids – Hearing aids or the examinations for the prescription or fitting of hearing aids.

Holistic, Homeopathic or Naturopathic Medicine – Services, supplies, drugs or accommodations provided in connection with holistic, homeopathic or naturopathic treatment.

Hypnotherapy – Treatment by hypnotism.

Maintenance Care – see "Custodial and Maintenance Care."

Massage Therapy

Medical Errors – Treatment that is required to treat Injuries that are sustained or an Illness that is contracted, including infections and complications, while the Covered Person was under, and due to, the care of a Provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This provision works in coordination with the Plan's subrogation, reimbursement, and/or third-party responsibility provisions. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment, that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

Megavitamin Therapy

Newborn Care – For a child of a Dependent child.

Non-Prescription Drugs – Drugs for use outside of a Hospital or other Inpatient facility that are purchased over-the-counter and without a Physician's written prescription – except as may be included in the Plan's prescription coverages or is a Preventive Care Service.

Drugs for which there is a non-prescription equivalent available except as covered as a Preventive Care Service.

Not Medically Necessary/Not Physician Prescribed/Not Generally-Accepted – Any services or supplies that are: (1) not Medically Necessary, (2) not recommended on the advice of a Physician – unless expressly included herein, or (3) not in accordance with generally-accepted professional medical standards. For example, Trauma activation fees or services related to the treatment of minor injuries for which such care is not Medically Necessary will not be covered under the Plan.

Inpatient room and board when hospitalization is for services that could have been performed safely on an Outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical observation, treatment of chronic pain or convalescent or rest cure.

Nutrition Counseling – Dietary treatment of disease or condition except those included within the "Preventive Care" coverages (see **Appendix B**).

Orthopedic Shoes – Orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet.

Personal Comfort or Convenience Items – Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-Hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

Rolfing – A holistic system of bodywork that uses deep manipulation of the body's soft tissue to realign and balance the body's myofascial structure.

Self-Procured Services – Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of Hospital confinement, that are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

Sex-Related Disorders – Non-organic sexual dysfunctions. Excluded services and supplies include, but are not limited to: therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment unrelated to Gender Dysphoria.

Subrogation, Reimbursement, and/or Third-Party Responsibility – Any charge for care, supplies, treatment, and/or services of an Injury or Illness not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions.

Therapy, Outpatient/Short-term Therapy – Spinal manipulation is not a covered benefit when rendered by a licensed or certified Physical Therapist.

TMJ – Splint therapy or surgical treatment for, or in connection with, temporomandibular joint disorders, myofacial pain dysfunction or orthognathic treatment.

Transplant Related Services – Transplant related expenses will not include any expenses incurred for travel, lodging or meals for the patient or for any companion(s) traveling with the patient. In addition, Eligible Expenses for a live donor who is covered by another plan or program, will not be covered.

Travel Outside United States – Non-Emergency medical services outside the United States are not covered.

Ultrasounds – The use of 3-D or 4-D fetal ultrasound is considered **investigational and not Medically Necessary** in all cases.

Vaccinations – Immunizations or vaccinations other than: (1) those included within the "Preventive Care" coverages (see the **Medical Benefit Summary** and **Appendix A**); (2) Hepatitis B screening and vaccination for healthcare workers; and (3) tetanus or rabies vaccinations administered in connection with an Injury.

Vision Care – Eye examinations for the purpose of prescribing corrective lenses.

Vision Supplies – (e.g., eyeglasses or contact lenses) or their fitting, replacement, repair or adjustment.

Orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy or laser surgery.

NOTE: THIS EXCLUSION WILL NOT APPLY TO: (1) SERVICES NECESSITATED BY AN ILLNESS OR INJURY, OR (2) THE INITIAL PURCHASE OF GLASSES OR CONTACT LENSES FOLLOWING CATARACT SURGERY, OR (3) APHAKIC PATIENTS AND SOFT LENSES OR SCLERA SHELLS INTENDED FOR USE AS CORNEAL BANDAGES.

Vitamins or Dietary Supplements – Prescription or non-prescription organic substances used for nutritional purposes.

Vocational Testing or Training – Vocational testing, evaluation, counseling or training.

Wigs or Wig Maintenance – see "Hair Restoration."

(See also **General Exclusions** section)

PRESCRIPTION DRUG PROGRAM

Prescription drug coverage is provided through Express Scripts – an independent prescription drug program Provider. The following is a summary of the program. See the attached addendum for Copay and additional details about the coverage provided through the prescription drug program.

Certain specialty drugs, such as injectables, must be obtained through Accredo, an Express Scripts Specialty Pharmacy. In some cases, when a prescription drug is used for the first time, a one month's supply may be available from a retail pharmacy. For certain drugs, there is no opportunity for a one month's supply through a retail pharmacy. Covered Persons may be required to enroll in SaveOnSP's Copay assistance program through Accredo to maximize their savings on the cost of such drugs. Otherwise, the prescription drug will not be covered. Accredo and/or SaveOnSP will contact the Covered Person directly. For a list of SaveOnSP Copay assistance prescriptions, please visit www.saveonsp.com/Primehealth or call SaveOnSP at (800) 683-1074.

HOW TO USE THE PRESCRIPTION DRUG PROGRAM

Using a Participating Pharmacy. To identify individuals as a Covered Persons for prescription drug benefits, individuals must present their ID Card to participating pharmacies when they have a prescription filled. Provided they have properly identified themselves as Covered Persons, a participating pharmacy will only charge them the Copay. Many participating pharmacies display an "Rx" decal with the Express Scripts logo in their windows. For information on how to locate a participating pharmacy, a Covered Person should call (866) 718-7955.

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If a Covered Person presents a prescription to a participating pharmacy, and the participating pharmacy indicates that the prescription cannot be filled, or requires an additional Copay, this is not considered an Adverse Benefit Determination. If the Covered Person wants the prescription filled, they will have to pay either the full cost, or the additional Copay, for the prescription drug. If the Covered Person believes they are entitled to some Plan benefits in connection with the prescription drug, they should submit a claim for reimbursement to Express Scripts at the address shown below:

Express Scripts Inc.
Attn Commercial Claims:
P.O. Box 14711
Lexington, KY 40512-4711

Participating pharmacies usually have claims forms, but, if the participating pharmacy does not have claim forms, claim forms from customer service are available by calling (866) 718-7955. A Covered Person should mail their claim form, with the appropriate portion completed by the pharmacist, to Express Scripts within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

Using a Non-Participating Pharmacy. The Plan does not provide any benefit for prescription drugs purchased at a non-participating pharmacy.

Out of State. If a Covered Person needs to purchase a prescription drug out of state, they may locate a participating pharmacy by calling (866) 718-7955.

When a Prescription is Ordered Through the Mail. Covered Persons can order their prescription through the mail service prescription drug program. Not all medications are available through the mail service pharmacy. The prescription must state the drug name, dosage, directions for use, quantity, the Physician's name and phone number, the Covered Person's name and address, and be signed by a Physician. The Covered Person must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. The Covered Person need only pay the cost of his Copay. A Covered Person's first mail service prescription must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number below. Covered Persons need only enclose the prescription or refill notice, and the appropriate payment for any subsequent mail service prescriptions or call the toll-free number. Copays can be paid by check, money order or credit card. Order forms can be obtained by contacting customer service at (866) 718-7955 or by accessing the website at www.expressscripts.com.

Maintenance Medication Program. The prescription-drug benefit includes a maintenance medication program – for those medications taken regularly to treat ongoing conditions. This program can help Covered Persons save time, spend less and stay safe by getting these medications through Home Delivery. Covered Persons can receive two fills of each maintenance medication at his participating retail pharmacy. After that, they may order these prescriptions through Home Delivery from the Express Scripts Pharmacy, or per the Plan, pay a higher Copay at the participating retail pharmacy.

- Mail the prescriptions – Request a Home Delivery order form by calling customer service at (866) 718-7955;

  OR

- Use the website or ask Express Scripts to call the Covered Person's Physician – Express Scripts will call the Covered Person's Physician to get a new prescription for Home Delivery. This process typically takes 2 to 3 weeks from the time the Covered Person completes his online request. Just visit:

  www.StartHomeDelivery.com
  If a Covered Person doesn't have Internet access, call: (800) 899-2125
  (7:30 a.m. – 5:00 p.m., Central time, Monday-Friday)

PRESCRIPTION DRUG UTILIZATION REVIEW

Express Scripts prescription drug benefits include utilization review of prescription drug usage for its Covered Person's health and safety. Certain drugs may require prior authorization. If there are patterns of over-utilization or misuse of drugs, a medical consultant will notify the Covered Person's personal Physician and his pharmacist. The Plan reserves the right to limit benefits to prevent overutilization of drugs.

PRESCRIPTION DRUG FORMULARY

Express Scripts uses a prescription drug formulary to help a Covered Person's doctor make prescribing decisions. The presence of a drug on the Plan's formulary list does not guarantee that the Covered Person will be prescribed that drug by their Physician. This list of Outpatient prescription drugs is developed by a committee of Physicians and pharmacists to determine which medications are sound, therapeutic and cost-effective choices. These medications,

which include both generic and brand name drugs, are listed in the prescription drug formulary. The committee updates the formulary quarterly to ensure that the list includes drugs that are safe and effective. NOTE: The formulary drugs may change from time to time. Some drugs may require prior authorization. If a Covered Person has a question regarding whether a particular drug is on Express Scripts' formulary drug list or requires prior authorization, they should call Express Scripts at (866) 718-7955.

Specialty drugs will be provided through Accredo, an Express Scripts, Inc. Specialty Pharmacy. If the Plan denies a request for prior authorization of a drug that is not part of the formulary, a Covered Person's Physician may file a grievance by following the procedures described in the Express Scripts Claims Disclosure Notice detailing why the Physician believes an exception to the formulary should be made.

PRESCRIPTION DRUG CONDITIONS OF SERVICE

To be covered, the drug or medication must satisfy all of the following requirements:

- It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.
- It must be approved for general use by the Food and Drug Administration (FDA) or similar state agency.
- It must be for the direct care and treatment of a Covered Person's Illness, Injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However, formulas prescribed by a Physician for the treatment of phenylketonuria are covered.
- It must be dispensed from a licensed retail pharmacy, or through the mail service program.
- It must not be used while a Covered Person is an Inpatient in any facility. Also, it must not be dispensed in or administered by an Outpatient facility.
- For a retail pharmacy, the prescription must not exceed a 30-day supply.
- For the mail service program, the prescription must not exceed a 90-day supply.
- The drug will be covered only if it is not covered under another benefit of the Plan.

Step Therapy – Drugs in certain ongoing drug therapy categories could be subject to Step Therapy. Step Therapy is a program in which certain drug classes are organized in a set of "steps" with generic drugs being the first step and brand name drugs being the second step. Please call Express Scripts at (866) 718-7955 for more information if you have a question regarding a specific medication.

COVERED PRESCRIPTION DRUGS

Covered drugs include most prescription drugs (i.e., federal legend drugs which are prescribed by a Physician and which require a prescription either by federal or state law – and including off-label drugs covered and dispensed by the prescription program vendor) and certain non-prescription items.

The following is a list of prescription and non-prescription drugs and supplies which are sometimes excluded by group health plans, but which are covered by this Plan:

Breast Cancer, Chemoprevention – see **Appendix A**.

Contraceptives – Subject to reasonable medical management techniques, the Plan will cover, without cost-sharing, all categories of Food and Drug Administration (FDA) approved

contraceptive drugs for all individuals with reproductive capacity, as prescribed by a Network Provider and purchased through Express Scripts. See **Appendix A**.

Abortifacient drugs are not covered except to the extent administered in the course of an Abortion covered under the Plan, and in such cases are not covered as Preventive Care.

Dermatology Drugs – Tretinoin agents used in the treatment of acne for Covered Persons through age 25.

NOTE: DEPIGMENTATION PRODUCTS USED FOR SKIN CONDITIONS REQUIRING A BLEACHING AGENT ARE NOT COVERED.

Diabetic Supplies – Insulin and diabetic supplies including syringes, needles, insulin injectable devices, pump supplies, swabs, blood glucose calibration solutions, and urine tests.

NOTE: THE PLAN WILL COVER ONE (1) DIABETIC TESTING MONITOR EVERY 365 DAYS AT NO COST TO THE COVERED PERSON.

Folic Acid, Fluoride, Aspirin, and Iron Supplements – see **Appendix A**.

Hormone Replacement Therapy – Continuous hormone replacement therapy for the treatment of Gender Dysphoria.

Hyperactivity (ADD, ADHD) Drugs – (i.e., Exubera, Dexedrine, Desoxyn, and Adderall)

Smoking Cessation/Deterrent Drugs – Any type of drug or supply for smoking cessation (e.g., Zyban, Nicotrol Inhaler).

EXPENSES NOT COVERED

Prescription Drug Expenses will not include any of the following:

Administration – Any charge for the administration of a drug.

Blood, Blood Plasma and Biological Sera

Compound Medications

Cosmetic Products – Cosmetic-type drugs including photo-aged skin products such as Renova and Avage.

- Hair growth agents such as Propecia and Vaniqa.
- Injectable cosmetics such as Botox.

Equipment, Devices, Etc. – Devices of any type, even though such devices may require a prescription. These include but are not limited to:

- Respiratory therapy supplies such as aerochambers, spacers or nebulizers;
- Peak flow meters;
- Non-insulin syringes; and
- Artificial appliances or braces.

Erectile Dysfunction Drugs – Erectile dysfunction drugs (e.g., Viagra, Levitra, Cialis, Muse, Caverject, or Edex).

Excess Refills – Refills which exceed the number of times specified by a Physician or which are dispensed more than one (1) year from the date of the Physician's prescription order.

Experimental and Non-FDA Approved Drugs – Experimental drugs and medicines, even though a charge is made to the Covered Person. Any drug not approved by the Food and Drug Administration. This exclusion does not apply to (i) off-label drugs covered and dispensed by the prescription program vendor, and (ii) covered drugs dispensed in connection with Clinical Trials.

Fertility Drugs – Except Oral/Vaginal drugs are covered.

Hair Loss Drugs – see "Cosmetic Products."

Homeopathic Drugs – Homeopathic drugs, legend or non-legend.

Immunization Agents – Serums, toxoids or vaccines, except those which are Preventive Care Services. See **Appendix A and Eligible Medical Expenses** Sections for more information on covered vaccinations.

Injectables – Injectable drugs, except for insulin and Avonex.

Investigational Drugs – A drug or medicine labeled: "Caution – limited by federal law to investigational use."

No Charge – A prescribed drug which may be properly received without charge under a local, state or federal program or for which the cost is recoverable under any workers' compensation or occupational disease law.

Non-Home Use – Drugs intended for use in a Health Care Facility (Hospital, Skilled Nursing Facility, etc.) or in Physician's office or setting other than home use.

Non-Prescription Drugs – A drug or medicine that is bought without a written prescription. This does not apply to insulin.

Ostomy Supplies

OTC Equivalents – Except as provided herein or in the **Appendix A**, products obtained "over-the-counter" (i.e., without a prescription) that are identical to prescription drugs in active chemical ingredient, dosage form, strength and route of administration.

Replacement Prescriptions – Replacement of a prescription that has been lost, except that replacement of one (1) lost prescription per year will be covered.

Vitamins – Legend and non-legend vitamins, except for prenatal vitamins and legend fluoride products.

Weight Management Drugs – Drugs used to suppress appetite and control fat absorption (e.g., Xenical, Meridia).

DISCLAIMER: THIS PRESCRIPTION INFORMATION IS ONLY A SUMMARY. IF THERE ARE ANY CONFLICTS BETWEEN THIS PRESCRIPTION INFORMATION AND THE TERMS OF AGREEMENT(S) BETWEEN THE PLAN SPONSOR AND THE PRESCRIPTION PROGRAM VENDOR, THE TERMS OF THE AGREEMENT(S) WILL GOVERN.

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, CA 91761
Attention: EHP

Administrative Review Requests:
Prime Healthcare Employee Benefits Plan
3480 East. Guasti Road
Ontario, CA 91761
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 or faxed to:

Prime Healthcare Employee Benefits Plan
3480 East. Guasti Road
Ontario, CA 91761
Attention: EHP

GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

Court-Ordered Care, Confinement or Treatment – Any care, confinement or treatment of a Covered Person in a public or private institution as the result of a court order, unless the treatment would have been covered in the absence of the court order.

Criminal Activities/Illegal Acts – Any Injury resulting from or occurring during a Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation.

This exclusion will not apply to Injuries suffered by a Covered Person who is a victim of domestic violence.

Drugs in Testing Phases – Medicines or drugs that are (i) in the Food and Drug Administration Phases I, II, or III testing, or (ii) not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Excess Charges – Charges in excess of the Allowable Charges for services or supplies provided.

Experimental/Investigational Treatment – Expenses for treatments, procedures, devices, or drugs which the Plan determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

- 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 not the subject of ongoing phase I, II, or III 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.*

Forms Completion – Charges made for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities – Services furnished to the Covered Person in any veterans Hospital, military Hospital, institution or facility operated by the United States

government or by any state government or any agency or instrumentality of such governments and for which the Covered Person has no legal obligation to pay.

NOTE: THIS EXCLUSION DOES NOT APPLY TO TREATMENT OF NON-SERVICE RELATED DISABILITIES OR FOR INPATIENT CARE PROVIDED IN A MILITARY OR OTHER FEDERAL GOVERNMENT HOSPITAL TO DEPENDENTS OF ACTIVE DUTY, ARMED SERVICE PERSONNEL OR ARMED SERVICE RETIREES AND THEIR DEPENDENTS. THIS EXCLUSION DOES NOT APPLY WHERE OTHERWISE PROHIBITED BY LAW.

Late-Filed Claims – Claims that are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims and Appeals Procedures** section.

Military Service – Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Missed Appointments – Expenses incurred for failure to keep a scheduled appointment.

No Charge/No Legal Requirement to Pay – Services for which no charge is made or for which a Covered Person is not required to pay or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved, and this Plan is a "secondary" coverage, this exclusion will apply to those amounts a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

NOTE: THIS EXCLUSION DOES NOT APPLY TO ANY BENEFIT OR COVERAGE THAT IS AVAILABLE THROUGH THE MEDICAL ASSISTANCE ACT (MEDICAID).

Not Listed Services or Supplies – Any services, care or supplies that are not specifically listed in the Benefit Document as Eligible Expenses.

Other Coverage – Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

Outside United States – Charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services or supplies.

Postage, Shipping, Handling Charges, Etc. – Any postage, shipping or handling charges that may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

Prior Coverages – Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces.

Prior to Effective Date/After Termination Date – Charges incurred prior to an individual's effective date of coverage hereunder or after coverage is terminated, except as may be expressly stated.

Relative or Resident Care – Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Sales Tax, Etc. – Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges imposed under state law.

Travel – Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included.

War or Active Duty – Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

Work-Related Conditions – Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, whether or not a claim is made for such benefits. If the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

COORDINATION OF BENEFITS (COB)

All health care benefits provided hereunder are subject to Coordination of Benefits as described below, unless specifically stated otherwise. These coordination provisions apply separately to each Covered Person, per Plan Year. Coordination of Benefits applies to the medical benefits included in This Plan.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Allowable Expense – Any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan covering the person for whom a claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value for each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

Claim Determination Period – A period that commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

Other Plan – Any of the following that provides health care benefits or services:

- Group, blanket, or franchise health insurance coverage;
- Group service plan contract, group practice, group individual practice and other group prepayment coverages;
- Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans;
- Medicare. However, this does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

NOTES: THE TERM "OTHER PLAN" REFERS SEPARATELY TO EACH AGREEMENT, POLICY, CONTRACT, OR OTHER ARRANGEMENT FOR SERVICES AND BENEFITS, AND ONLY TO THAT PORTION OF SUCH AGREEMENT, POLICY, CONTRACT OR ARRANGEMENT WHICH RESERVES THE RIGHT TO TAKE THE SERVICES OR BENEFITS OF OTHER PLANS INTO CONSIDERATION IN DETERMINING BENEFITS.

An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them.

If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

Primary Plan – The plan which will have its benefits determined first.

This Plan – The medical benefits that are described in this Benefit Document.

EFFECT ON BENEFITS UNDER THIS PLAN

Whether This Plan is the Primary Plan or a secondary plan is determined in accordance with the following rules. However, these rules do not apply when This Plan provides "excess" benefits. See the "When This Plan Provides Excess Benefits Only" provision at the end of this section for more information.

- If this Plan is the Primary Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
- If This Plan is not the Primary Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed the Allowable Expense.
- The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if the Covered Person were covered under This Plan only.

When an HMO or Service Plan Contract is the Primary Plan – If an individual is covered by a Health Maintenance Organization (HMO) or service plan contract and that coverage is the individual's Primary Plan but the individual does not use the HMO or service plan for their health care needs, then the HMO must be presented with the non-HMO health care billings. Upon the HMO's or service plan's refusal to pay for health care expenses incurred by the Claimant, the respective denials and the Claimant's bills for health care services must be submitted to the Plan's Contract Administrator before any benefits will be considered under This Plan.

When an Other Plan Does Not Contain a COB Provision – If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be the Primary Plan and This Plan will pay its benefits AFTER such Other Plan. This Plan's liability will be the lesser of: (a) its normal liability, or (b) total Allowable Expenses minus benefits paid or payable by the Other Plan.

When an Other Plan Contains a COB Provision – When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan, it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan.

ORDER OF BENEFIT DETERMINATION

Whether This Plan is the Primary Plan or a secondary plan is determined in accordance with the following rules. However, these rules do not apply when This Plan provides "excess" benefits. See the "When This Plan Provides Excess Benefits Only" provision at the end of this section for more information.

No COB Provision – If an Other Plan does not contain a coordination of benefit provision, then the Other Plan will be primary and This Plan will be secondary. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.

Non-Dependent vs. Dependent – The benefits of a plan that covers the Claimant as an Employee pays before a Plan that covers the Claimant as a Dependent. But, if the Claimant is retired and eligible for Medicare, Medicare pays: (a) after the plan which covers the Claimant

as a Dependent of an active Employee, but (b) before the plan which covers the Claimant as a retired Employee.

Child Covered Under More Than One Plan – When the Claimant is a Dependent child, the Primary Plan is the plan of the parent whose birthday is earlier in the Plan Year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

EXCEPTION: FOR A DEPENDENT CHILD OF PARENTS WHO ARE DIVORCED, SEPARATED OR DOMESTIC PARTNERSHIP DISSOLVED THE FOLLOWING RULES WILL BE USED IN PLACE OF THE ABOVE PARAGRAPH:

- If the parent with custody of the child for whom a claim has been made has not remarried or has not entered into a domestic partnership, then the plan of the parent with custody that covers that child as a Dependent pays first.
- If the parent with custody of the child for whom a claim has been made has remarried or has entered into a Partnership, then the order in which benefits are paid will be as follows:
  a) The plan which covers the child as a Dependent of the parent with custody.
  b) The plan which covers the child as a Dependent of the stepparent (married/ Partner to the parent with custody).
  c) The plan which covers the child as a Dependent of the parent without custody.
  d) The plan which covers the child as a Dependent of the stepparent (married/ Partner to the parent without custody).

When the Claimant is a Dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, then that plan is primary. This rule applies to Claim Determination Periods commencing after the plan is given notice of the court decree.

When a Dependent child who has coverage under either or both parents' plans and also has coverage as a Dependent under a spouse's or Partner's plan, the Longer vs. Shorter Length of Coverage rule is used.

Active vs. Inactive Employee – The plan that covers the Claimant as a laid-off or retired Employee or as a Dependent of a laid-off or retired Employee pays after a plan that covers the Claimant as the Dependent of such a person. But if either plan does not have a provision regarding laid-off or retired Employees, the "Failure to Establish Order of Payment" provision (below) will apply.

Continuation Coverage (COBRA) Enrollee – If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an Employee, Covered Person, subscriber, or retiree (or as that person's Dependent) is primary and This Plan is secondary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage – If none of the above rules establish which plan is primary, the benefits of the plan that has covered the Claimant for the longer period of time will be determined before those of the plan that has covered that person for the shorter period of time.

Failure to Establish Order of Payment – If the preceding rules do not determine the order of payment between plans, then the plan under which the Claimant has been enrolled for the longest period of time will be the Primary Plan unless two of the plans have the same effective date. In this case, Allowable Expenses shall be shared equally between the two plans.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information – For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

This Plan is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value – If an Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and This Plan's liability will be reduced accordingly.

Facility of Payment – A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery – If the amount of the payments made by This Plan is more than it should have paid under this COB section, This Plan may recover the excess from one or more of the persons it has paid or for whom it has paid – or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

BENEFITS FOR MEDICARE-ELIGIBLE COVERED PERSONS

If a Claimant is entitled to Medicare, he will receive the full benefits of This Plan, except as follows:

1. A Claimant receiving treatment for end-stage renal disease, up to the Plan limits, following the first 30 months may be entitled to end-stage renal disease benefits under Medicare; or

2. A Claimant is entitled to Medicare benefits as a disabled person, unless they have a current employment status as determined by Medicare rules through a group plan of 100 or more Employees (according to federal COBRA legislation).

In cases where exceptions 1 or 2 apply, This Plan's payment will be determined according to these COB provisions and the following: This Plan will not provide benefits that duplicate any benefits to which a Claimant would be entitled under Medicare. This exclusion applies to all parts of Medicare in which the Claimant can enroll without paying additional premium. If a

Claimant is required to pay additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if the Claimant is enrolled in that part.

WHEN "THIS PLAN" WILL PROVIDE EXCESS BENEFITS ONLY

Excess Benefits – If at the time of Injury or Illness, there is available, or potentially available any Coverage (see "Coverage" as defined in the **Subrogation and Reimbursement Provisions** section and including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. This Plan's benefits shall be excess to:

- Any responsible third party, its insurer, or any other source on behalf of that party;
- Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Workers' compensation or other liability insurance company; or
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation – When medical payments are available under any vehicle insurance, this Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

SUBROGATION AND REIMBURSEMENT PROVISIONS

Payment Condition – The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury or Illness is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan Beneficiaries, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where another party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Covered Person(s), their attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and the Covered Person shall be a trustee over those assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

Subrogation – As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion if the Covered Person fails to so pursue said rights and/or action.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. This Covered Person is also

obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person(s) fails to file a claim or pursue damages against:

- The responsible party, its insurer, or any other source on behalf of that party;
- Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Workers' compensation or other liability insurance company; or
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement – The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by their recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a

subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness or Injury.

Excess Insurance – If at the time of Injury or Illness there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the **Coordination of Benefits** section.

The Plan's benefits shall be excess to:

- The responsible party, its insurer, or any other source on behalf of that party;
- Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Workers' compensation or other liability insurance company; or
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Covered Person is a Trustee Over Plan Assets – Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or accident. By virtue of this status, the Covered Person understands that they are required to:

- Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
- Instruct their attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
- In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other sourced of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and
- Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any and all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys fees, for which they exercise

control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Separation of Funds – Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death – In the event that the Covered Person(s) dies as a result of their Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations – It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan to:

- To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- To provide the Plan with pertinent information regarding the Illness or Injury, including accident reports, settlement information and any other requested additional information;
- To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
- To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
- To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage;
- To instruct their attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;
- In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
- To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

If the Covered Person(s) and/or their attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or Illness, out of any proceeds, judgment or settlement

received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person(s)' cooperation or adherence to these terms.

Offset – If timely repayment is not made, or the Covered Person and/or their attorney fail to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status – In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and their estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation – The Plan Administrator retains, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may delegate these duties. The Plan Administrator may amend these provisions of the Plan at any time without notice.

Severability – In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The invalid or illegal language in such section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal provisions had never been inserted in the Plan.

ELIGIBILITY AND EFFECTIVE DATES

ELIGIBILITY REQUIREMENTS – EMPLOYEES

Employees are eligible to participate in the Plan if they are in Active Service for the Employer, performing all customary duties of their occupation at their usual place of employment (or at a location to which the business of the Employer requires them to travel) and are regularly scheduled to work at least sixty (60) Hours of Service per pay period if a full-time Employee – or no less than forty (40) Hours of Service per pay period if a part-time Employee.

An Employee will be deemed in "Active Service" on each day they are actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided 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 during an approved FMLA leave or solely due to their own health status (see "Non-Discrimination Due to Health Status" in the General Plan Information section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on their first scheduled workday, they will not be considered as having commenced Active Service.

An Employee who is eligible to be covered as an Employee and as a Dependent cannot be covered as both.

See the Extensions of Coverage section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicare, Medicaid or TRICARE or the receipt of benefits under such programs will not be taken into account in determining eligibility.

EFFECTIVE DATE – EMPLOYEES

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.

ELIGIBILITY REQUIREMENTS – DEPENDENTS

A Dependent who is eligible to be covered as an Employee and as a Dependent cannot be covered as both.

Except as noted at the end of this provision, an eligible Dependent of an Employee is a person who resides in the United States and is considered to be an eligible dependent. Please refer to the facility Benefit Guide for additional information on eligibility requirements for dependents.

An "eligible child" is one who has a relationship with the Employee (e.g., a son, daughter, stepson or stepdaughter of the Employee, a legally adopted child or a child who is placed with the Employee for legal adoption. An eligible child also includes one for whom coverage is required due to an administrative or court order or a Qualified Medical Child Support Order.

NOTE: AN ELIGIBLE DEPENDENT DOES NOT INCLUDE:

- A spouse following legal separation or a final decree of dissolution of marriage or divorce (including any children of the spouse who were eligible only because of the marriage);
- A Partner following dissolution of the partnership (including any children of the Partner who were eligible only because of the Partnership);
- A spouse or Partner who is eligible for coverage under another group medical plan that provides minimum value as described in section 36B(c)(2)(C)(ii) of the Code;
- Any person who is on active duty in any military service, except where eligibility is required by U.S. law;
- Any Dependent who is eligible for Dependent coverage but chooses to be enrolled as an Employee;
- Any person who is covered as a Dependent of another Employee;
- Any grandchild of an Employee, and other family members, i.e. brothers, sisters, (unless the Employee, spouse or Partner has legal guardianship) and parents, in-laws, etc.;
- Any child born to a Covered Person resulting from an Assisted Reproduction Agreement under California Family Code Sections 7960-7962, or other similar applicable state law, and with respect to whom the Covered Person is not the "intended parent"; or
- Any person for whom an Employee is unable or refuses to show timely proof of eligibility as may be required from time to time by the Plan Administrator.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

EFFECTIVE DATE – DEPENDENTS

A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date. See the "Special Enrollment Rights and Mid-Year Election Change Allowances" provision for additional details as well as instances when the loss of other coverage and other circumstances can allow a Dependent to be enrolled. Otherwise, a Dependent can be enrolled only in accordance with **the "Late Enrollment/Re-Enrollment" provision.**

NOTE: IN NO INSTANCE WILL A DEPENDENT'S COVERAGE BECOME EFFECTIVE PRIOR TO THE EMPLOYEE'S COVERAGE EFFECTIVE DATE.

SPECIAL ENROLLMENT RIGHTS AND MID-YEAR ELECTION CHANGE ALLOWANCES

A Participant may enroll himself and/or family members into the Plan and change elections outside of the normal open enrollment period upon the happening of certain events as

described below. However, the change must be requested timely (i.e. within the specified time frames).

Entitlement to Enroll Due to Loss of Other Coverage – An individual who did not enroll in the Plan when previously eligible will be allowed to apply for coverage hereunder at a later date if:

- An individual was covered under another group health plan or other health insurance coverage (including Medicaid or a State Children's Health Insurance Plan (CHIP) at the time coverage was initially offered or previously available to him. "Health insurance coverage" means benefits consisting of major medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or Health Maintenance Organization (HMO) contract offered by a health insurance issuer;
- The Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Administrator required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement; and
- The individual lost the other coverage as a result of an event, described below, and the Employee requested Plan enrollment within thirty (30) days of termination of the other coverage and within sixty (60) days with regard to Medicaid or CHIP – see last sub-entry below. A loss of coverage event includes but is not limited to:
  a) Loss of eligibility as a result of a legal separation, divorce, cessation of Dependent status, death of an Employee, termination of employment or reduction in the number of Hours of Service;
  b) Loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
  c) Loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
  d) Loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other Employees;
  e) Loss of eligibility when employer contributions toward the Employee's or Dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;
  f) Loss of eligibility when COBRA continuation coverage is exhausted; and
  g) Loss of eligibility under Medicaid or a state Children's Health Insurance Program (CHIP) or gain of eligibility for state premium assistance under Medicaid or CHIP.

If the above conditions are met, Plan coverage will become effective on the date the Plan is notified of the loss of other coverage.

NOTE: FOR A DEPENDENT TO ENROLL UNDER THE TERMS OF THIS PROVISION, THE EMPLOYEE MUST BE ENROLLED OR MUST ENROLL CONCURRENTLY.

Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes.

Entitlement to Enroll Due to Acquisition of New Spouse/Partner or any Dependent by Marriage/Partnership, Birth, Adoption or Placement for Adoption – If an Employee acquires one (1) or more new eligible Dependents through marriage, Partnership, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage must be made within thirty-one (31~~)~~ days of the date the new Dependent or Dependents are acquired (i.e. date of marriage/Partnership, birth, adoption or placement for adoption). Plan coverage will be effective as follows – see NOTE:

- Employee's marriage or Partnership – the spouse's or partner's coverage (and the coverage of any newly eligible children) will be effective on the later of the date of marriage/registration or the date notice is provided to the Plan, subject to enrollment within thirty-one (31) days of the event;
- Acquisition of a child – the child's coverage will be effective on the date of birth, date of placement or date of adoption, subject to enrollment within 31 days of the event. The event date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within thirty-one (31) days of birth.

NOTE: FOR A NEWLY-ACQUIRED DEPENDENT TO BE ENROLLED UNDER THE TERMS OF THIS PROVISION, THE EMPLOYEE MUST BE ENROLLED OR MUST BE ELIGIBLE TO ENROLL (I.E., MUST HAVE SATISFIED ANY WAITING PERIOD REQUIREMENT) AND MUST ENROLL CONCURRENTLY. IF THE NEWLY-ACQUIRED DEPENDENT IS A CHILD, THE SPOUSE IS ALSO ELIGIBLE TO ENROLL. HOWEVER, OTHER DEPENDENT CHILDREN WHO WERE NOT ENROLLED WHEN THEY WERE FIRST ELIGIBLE ARE NOT CONSIDERED TO BE NEWLY ACQUIRED AND CAN ONLY BE ENROLLED IN ACCORDANCE WITH OTHER ENROLLMENT ALLOWANCES.

Court or Agency Ordered Coverage – If an Employee is required to provide coverage for a child under a Medical Child Support Order (MCSO), coverage for the child shall be effective as soon as administratively possible following the Plan Administrator's determination that the order is qualified (i.e., is a QMCSO). A request to enroll the child may be made by the Employee or by a State Agency on the child's behalf.

If the Employee is not enrolled when the Plan is presented with a MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both

must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

OPEN ENROLLMENT

If an eligible Employee does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an open enrollment period that will be held annually. Plan coverage will be effective on the date specified by the Plan Sponsor.

The open enrollment period is also a time when Employees can transfer coverage from one benefit option to another. The newly-elected option will become effective on the date specified by the Plan Sponsor following the open enrollment period.

NOTE: SEE "SPECIAL ENROLLMENT RIGHTS AND MID-YEAR ELECTION CHANGE ALLOWANCES" FOR EXCEPTIONS TO THIS PROVISION.

REINSTATEMENT/REHIRE

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines, the Family and Medical Leave Act (FMLA), the California Family Rights Act (CFRA) or other similar applicable state law, and during the leave the Employee discontinued paying their share of the cost of coverage, such Employee may have coverage reinstated as if there had been no lapse (for himself and any Dependents who were covered at the point contributions ceased). To avoid interruption of coverage during the leave, the Plan Sponsor will have the right to keep coverage in force at its own expense and can require that unpaid coverage contribution costs be repaid by the Employee at the end of the FMLA/CFRA leave.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States Uniformed Services, will be reinstated to coverage hereunder immediately upon returning from such service.

See the **Extensions of Coverage** section for more information on when coverage may be continued during certain leaves of absence.

NOTE: EXCEPT IN THE ABOVE INSTANCES, ANY (I) CURRENT EMPLOYEE WHO PERFORMS NO HOURS OF SERVICE, OR (II) TERMINATED EMPLOYEE WHO IS REHIRED AND, IN EITHER CASE, RESUMES PROVIDING SERVICES (OR IS OTHERWISE CREDITED WITH AN HOUR OF SERVICE) AFTER A PERIOD OF 13 CONSECUTIVE WEEKS DURING WHICH NO HOURS OF SERVICE WERE CREDITED, MAY BE TREATED AS HAVING TERMINATED EMPLOYMENT AND HAVING BEEN REHIRED AS A NEW EMPLOYEE UPON THE RESUMPTION OF SERVICES AND WILL BE REQUIRED TO SATISFY ALL ELIGIBILITY AND ENROLLMENT REQUIREMENTS.

TRANSFER OF COVERAGE

If a husband and wife or members of a Partnership are both Employees and are covered as Employees under this Plan and one of their employment terminates or they are on approved leave of absence, the terminating/leave spouse/Partner and any of their eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such transferred coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

TERMINATION OF COVERAGE

EMPLOYEE COVERAGE TERMINATION

Except as noted, an Employee's coverage will terminate upon the earliest of the following:

- Termination of the Plan or termination of the Plan benefits as described herein;
- Employee's election to terminate participation, unless prohibited by law (i.e., when election changes cannot be made due to Code section 125 guidelines);
- Employee's failure to abide by the terms and conditions of the Plan;
- At midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer or ceases to be eligible or engaged in active employment for the required number of Hours of Service as specified in **Eligibility and Effective Dates** section – except when coverage is extended under the **Extensions of Coverage** section;
- The date the Employee dies.

See also "Termination for Fraud" at the end of the **General Plan Information** section.

NOTE: UNUSED VACATION DAYS OR SEVERANCE PAY FOLLOWING CESSATION OF ACTIVE WORK WILL NOT COUNT AS EXTENDING THE PERIOD OF TIME COVERAGE WILL REMAIN IN EFFECT.

Employees otherwise eligible and validly enrolled hereunder shall not be terminated solely due to their health status or need for health services.

DEPENDENT COVERAGE TERMINATION

Except as noted, a Dependent's coverage will terminate upon the earliest of the following:

- Termination of the Plan or these Plan benefits or discontinuance of Dependent coverage hereunder;
- Termination of the coverage of the Employee;
- At midnight of the last day of the month in which the Dependent ceases to meet the eligibility requirements of these Plan benefits, except when coverage is extended under the **Extensions of Coverage** section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;
- In the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has comparable replacement coverage that is in effect or will take effect immediately upon termination;
- The date the Dependent dies;
- Immediately upon an Employee's failure to provide proof of eligibility for such Dependent as may be requested from time to time by the Plan Administrator or retroactively if coverage is Rescinded.

See also "Termination for Fraud" at the end of the **General Plan Information** section.

NOTE: DEPENDENTS OTHERWISE ELIGIBLE AND VALIDLY ENROLLED HEREUNDER SHALL NOT BE TERMINATED SOLELY DUE TO THEIR HEALTH STATUS OR NEED FOR HEALTH SERVICES.

(SEE **COBRA CONTINUATION COVERAGE**)

EXTENSIONS OF COVERAGE

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage will not extend: (1) beyond the date the Plan is terminated, and (2) for a Dependent, beyond the date the Employee's coverage ceases.

EXTENSION OF COVERAGE FOR HANDICAPPED DEPENDENT CHILDREN

If a Dependent child is incapable of self-support due to a mental or physical disability that began before the child attained the maximum age of 26 (regardless of current age), and such child is unable to be independent and is entirely dependent upon the Employee for support and maintenance, coverage may continue past the maximum age.

The Employee must submit proof of the child's incapacity to the Plan Administrator within thirty-one (31) days of the child's attainment of the maximum age, or if a newly eligible Employee, at the time of enrollment, and as may reasonably be required thereafter, but not more frequently than once a year.

A child's coverage will cease on the earlier of the following: (1) cessation of the disability; (2) the child is no longer primarily dependent upon the Employee for support and maintenance; (3) Employee's failure to provide proof that the disability continues when such proof is requested; or (4) when the child ceases to be eligible for any reason other than reaching the maximum age.

EXTENSIONS OF COVERAGE DURING ABSENCE FROM WORK

If an Employee fails to continue in Active Service but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, or is eligible for an extension required by law, etc.), they may be permitted to continue health care coverages for themselves and their Dependents although they could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except where the Family and Medical Leave Act (FMLA), the California Pregnancy Disability Leave (PDL), the California Family Rights Act (CFRA), or other similar applicable state law, any coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

- On the date coverage terminates as specified in the Employer's written personnel policies and Employee communications. Such documents are incorporated herein by reference;
- The end of the period for which the last contribution was paid, if such contribution is required;
- The date of termination of the Plan or the benefits of the Plan.

To the extent that the Employer is subject to FMLA and/or PDL, and CFRA, it intends to comply to the fullest extent required. Continued coverage under PDL shall run concurrently with coverage under FMLA.

Plan benefits may be maintained during an FMLA/CFRA/PDL leave at the levels and under the conditions that would have been present if employment was continuous. An Employee

can obtain a more complete description of FMLA/CFRA/PDL rights from the Plan Sponsor's Human Resources or Personnel department.

Any Plan provisions which are found to conflict with the FMLA/CFRA/PDL are modified to comply with at least the minimum requirements of the Act.

NOTE: An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered service member. A "covered service member" is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an Outpatient, or is on the temporary disability retired list, for a "serious Injury or Illness" (an Injury or Illness incurred in line of duty on active duty in the Armed Forces that may render the service member medically unfit to perform their duties).

Extension of Coverage During Labor Dispute
If an Employee fails to continue in active employment due to a labor dispute, the Employee can arrange to continue coverage for up to six (6) months. This extension will cease, however, on the earlier of the following:

- at the beginning of the period for which the Employee fails to make the required payment toward the cost of coverage to his collective bargaining unit representative;
- at the beginning of the period for which the representative fails to make the required cost of coverage payments to the Plan Sponsor or Contract Administrator;
- on the date the Employee commences active employment with another employer;
- on any contribution due date when less than 75% of the affected Employees have elected to continue coverage under the terms of this provision;
- at the end of six (6) months following the cessation of active employment.

Extension of Coverage During Uniformed Service
Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active uniformed service is (and the Employee's eligible Dependent(s) are) has the right to elect continuation of coverage under either USERRA or COBRA but not both. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements – To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of their uniformed service. Notice may be written or oral or may be given by an appropriate officer of the uniformed branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active uniformed service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of their military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee's departure from employment due to active uniformed service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active uniformed service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active uniformed service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage – The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage and may not exceed the active Employee cost share if the uniformed leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the Plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active uniformed service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage – The maximum period of USERRA continuation coverage following Employee's cessation of active employment is the lesser of:

- 24 months;
  OR
- The duration of Employee's active military service.

Reinstatement of Coverage Following Active Duty – Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions.

An Employee returning from uniformed leave must notify the Employer of their intent to return to work. Notification (application for re-employment) must be made:

- Within 14 days after active uniformed service ceases for military leave of 31–180 days;
  OR
- Within 90 days of completion of uniformed service for service of more than 180 days.

No re-employment application is required if the uniformed leave is less than 31 days. In that case, generally the Employee need only report for work on the next regularly scheduled workday after a reasonable period for travel and rest. Uniformed Service members who are unable to report back to work because they are in the Hospital or recovering from an Injury or Illness suffered during active duty have up to two (2) years to apply for re-employment.

When coverage hereunder is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken USERRA leave and coverage had been continuous. No waiting period can be imposed on a returning Employee

or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

(SEE **COBRA CONTINUATION COVERAGE**)

CLAIMS AND APPEALS PROCEDURES

It is the intent of the Plan Administrator that the following claims and appeals procedures comply with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Where any provision is in conflict with ERISA or any other applicable law, such law shall control.

Nothing herein, shall be construed to supersede any provision of state law that regulates insurance, except to the extent that such law prevents application of a requirement under ERISA.

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.

SUBMITTING A CLAIM

A claim is a request for a benefit determination that is made in accordance with the Plan's procedures by a Claimant or their authorized representative. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services were received, and Provider name, address, phone number and tax identification number. Claims must be filed within one year from the date of service or the claim will be denied.

There are two types of claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

1. **A Pre-Service Claim** is one in which the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the **Utilization Management Program** section for that information.

   IMPORTANT: A PRE-SERVICE CLAIM IS ONLY FOR THE PURPOSES OF ASSESSING THE MEDICAL NECESSITY AND APPROPRIATENESS OF CARE AND DELIVERY SETTING. A DETERMINATION ON A PRE-SERVICE CLAIM IS NOT A GUARANTEE OF BENEFITS FROM THE PLAN. PLAN BENEFIT PAYMENTS ARE SUBJECT TO REVIEW UPON SUBMISSION OF A CLAIM TO THE PLAN AFTER MEDICAL SERVICES HAVE BEEN RECEIVED AND ARE SUBJECT TO ALL RELATED PLAN PROVISIONS, INCLUDING EXCLUSIONS AND LIMITATIONS.

2. **A Post-Service Claim** is a written request for a benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the Contract Administrator within three hundred sixty-five (365) days from the date of service. Providers may submit a Post-Service Claim on behalf of a Covered Person using HIPAA Electronic Transaction Standards.

   A Post-Service Claim should be submitted to:

   Keenan HealthCare
   P. O. Box 2744
   Torrance, CA 90509
   Fax: (310) 533-5755

NOTE: IN ACCORDANCE WITH FEDERAL LAW, THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) HAVE THREE (3) YEARS TO SUBMIT CLAIMS WHEN CMS HAS PAID AS THE PRIMARY PLAN AND THE PLAN SHOULD HAVE BEEN PRIMARY.

ASSIGNMENTS TO PROVIDERS

To the extent permitted by law, and except as specified under the terms of the Plan, no benefits will be subject to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void. This means, for example, you may not assign to anyone your right to file a lawsuit against the Plan. Benefits under the Plan may be subject to a Qualified Medical Child Support Order (QMCSO), however.

The Plan may pay benefits directly to Providers. This payment, however, is made as a convenience to you and does not constitute an assignment of benefits under the Plan.

In the event the Plan does not pay benefits to a Provider in respect of a claim incurred by a Covered Person, the Covered Person will be responsible for paying the Provider any amounts due for the services received.

NOTE: BENEFIT PAYMENTS ON BEHALF OF A COVERED PERSON WHO IS ALSO COVERED BY A STATE'S MEDICAID PROGRAM WILL BE SUBJECT TO THE STATE'S RIGHT TO REIMBURSEMENT FOR BENEFITS IT HAS PAID ON BEHALF OF THE COVERED PERSON, AS CREATED BY AN ASSIGNMENT OF RIGHTS MADE BY THE COVERED PERSON AS MAY BE REQUIRED BY THE STATE MEDICAID PLAN. FURTHERMORE, THE PLAN WILL HONOR ANY SUBROGATION RIGHTS THAT A STATE MAY HAVE GAINED FROM A MEDICAID-ELIGIBLE BENEFICIARY DUE TO THE STATE'S HAVING PAID MEDICAID BENEFITS THAT WERE PAYABLE HEREUNDER.

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (e.g., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond). If there is any variance between the following information and the intended requirements of the law, the law will prevail.

IMPORTANT: THESE CLAIMS PROCEDURES ADDRESS THE PERIODS WITHIN WHICH CLAIMS DETERMINATIONS MUST BE DECIDED, NOT PAID. BENEFIT PAYMENTS MUST BE MADE WITHIN REASONABLE PERIODS OF TIME FOLLOWING PLAN APPROVAL AS GOVERNED BY ERISA.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Urgent Claim - defined below	
Claimant Makes Initial Incomplete Claim Request	Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice. The Claimant has a reasonable amount of time to provide the additional information but not less than 48 hours.
Plan Receives Completing Information	Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing information.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial Complete Claim Request	Whether adverse or not, within not more than 72 hours (and as soon as possible considering the medical exigencies), Plan responds with written or electronic benefit determination.
Claimant Appeals	See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.
Plan Responds to Appeal	Within not more than 72 hours (and as soon as possible considering the medical exigencies), after receipt of Claimant's appeal.
An "urgent claim" is an oral or written request for a benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed. Where the "Time Limit or Allowance" stated above reflects "or sooner if possible," this phrase means that an earlier response may be required, considering the urgency of the medical situation.	
Concurrent Care Claim - defined below	
Plan Wants to Reduce or Terminate Already Approved Care	Plan notifies Claimant of intent to reduce or deny benefits before any reduction or termination of benefits is made and sufficiently in advance to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary, is subject to the urgent claim rules.
Claimant Requests Extension for Urgent Care	Whether adverse or not, Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment.
A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.	
Non-Urgent Claim	
Claimant Makes Initial Incomplete Claim Request	Within 15 days of receipt of the incomplete claim request, Plan notifies Claimant of information needed to complete the claim request. Claimant has 45 days from receipt of the notice from the Plan within which to provide the information.
Plan Receives Completing Information	Plan responds with written or electronic benefit determination within 15 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Whether adverse or not, within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeal Procedures" subsection.
Plan Responds to Appeal	Within 30 days after receipt of appeal.
"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15-day period.	

"POST-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request and the Claimant is afforded at least 45 days from receipt of the notice to provide the specified information.
Plan Receives Completing Information	Plan approves or denies claim within 30 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within a reasonable period of time but not later than 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.
Plan Responds to First Appeal	Within a reasonable period of time but not later than 30 days after receipt of the first appeal.
Plan Responds to Second Appeal	Within a reasonable period of time but not later than 30 days after receipt of the second appeal.
"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.	

AUTHORIZED REPRESENTATIVE MAY ACT FOR CLAIMANT

Any of the above actions that can be done by the Claimant can also be done by an Authorized Representative acting on the Claimant's behalf and who is authorized pursuant to the Plan Administrator's procedures and forms. For an urgent claim, a health care professional with knowledge of a Claimant's medical condition will be permitted to act as the Authorized Representative of the Claimant.

Independent Medical Examination

The Plan at its own expense will have the right and opportunity to require the examination of the person whose Injury or Illness is the basis of a claim when and as often as may be reasonably required during the pendency of a claim.

Claims Administration

For purposes of determining the amount of, and entitlement to, benefits under the Plan, the Plan Administrator or its delegate has the power to make factual determinations, request additional information and to interpret and apply the terms of the Plan in its complete and absolute discretion.

The Contract Administrator assists the Plan Administrator but cannot deviate from the terms of the Plan in its administration of claims. However, the Contract Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary for the proper administration of a claim. (NOTE: The Contract Administrator is not the Plan Administrator for the purposes of ERISA.)

Avoiding Conflicts of Interest

The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert)

must not be made based upon the likelihood that the individual will support the denial of benefits.

CONTENT OF NOTICE OF INITIAL ADVERSE BENEFIT DETERMINATION

Except as provided in the subsection immediately below, the Contract Administrator shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. Any electronic notification shall comply with the standards imposed by Department of Labor Regulations at 29 CFR 2520.104b-1(c)(l)(i), (iii), and (iv) and 29 CFR 2590.715-2719. The notification shall set forth, in a culturally and linguistically appropriate manner, calculated to be understood by the Claimant:

- Information sufficient to identify the claim involved (including the date of service, the Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- The specific reason or reasons for the Adverse Benefit Determination;
- A description of the Plan's standard, if any, that was used in denying the claim;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures;
- Whichever of the following applies:
    a) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

    b) If the Adverse Benefit Determination is based on a medical necessity or Experimental and/or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

- In the case of an Adverse Benefit Determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims; and
- A statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an External Review.

In the case of an Adverse Benefit Determination concerning a claim involving urgent care, the information described above may be provided to the Claimant orally within the time frame prescribed above, provided that a written or electronic notification is furnished to the Claimant not later than 3 days after the oral notification.

CLAIMANT RIGHTS TO A FULL AND FAIR REVIEW

A Claimant shall have a reasonable opportunity to appeal an Adverse Benefit Determination to an appropriate Fiduciary of the Plan and shall be afforded a full and fair review of the claim and Adverse Benefit Determination.

A Claimant must appeal an initial Adverse Benefit Determination within 180 calendar days following receipt of notification of the Adverse Benefit Determination of a Post-Service Claim. Following notice of an Adverse Benefit Determination on review (i.e. first appeal), a Claimant may request a final review (i.e. second appeal) within 60 calendar days of the Notice of Adverse Benefit Determination on review.

A Claimant must submit a request for review of an initial Adverse Benefit Determination before a request for an External Review can be made unless this review process is deemed exhausted or a request for an Expedited Review is made, as described below:

- The Claimant will have an opportunity to submit written comments, evidence, testimony, documents, records, and other information relating to the claim;
- Upon request and free of charge, the Claimant will be provided reasonable access to and copies of all documents, records, and other information relevant to the claim, as defined under applicable ERISA regulations.;
- The Plan will take into account all comments, documents, records, and other information submitted that are related to the claim, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination;
- The Plan's review of an Adverse Benefit Determination on review must not afford deference to the initial Adverse Benefit Determination. It must ensure that a review is conducted by an appropriate Fiduciary who is neither the individual who made the original Adverse Benefit Determination, nor that person's subordinate;
- In deciding an Appeal based, in whole or in part, on medical judgment, including a determination with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary or appropriate, the appropriate Fiduciary reviewing the appeal must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment to evaluate the claim;
- Such review shall provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;
- The Plan must ensure that a health care professional consulting on an appeal is not an individual who was consulted in connection with the original Adverse Benefit Determination, nor a subordinate of any such individual;
- Any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim will be provided, free of charge, automatically, as soon as possible and sufficiently in advance of the date of a Final Internal Adverse Benefit Determination to afford the Claimant a reasonable opportunity to respond before that date;

- Before the Plan can issue a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible, automatically, and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date. (If the new or additional evidence is received so late that it would be impossible to provide it to Claimant in time, for the Claimant to have a rasonable opportunity to respond, the period for providing the Final Internal Adverse Benefit Determination is tolled until such time as the Claimant has a reasonable opportunity to rsepond. After the Claimant responds, or has a reasonable opportunity to respond but fails to do so, the Plan Administrator shall notify the Claimant of the Plan's benefit determination as soon as the Plan, acting in a reasonable and prompt fashion, can provide the notice, taking into account the medical exigencies.

For the purpose of these provisions, a health care professional is a Physician or other health care Provider.

A request for diagnosis and treatment information, in itself, shall not be considered to be a request for review under this Article.

Appeals should be submitted in writing to:

Keenan HealthCare
P. O. Box 2744
Torrance, CA 90509
Fax: (310) 533-5755
Attention: Appeals

A Claimant may have representation throughout the Appeals and review procedure.

CONTENT OF NOTICE OF DECISION ON INTERNAL APPEAL

The Plan Administrator shall provide a Claimant with written or electronic notice of the Plan's Adverse Benefit Determination on review or Final Internal Adverse Benefit Determination in accordance with the applicable time frames set forth above. In the case of any Adverse Benefit Determination on review or Final Internal Adverse Benefit Determination, the notice must state, in a culturally and linguistically appropriate manner and calculated to be understood by the Claimant:

- Information sufficient to identify the claim (including date of service, the Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
- The specific reason or reasons for the Adverse Benefit Determination.
- The reason or reasons for the Adverse Benefit Determination on review or Final Internal Adverse Benefit Determination must include the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim; in the case of a Final Adverse Benefit Determination, a discussion of the decision.
- Reference to the specific Plan provisions on which the benefit determination is based.

- A statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records, and other information "relevant" to the Claimant's claim for benefits.
- If the Adverse Benefit Determination on review or Final Internal Adverse Benefit Determination is based on Medical Necessity or Experimental and/or Investigational treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical condition, or a statement that this will be provided without charge upon request.
- A statement describing the Plan's optional appeals procedures, if any, and the Claimant's right to receive information about the procedures as well as the Claimant's right to bring a civil action under section 502(a) of ERISA.
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."
- A description of available internal appeals and external review processes, including information regarding how to initiate an Appeal.
- If applicable, disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

EXTERNAL REVIEW REQUIREMENTS

A Claimant may request an External Review of an Adverse Benefit Determination (subject to the conditions stated herein) or Final Internal Adverse Benefit Determination that is based on the Plan's requirements for (i) medical judgment (including, but not limited to, the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a Covered Medical Expense); (ii) its determination that a treatment is Experimental and/or Investigational; (iii) its determination whether a Participant or other Covered Person is entitled to a reasonable alternative standard for a reward under a wellness program; (iv) its determination whether the Plan is complying with the nonquantitative treatment limitations provisions of MHPAEA (which generally require, among other things, parity in the application of medical management techniques); (v) a Rescission (whether or not the Rescission has any effect on any particular benefit at that time); and (vi) Adverse Benefit determinations that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in ERISA sections 716 and 717 (No Surprises Act).

A denial, reduction, termination, or a failure to provide payment for a benefit based upon a determination that a Covered Person fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the External Review Process.

In connection with a request for an External Review, the request must be filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four (4) months after the date of receipt (e.g. February 28), the request must be filed by the first day of the fifth month following receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday,

or Federal holiday. The request is filed as described in the notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination.

External Review Process

Preliminary Review. Within five (5) business days after the date of the receipt of the External Review Request, a preliminary review must be completed by the Plan to determine whether:

- The claimant is or was covered by the Plan at the time the health care service or item was requested, or in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- The Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the individual's failure to meet the requirements for eligibility under the terms of the Plan;
- The Claimant has exhausted the Plan's internal appeal process, unless not required to exhaust the Internal Appeals Process as described in the **Expedited External Review** section; and
- The Claimant has provided all the information and forms required to process an External Review.

Completion of Preliminary Review. Within one (1) business day after completing the preliminary review, a written notification will be issued to the Claimant about the requested eligibility or ineligibility for External Review.

- If the request is complete but not eligible for External Review, the notification must include the reasons for its ineligibility and contact information for the Employee Benefit Security Administration (EBSA) (Phone 866-444-EBSA(3272)).
- If the request is not complete, the notification must describe the information or materials needed to make the request complete, and the Claimant must be allowed to perfect the request for External Review within the four (4) month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Independent Review Organization Process

The External Review process is independent without bias and without cost or fees to the Claimant. If the request is eligible for External Review, the claim is assigned to and the review is conducted by an Independent Review Organization.

Each IRO has been contracted by the Plan. Assignments are rotated among IRO's on an objective and standardized basis. The IRO is not eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. Referral timelines are as follows:

- The assigned IRO shall notify the Claimant, in a timely manner and in writing, whether the request is eligible for External Review. The notice from the IRO will include a statement that the Claimant may submit in writing to the assigned IRO, within ten (10) business days following the date of receipt of the notice, additional information. The assigned IRO must consider information submitted by the Claimant within the ten (10) business day period. The IRO may but is not required to accept and consider additional information submitted after ten (10) business days.
- Within five (5) business days after the assignment of the External Review to the IRO, the Plan will provide the IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit

Determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination.

- Upon receipt of information submitted by the Claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of the information, the Plan may reconsider its determination. Reconsideration by the Plan must not delay the External Review. The External Review may be terminated as a result of the Plan's reconsideration only if the Plan decides to reverse its decision and provide coverage or payment. Within one business day after making such decision, the Plan must provide written notice of its decision to the Claimant and IRO. The IRO must terminate the External Review upon receipt of the notice from the Plan.
- The IRO will review all of the information and documents timely received to review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.
- The assigned IRO must provide written notice of its Final External Review Decision within 45 days after receiving the request for the External Review from the Plan. The notice must be delivered to the Claimant and to the Plan. The written notice will contain:
  a) A general description of the reason for the request for External Review, including information sufficient to identify the claim;
  b) The date the IRO received the assignment;
  c) Reference to evidence or documentation, including the specific coverage provisions and evidence-based standards considered in reaching the decision;
  d) A discussion of the principal reason or reasons for its decision;
  e) A statement that the Final External Review Decision is binding except to the extent that other remedies may be available to the Plan or Claimant; and
  f) A statement that judicial review may be available to Claimant.

Upon receipt of the Final External Review Decision from the IRO that reverses (in whole or in part) the Adverse Benefit Determination of the Plan, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim to the extent reversed by the Final External Review Decision.

EXPEDITED EXTERNAL REVIEW

External Review procedures may be expedited for cases where an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination involves:

- a medical condition for which the timeframe for completion of an expedited internal Adverse Benefit Determination on review would seriously jeopardize the life or health of the Claimant, or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal review of the initial Adverse Benefit Determination;
- with respect to a Final Internal Adverse Benefit Determination, the Claimant has a medical condition where the timeframe for completion of the standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued

stay, or health care service for which the Claimant received Emergency Services, but has not been discharged from a facility;

- Upon receipt of the request for Expedited External Review, the Plan must determine whether the request meets the preliminary review requirements;
- The Plan must provide all documents and any necessary information to the assigned IRO electronically, by telephone or facsimile or any other available expeditious method; and
- For an expedited External Review, the IRO must provide notice of the Final External Review Decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the notice to the Claimant is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to the Claimant and the Plan.

ARBITRATION AGREEMENT

For cases that do not qualify for expedited External Review, all such disputes between a Plan Participant, a Participant's heirs, relatives, personal representatives, or other associated parties on the one hand, and the Plan, the Plan sponsor or any of its affiliates, its contracted health care Providers, their agents, employees, or other associated parties on the other hand, arising out of or relating to the Plan, including any claim for benefits under the Plan (after exhausting the claims and appeals provisions provided herein), or relating to the coverage for, or the delivery of, services or items, irrespective of the legal theories upon which the claim is asserted, shall be decided by binding and confidential arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Such arbitration shall address claims on an individual basis, and not on a class, collective or representative basis. By accepting coverage and/or benefits under the Plan, all Participants and beneficiaries expressly waive their right to a court or jury trial and accept the use of binding arbitration pursuant to the rules of the American Arbitration Association and waive their right to be part of any class action related to the Plan. The venue for such arbiration shall be Los Angeles County unless otherwise agreed to by all parties to the dispute. Any demand for arbitration must be filed within two years after the Claimant's initial claim or within six months from the date of the claim decision on appeal, whichever comes first.

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

An Injury will also include Injuries suffered by a Covered Person who is the victim of domestic violence.

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.

Adverse Benefit Determination – Any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or other Covered Person's eligibility to participate in the Plan, and including, any denial, reduction or termination (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate.

Adverse Benefit Determinations apply to pre-service claims, post-service claims and Rescissions (whether or not there is an adverse effect on any particular Benefit at that time), including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility to participate in the Plan;
- A determination that an item or service is not a Covered Medical Expense or that a Prescription Drug is not a Covered Prescription Drug;
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise Covered Medical Expenses or Covered Prescription Drugs;
- A determination that an item or service is Experimental and/or Investigational, or not Medically Necessary or appropriate;
- A determination of entitlement to a reasonable alternative standard for a reward under a wellness program; or
- A determination of whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act.

Air Ambulance Service – Medical transport by a rotary wing air ambulance, or fixed wing air ambulance, for patients.

Affordable Care Act (ACA) – The Patient Protection and Affordable Care Act enacted on March 23, 2010.

Allowable Charge(s) – Except as expressly allowed in the **Medical and Prescription Drug Benefits** sections of this Plan, Allowable Charges will apply to covered services that are approved under the rules of the Utilization Management Program as follows:

Network Providers – Allowable Charges shall be the lesser of:

- The amount billed; or
- The amount contracted (the Network Provider's Prime negotiated rate, if any).

Non-Network Providers (Non-Emergency Services) – Allowable Charges for pre-approved Non-Emergency Services at a Non-Network Health Care Facility shall be the lesser of:

- The amount billed; or
- The Tier 1 Prime Healthcare Network negotiated rate.

Non-Network Providers (Non-Emergency Services) at a Network Provider Health Care Facility – Allowable Charges for pre-approved Non-Emergency Visits at a Network Provider facility shall be the Out-of-Network Rate.

Non-Network Providers (Emergency Services) – Allowable Charges for Emergency Services shall be the Out-of-Network Rate.

Non-Network Provider of Air Ambulance Services – Allowable Charges for Non-Network Air Ambulance Services shall be the Out-of-Network Rate.

Ambulatory Surgical Center – Any public or private establishment that:

- Complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- Has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- Provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and
- Does not provide services or other accommodations for patients to stay overnight.

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.

Authorized Representative – An individual who has been authorized to act on behalf of a Claimant with respect to a Benefit claim or an Appeal of an Adverse Benefit Determination in accordance with the procedures set forth in the **Claims and Appeals Procedures** section. An assignment for purposes of payment (e.g., to a Health Care Provider) does not constitute appointment of an Authorized Representative under the **Claims and Appeals Procedures** section. Health Care Providers are not, and shall not be construed as, either "Covered Persons" or "beneficiaries" under the Plan and have no right to receive benefits from the Plan or pursue legal causes of action on behalf of (or in place of) the Participant or other Covered Persons under any circumstance.

Balance Billing – The practice by some Non-Network Providers of billing a Covered Person for the difference between what the Plan pays and what the Non-Network Provider chooses to charge. See "**Your Rights and Protections Against Surprise Medical Bills**" in the Section entitled "**Important Notices**."

Bariatric Surgical Procedures – Surgical procedure performed on the stomach to induce weight loss.

Benefit Document – A document that describes one (1) or more benefits of the Plan.

Birthing Center – A special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility that:

- Is in compliance with licensing and other legal requirements in the jurisdiction where it is located;
- Is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;
- Has organized facilities for birth services on its premises;
- Provides birth services by or under the direction of a Physician specializing in obstetrics and gynecology;
- Has 24-hour-a-day registered nursing services;
- Maintains daily clinical records.

Calendar Year - The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1.

Claimant – Any Covered Person on whose behalf a claim is submitted for Plan benefits.

Clinical Trial – A Clinical Trial that is an "approved Clinical Trial" within the meaning of Section 2709(d) of the Affordable Care Act, that is, a phase I, phase II, phase III, or phase IV Clinical Trial in which a Qualified Individual participates and which is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, which is Federally Funded, conducted under an investigational new drug application reviewed by the Food and Drug Administration or if the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

For purposes of this definition, "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

For purposes of this section, a "Qualified Individual" is generally a Covered Person who is eligible to participate in an approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring Network Provider is a participating Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

Code – The Internal Revenue Code of 1986, as amended.

Coinsurance – The Covered Person's share of the costs of a covered health care service, calculated as a percent of the Allowable Charges for the service. For Non-Network Emergency Services or services from a Non-Network Provider at a Network Health Care Facility, Coinsurance is calculated as a percentage of the Recognized Amount. For Non-Network Providers of Air Ambulance Services, Coinsurance is calculated as a percentage of the lesser of the amount billed or the Qualifying Payment Amount.

Continuing Care Patient – A Covered Person who, with respect to a Provider or Health Care Facility, is (i) undergoing treatment for a Serious and Complex Condition from the Provider or Health Care Facility; (ii) undergoing a course of institutional or Inpatient Care; (iii) scheduled to undergo nonelective surgery from the Provider or Health Care Facility, including postoperative care; (iv) Pregnant and undergoing a course of treatment for the

Pregnancy from the Provider or Health Care Facility; or (v) is or was determined to be terminally ill and is receiving treatment from such Provider or Health Care Facility.

Contract Administrator – A company that performs all functions reasonably related to the administration of one or more benefits of the Plan (e.g., processing of claims for payment) in accordance with the terms and conditions of the Benefit Document and an administration agreement between the Contract Administrator and the Plan Sponsor.

Copay – A fixed amount which is required to be paid by or on behalf of a Covered Person for Plan benefits.

Cost Sharing – The amount a Covered Person is responsible for paying for a covered item or service. Cost Sharing generally includes Copays, Coinsurance and amounts paid towards deductibles, but does not include amounts paid towards premiums, Balance Billing by Non-Network Providers, or the cost of items or services that are not covered under the Plan.

Covered Person – An individual who meets the eligibility requirements as contained herein (e.g., a covered Employee, a covered Dependent, or a Qualified Beneficiary). See **Eligibility and Effective Dates, Extensions of Coverage** and the **COBRA Continuation Coverage** sections for further information.

NOTE: IN ENROLLING AN INDIVIDUAL AS A COVERED PERSON OR IN DETERMINING OR MAKING BENEFIT PAYMENTS TO OR ON BEHALF OF A COVERED PERSON, THE ELIGIBILITY OF THE INDIVIDUAL FOR STATE MEDICAID BENEFITS WILL NOT BE TAKEN INTO ACCOUNT.

Day Treatment Center – A licensed or certified facility which is licensed to provide Outpatient Mental Health and Outpatient Substance Use Disorder Care under the supervision of Physicians.

Dependent – see Eligibility and Effective Dates section.

Eligible Medical Expense(s) – Health care expenses as defined in this Benefit Document/ Summary Plan Description, for which benefits may be payable.

Emergency Department of a Hospital – The emergency department of a Hospital including a Hospital Outpatient department that provides Emergency Services.

Emergency Medical Condition – A medical condition, including a Mental Health Condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another Hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services – With respect to an Emergency Medical Condition, (i) an appropriate medical screening examination (as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the Emergency Department of a Hospital or of an Independent Freestanding Emergency

Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition, and (ii) within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department as may be necessary To Stabilize the individual (regardless of the department of the Hospital in which such further examination or treatment is furnished).

Subject to the conditions of the next succeeding paragraph, Emergency Services include items or services (i) for which benefits are provided or covered under the Plan and (ii) are furnished by a Non-Network Provider (regardless of the department of the Hospital in which such items or services are furnished) after the Covered Person is Stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the Emergency Services visit.

Items and services furnished after an individual is Stabilized are not Emergency Services if (i) the attending emergency Physician or Treating Provider determines that the Covered Person is able to travel using nonmedical transportation or nonemergency medical transportation to an available Network Provider within a reasonable travel distance, taking into account the individual's medical condition; (ii) all notice and consent criteria are satisfied; and (iii) all other requirements under State law are satisfied.

Employee – A person regularly employed by the Employer as a common law Employee on its payroll (W-2), being compensated for specific duties performed and who performs services for an Employer and whom the Employer controls the individual's performance, time and the manner and means by which the work is performed, regardless of that individual's official title within the Employer's organization.

The term "Employee" shall not include any individual for the period of time such individual was classified by the Employer as an independent contractor, leased Employee (whether or not a "Leased Employee" under the Code) or any other classification other than Employee. In the event an individual who is excluded from Employee status under the preceding sentence is reclassified as an Employee of the Employer pursuant to a final determination by the Internal Revenue Service, another governmental entity with authority to make such a reclassification, or a court of competent jurisdiction, such individual shall not retroactively be an Employee under the Plan. Such reclassified Employee may become a Covered Person in the Plan at such later time as the individual satisfies the conditions of participation set forth in the Plan.

Employer(s) – The Employer or Employers participating in the Plan as reflected in the Plan document.

Essential Health Benefits – Items and services covered within the following categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; Mental Health Conditions and Substance Use Disorder services, including behavioral health treatments; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services, chronic disease management; and pediatric services, including oral and vision care. Not all items and services covered under

the Plan are Essential Health Benefits and not all Essential Health Benefits are covered under the Plan.

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.

Final External Review Decision – A determination by an Independent Review Organization at the conclusion of an External Review.

Final Internal Adverse Benefit Determination – An Adverse Benefit Determination that has been upheld by the Plan at the completion of two Internal Appeals (or an Adverse Benefit

Determination with respect to which the Internal Appeals process has been exhausted under the deemed exhausted rules of 29 C.F.R. §2590.715-2715(b)(2)(ii)(F).

Health Care Facility – In the context of Non-Emergency Services, is each of (i) a Hospital; (ii) a Hospital Outpatient department; (iii) a critical access Hospital; and (iv) an Ambulatory Surgical Center.

Health Insurance Marketplace ("Exchange") – The Health Insurance Marketplace ("Exchange"), created by the Affordable Care Act, for purchasing coverage under common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them.

Home Health Care Agency – An agency or organization that:

- Is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide Skilled Nursing services and other therapeutic services;
- Has policies established by a professional group associated with the agency or organization that includes at least one Registered Nurse to govern the services provided;
- Provides for full-time supervision of its services by a Physician or by a Registered Nurse;
- Maintains a complete medical record on each Covered Person under its care;
- Has a full-time administrator.

In rural areas where there are no agencies that meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice or Hospice Agency – An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one Registered Nurse and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable State licensing requirements.

Hospital – An institution licensed by the State in which it is situated and operated in accordance with that State's laws. The Hospital must provide Inpatient care and treatment through medical, diagnostic, and major surgical facilities on its premises. Inpatient care and treatment must be provided under the supervision of a staff of Physicians with 24-hour-a-day nursing services.

Hours of Service – Each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer; and each hour for which an Employee is paid, or entitled to payment by the Employer for a period of time during which no duties are performed due to vacation, holiday, Illness, incapacity (including disability), layoff, jury duty, military leave or leave of absence.

Bona Fide Volunteers and Students. Hours of Service do not include any hour for services performed as a bona fide volunteer or any hour for services to the extent those services are performed as part of a Federal Work-Study Program as defined under 34 CFR 675 or a substantially similar program of a State or political subdivision thereof. Hours of Service do

not include the services of a student intern or extern to the extent the student does not receive, and is not entitled to, payment in connection with those hours.

Non-Hourly Employees. Hours of Service may be calculated using a "days-worked" equivalency or "weeks-worked" equivalency that substantially reflect the Hours of Service performed and does not understate such Hours of Service in a manner that would cause the Employee to lose coverage under the Plan.

Hourly Employees. Hours of Service are calculated from payroll records reflecting actual Hours of Service worked and Hours of Service for which payment is made or due.

On-Call Employees. Hours of Service include on-call hours for which payment is made or due by the Employer, for which the Employee is required to remain on-call on the Employer's premise, or for which the Employee's activities while remaining on-call are subject to substantial restrictions that prevent the Employee from using the time effectively for the Employee's own purposes.

ID Card – Prime Healthcare will provide ID cards to Covered Persons for purposes of identifying the Covered Person to Network Providers.

Illness – Sickness or disease (including covered Mental Health Conditions and covered Substance Use Disorders), congenital abnormalities, birth defects and premature birth. A condition must be diagnosed by a Physician or other appropriate Provider in order to be considered an Illness hereunder. Illness does not include any Work-related Injury including self-employment or occupation for compensation or profit (see **General Exclusions** section).

Independent Freestanding Emergency Department – A Health Care Facility (not limited to those described in the definition of Health Care Facility with respect to Non-Emergency Services) that (i) is geographically separate and distinct and licensed separately from a Hospital under applicable State law; and (ii)provides any Emergency Services. If under State licensure laws, an Urgent Care Facility is permitted to provide Emergency Services, then an Urgent Care Facility in that State that is geographically separate and distinct from a Hospital would fall within the definition of Independent Freestanding Emergency Department.

Independent Review Organization (IRO) – An entity that conducts independent external reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations and renders a Final External Review Decision pursuant to the section entitled **Claims and Appeals Procedures.**

Injury – Any Injury including accidental bodily Injury that is caused by external forces under unexpected circumstances and which is not a consequence of any Work-related Injury including self-employment or occupation for compensation or profit (see **General Exclusions** section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Injuries for purposes of benefit determination.

Inpatient – Occupation of a room and being charged for room and board in a facility (e.g., Hospital, Skilled Nursing Facility or Residential Treatment Center) that is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit – A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, that provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and that is separated from the rest of the Hospital's facilities.

Medical Child Support Order (MCSO) – A judgment, decree, or order, including a National Child Support Order, that is made pursuant to State domestic relations law or certain other State laws relating to medical child support and provides for child support or health benefits coverage for a child of a Covered Person under a group health plan and relates to benefits under the plan.

Medically Necessary (Medical Necessity) – Any health care treatment, service or supply determined by the Plan Administrator to meet each of the following requirements:

- It is ordered by a Physician exercising prudent clinical judgment for the purposes of evaluation, diagnosis or treatment of an Illness or Injury or a covered Mental Health Condition or a covered Substance Use Disorder (a "Condition");
- Such services must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of that Condition;
- The setting and level of service is that setting and level of service which, considering the Covered Person's medical symptoms and conditions, cannot be provided in a less intensive medical setting;
- Such services must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Person's Condition without adversely affecting that Condition;
- The prevailing opinion within the appropriate specialty of the United States Medical Profession is that it is safe and effective for its intended use and that omission would adversely affect the person's condition;
- It is furnished by a Provider with appropriate training and experience, acting within the scope of their license; and
    a) It must not be maintenance therapy or maintenance treatment;
    b) Its purpose must be to restore health;
    c) It must not be primarily custodial in nature;
    d) It must not be a listed item or treatment not allowed for reimbursement by Medicare;
    e) The Plan Administrator reserves the right to incorporate Medicare guidelines in effect on the date of treatment as additional criteria for determination of Medically Necessary.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment that can be provided ONLY on an Inpatient basis. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under the Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

Medically Necessary treatment, services or supplies for routine patient Eligible Expenses provided to Qualified Individuals participating in Clinical Trials.

The Plan Administrator will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listings in the following compendia: The American Hospital Formulary Service Drug Information and The United States Pharmacopoeia Dispensing Information, and (4) other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

Medicare – Health Insurance for the Aged and Disabled as established by Title I of Public Law 8998 including Parts A, B and D and Title XVIII of the Social Security Act, and as amended from time to time.

Mental Health Condition – A syndrome characterized by clinically significant disturbance in an individual's, cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning as described in DSM V.

Network Provider – Providers of health care designated by Prime Healthcare as "Prime Healthcare Network Providers," "BCBS BlueCard Network Providers" and "Blue Shield of CA Providers."

Non-Emergency Visit – With respect to items and services furnished to an individual at a Health Care Facility in the context of Non-Emergency Services, in addition to items and services furnished by a Provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the Provider furnishing such items or services is at the facility.

Non-Emergency Services – Items and services which are not Emergency Services.

Non-Network Provider – A facility, Physician or other Provider who does not have a direct or indirect Network Provider agreement with Prime Healthcare or is not a member of the BCBS BlueCard/BlueShield of CA Network.

Out-of-Network Rate –The total amount paid to a Provider by the Plan equal to (i) an agreed amount; (ii) an amount determined by independent dispute resolution; or (iii) the amount the State approves under an All-Payer Model Agreement plus Cost Sharing.

Out-of-Pocket Maximum – Out-of-Pocket-Maximum as described below and as it applies to the relevant addendum:

- Prime Healthcare Network Eligible Medical Expenses – The most a Covered Person pays for Eligible Medical Expenses during a Plan Year before the Plan begins to pay 100% of the medical Allowable Charges.
- Prime Healthcare Network Prescription (Rx) Drug Expenses – The most a Covered Person pays for covered Prescription (Rx) Drug Expenses during a Plan Year before the Plan begins to pay 100% of the covered Prescription Drug Expense.
- Non-Prime Healthcare Network (BCBS BlueCard/Blue Shield of CA PPO) & Rx – The most a Covered Person pays for Eligible Medical Expenses and covered

Prescription (Rx) Drug Expenses (Medical and Rx combined) during a Plan Year before the Plan begins to pay 100% of the Allowable Charges and covered Prescription Drug Expense.

NOTE: THESE AMOUNTS INCLUDE COINSURANCE, AND COPAYS FOR SERVICES PROVIDED BY PRIME HEALTHCARE AND BCBS BLUECARD/BLUE SHIELD OF CA NETWORK PROVIDERS AND PRESCRIPTIONS, BUT DO NOT INCLUDE EMPLOYEE CONTRIBUTIONS (PREMIUMS), PAYMENTS FOR SERVICES NOT COVERED BY THE PLAN, BALANCE BILLING AMOUNTS (WHEN A PROVIDER BILLS FOR THE DIFFERENCE BETWEEN THE PROVIDER'S CHARGE AND THE ALLOWABLE CHARGES), PAYMENTS MADE TO NON-NETWORK PROVIDERS (OTHER THAN FOR EMERGENCY SERVICES OR AUTHORIZED SERVICES FROM A NON-NETWORK PROVIDER AT A NETWORK FACILITY AS REQUIRED UNDER THE NO SURPRISES ACT (NO CHOICE PROVIDER) OR PENALTIES FOR NON-COMPLIANCE OF PRE-SERVICE REVIEW REQUIREMENTS.

Outpatient – Services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

Participant – An Employee who is a Covered Person.

Participating Employer – An Employer who is participating in the Plan coverages described herein. See **General Plan Information** section for the identity of the Participating Employer(s).

Partner – A relationship established between two people under applicable State law. See the Benefit Guide, hereby incorporated by reference, for eligibility.

Physician – A Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who is licensed to practice medicine or osteopathy where the care is provided.

NOTE: THE TERM "PHYSICIAN" WILL NOT INCLUDE COVERED PERSONS THEMSELVES, THEIR RELATIVES (SEE **GENERAL EXCLUSIONS**) OR INTERNS, RESIDENTS, FELLOWS OR OTHERS ENROLLED IN A GRADUATE MEDICAL EDUCATION PROGRAM.

Plan – The Prime Healthcare Welfare Benefits Plan and Prime Healthcare Foundation Welfare Benefits Plan.

Plan Administrator – The Committee or its delegate.

Plan Sponsor – Prime Healthcare Services, Inc and Prime Healthcare Foundation, Inc.

Plan Year – The calendar year.

Pregnancy – The state of an individual after conception and until termination of the gestation. See "Pregnancy Care" in the list of **Eligible Medical Expenses** for further information.

Preventive Care Services – Services that are required to be provided without Cost Sharing under the Affordable Care Act as described in **Appendix A.**

Primary Care Provider – A Physician in family practice, internal medicine, obstetrics/ gynecology, or pediatrics who is a Covered Person's first contact for health care in a medical office setting and who coordinates referrals to specialists as needed. Covered Persons do not need prior authorization for the Annual Well Woman exam from Prime Healthcare Utilization Management Department or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a Prime Healthcare Network

Provider or a BCBS BlueCard/Blue Shield of CA Network Provider who specializes in obstetrics or gynecology.

Provider – An individual or entity who is:

- Licensed in the State to perform certain health care services that are covered hereunder and who is acting within the scope of their license; or
- In the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

  and who is a/an:

  - Audiologist
  - Certified or Registered Nurse Midwife
  - Certified Registered Nurse Anesthetist
  - (CRNA)
  - Chiropractor (DC)
  - Dentist (DDS or DMD)
  - Dietician
  - Enterostomal Therapist
  - Licensed Clinical Psychologist (PhD or EdD)
  - Licensed Clinical Social Worker (LCSW)
  - Licensed Professional Counselor (LPC)
  - Licensed Vocational Nurse (LVN)
  - Marriage Family and Child Counselor (MFCC)
  - Mental Health Professional
  - Nurse Practitioner
  - Occupational Therapist (OTR)
  - Optometrist (OD)
  - Physical Therapist (PT or RPT)
  - Physician – see definition of "Physician"
  - Physician Assistant (PA)
  - Podiatrist or Chiropodist (DPM,
  - DSP, or DSC)
  - Psychiatrist (MD)
  - Registered Nurse (RN)
  - Respiratory Therapist
  - Speech Pathologist

A Provider will also include the following when appropriately-licensed and providing services that are covered hereunder:

- Any practitioner of the healing arts who is licensed and regulated by a State or federal agency, is providing services or supplies that are covered hereunder, and is acting within the scope of their license;
- Facilities as are defined herein including, but not limited to, Hospitals, Residential Treatment Facilities, Ambulatory Surgical Centers, Birthing Centers, clinics;
- Licensed Outpatient Mental Health Condition facilities;
- Freestanding public health facilities;
- Hemodialysis and Outpatient clinics under the direction of a Physician (MD);
- Enuresis Control Centers;
- Home infusion therapy Providers;
- Durable Medical Equipment Providers;
- Prosthetists and Prosthetist-Orthotists;
- Portable X-ray companies;
- Independent laboratories and lab technicians;
- Diagnostic imaging facilities;
- Blood banks;
- Speech and hearing centers;
- Ambulance companies/ Air Ambulance Service

NOTE: A NETWORK PROVIDER DOES NOT INCLUDE: (1) A COVERED PERSON TREATING THEMSELVES OR ANY RELATIVE OR PERSON WHO RESIDES IN THE COVERED PERSON'S HOUSEHOLD – SEE "RELATIVE OR RESIDENT CARE" IN THE LIST OF **GENERAL EXCLUSIONS**, OR (2) ANY PHYSICIAN, NURSE OR OTHER PROVIDER WHO IS AN EMPLOYEE OF A HOSPITAL OR OTHER NETWORK PROVIDER FACILITY AND WHO IS PAID BY THE FACILITY FOR THEIR SERVICES.

Provider of Air Ambulance Services – An entity that is licensed under applicable State and Federal law to provide Air Ambulance Services.

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.

Qualifying Payment Amount (QPA) – The median contracted rates for a specific service in the same geographic region within the same insurance market as of January 31, 2019, as adjusted per the Consumer Price Index for All Urban Consumers (CPI-U).

Qualifying Payment Amount For Air Ambulance Services – The amount calculated using the methodology described in 29 CFR § 2590.716-6(c).

Recognized Amount – With respect to an item or service furnished by a Non-Network Provider or Non-Network Emergency Department of a Hospital or Independent Freestanding Emergency Department, (i) an amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; (ii) if there is no All-Payer Model Agreement, an amount determined by a specified State law; or (iii) if (i) and (ii) are not applicable, the lesser of the amount billed by the Provider or Health Care Facility or the Qualifying Payment Amount.

Rehabilitation Center – See "Skilled Nursing Facility."

Rescission or Rescind – The retroactive cancellation of coverage under the Plan following 30 days' notice.

Residential Treatment Facility – A State-licensed facility and community-based facility that is not a Hospital, but that provides residential care for persons with serious and persistent Mental Health Conditions or Substance Use Disorders. The facility must be operated 24 hours per day to provide psychiatric and/or substance use disorder and dependency treatment to its resident patients.

Semi-Private Room – Inpatient Hospital or Facility room shared by two or more patients.

Serious and Complex Condition – With respect to a Continuing Care Patient, an acute Illness or condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or a chronic Illness or condition that is life-threatening, degenerative, potentially disabling or congenital, and requires specialized medical care over a prolonged period of time.

Skilled Nursing Facility – An institution that is licensed to provide, and does provide, the following on an Inpatient basis for persons who are convalescing from Illness or Injury:

- Professional nursing care by a Registered Nurse or by a Licensed Vocational Nurse directed by a full-time Registered Nurse; and
- Provides physical restoration services to help a patient meet a goal of self-care in daily living activities;
- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time Registered Nurse;
- Is supervised full-time by a Physician or Registered Nurse;
- Keeps a complete medical record on each patient;
- Has a utilization review plan;
- Is not mainly a place for rest, for the aged, for Substance Use Disorders or for Mental Health Conditions, custodial or educational care; and
- Makes charges for the services and supplies it provides.

Stabilize or To Stabilize – With respect to an Emergency Medical Condition, to assure, within reasonable medical probability, as determined by the attending emergency physician or Treating Provider that no material deterioration of the condition is likely to result from or occur during the Transfer of the individual from a facility, or, with respect to an Emergency Medical Condition for a pregnant person, that the woman has delivered (including the placenta).

State – Each of the 50 States of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Substance Use Disorder – Recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school or house based on DSM V criteria.

Transfer – With respect to an Emergency Medical Condition and Stabilize, the movement (including the discharge) of an individual outside a Hospital's or Independent Freestanding Emergency Department's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the Hospital or Independent Freestanding Emergency Department, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.

Treating Provider – A Physician or other Provider who has evaluated the individual.

Urgent Care Facility – A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

- A board-certified Physician, a Registered Nurse and a Registered X-ray Technician in attendance at all times;
- X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or that is part of a regular Hospital.

Utilization Management Organization (UMO) – For services provided at a Prime Healthcare Network facility or at a BCBS BlueCard/BlueShield of CA facility, the UMO is the Prime Healthcare Utilization Management Department.

HIPAA STANDARDS FOR PRIVACY

The provisions of this Article 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:

  (i) 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

  (ii) 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:

  (i) Not use or further disclose the information other than as permitted or required by the contract or as required by law;

  (ii) 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;

(iii) 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;

(iv) 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);

(v) Make available Protected Health Information in accordance with 45 C.F.R. §164.524;

(vi) Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. §164.526;

(vii) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;

(viii) 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;

(ix) 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

(x) 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 B**.

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 in subparagraph (d).

(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.

GENERAL PLAN INFORMATION

FOR THOSE PARTICIPATING FACILITIES SET FORTH IN THE PRIME HEALTHCARE LIST IN THE ADDENDUM	
Name of Plan:	**Prime Healthcare Services, Inc. Welfare Benefits Plan**
Plan Sponsor Address: Business Phone Number:	**Prime Healthcare Services, Inc.** 3480 East Guasti Road Ontario, CA 91761 (909) 235-4400
Plan Sponsor ID Number (EIN):	**33-0943449**
Plan Number:	**501**
FOR THOSE PARTICIPATING FACILITIES SET FORTH IN THE FOUNDATION LIST IN THE ADDENDUM	
Name of Plan:	**Prime Healthcare Foundation Welfare Benefits Plan**
Plan Sponsor Address: Business Phone Number:	**Prime Healthcare Foundation** 3480 East Guasti Road Ontario, CA 91761 (909) 235-4400
Plan Sponsor ID Number (EIN):	**20-8065139**
Plan Number:	**507**
FOR BOTH PLANS	
Plan Year:	**January 1 through December 31**
Named Fiduciary: Address: (See also definition of "Fiduciary")	**Committee** 3480 East Guasti Road Ontario, CA 91761
Agent for Service of Legal Process: Address:	**General Counsel** **Prime Healthcare Services, Inc.** 3480 East Guasti Road Ontario, CA 91761
(Legal process may be served upon the Plan Administrator or a Fiduciary)	
Type of Plan:	**An Employee welfare benefit plan providing group benefits**
Applicable Collective Bargaining Agreement(s):	**(See "Collective Bargaining Agreement(s)" in the Administrative Provisions, below)**
Plan Benefits Described in this Benefit Document:	**Self-Funded Medical and Prescription Drug Benefits**
Type of Administration for Benefits Described herein:	**Contract Administration** – see "Administrative Provisions" for additional information

COBRA Administrator:	**HR Simplified**
Mailing Address:	5320 West 23rd Street, Ste. 350 Minneapolis, MN 55416
Phone:	(888) 318-7472
Contract Administrator:	**Keenan & Associates**
Mailing Address:	2355 Crenshaw Blvd. Torrance, CA 90501
Phone:	(800) 653-3626 or (800) 6 Keenan
EHB Benchmark Plan:	**Utah Basic Plus**

FUNDING – SOURCES AND USES

Plan benefits described herein are paid from the general assets of the Plan Sponsor. Any amounts to be paid by active Employees are handled through a code section 125 pre-tax premium plan.

See the **COBRA Continuation Coverage** section for more information.

ADMINISTRATIVE PROVISIONS

Administration
The Plan benefits described herein are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator.

Alternative Care
In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any Provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Administrator's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Administrator elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Administrator's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Document.

Amendment or Termination of the Plan
Since future conditions affecting the Plan Sponsor or Participating Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any Covered Person or beneficiary:

- Reduce, modify or terminate health care benefits hereunder, if any;
- Alter or postpone the method of payment of any benefit;
- Amend any provision of these administrative provisions;

- Make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and
- Terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those Plan benefits to which he has become entitled.

NOTE: ANY MODIFICATION, AMENDMENT OR TERMINATION ACTION WILL BE MADE BY WRITTEN AMENDMENT THAT IS SIGNED BY AN AUTHORIZED REPRESENTATIVE OF THE PLAN SPONSOR. EMPLOYEES WILL BE PROVIDED WITH NOTICE OF THE CHANGE WITHIN THE TIME ALLOWED BY FEDERAL LAW.

Anticipation, Alienation, Sale or Transfer
Except for assignments to Providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error
Clerical error by the Plan Administrator will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Collective Bargaining Agreement(s)
The Plan is subject to the terms of collective bargaining agreement(s). A complete list of the bargaining units participating in the Plan may be obtained upon written request to the Plan Sponsor and is available for examination by Covered Persons and beneficiaries at the office of the Plan Sponsor. Covered Persons and beneficiaries may receive from the Plan Sponsor, upon written request, information as to whether a particular Employee organization is participating in the Plan and, if the organization is participating, the address of such entity.

Discrepancies
In the event that there may be a discrepancy between this Benefit Document and any other document or communication, this Benefit Document will control.

Discretionary Authority
The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Persons rights; and to determine all questions of fact and law arising under the Plan. The Plan Administrator shall have the sole discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides, in its sole

discretion, that the applicant is entitled to them. The Plan Administrator may delegate any of its duties under the Plan.

Governing Law

The Plan will be construed in accordance with the laws of the State of California (determined without regard to any conflicts of law provisions), to the extent not preempted by federal law. Any legal action (whether in law, in equity or otherwise) must be brought in the U.S. District court of the Central District of California , where the Plan is administered.

Facility of Payment
Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which they can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the spouse, Partner or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, Partner, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Administrator in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Plan Administrator. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefor under the Plan.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

Illegality of Particular Provision
The illegality of any particular provision of the Benefit Document will not affect the other provisions and the Benefit Document will be construed in all respects as if such invalid provision were omitted.

Legal Actions
Claimants will not be entitled to challenge the Plan Administrator's, or its delegates, determinations in judicial or administrative proceedings without first complying with the

administrative claims procedures set forth in this Summary Plan Description or under the Plan, as appropriate. All such claims must be brought within the timeframes set forth this Summary Plan Description or the Plan, as applicable, for the claimant's type of claim. The decisions made pursuant to applicable administrative claims procedures are final and binding on the claimant and any other party. A claimant may, however, seek an external review if his or her claim meets the conditions set forth in this Summary Plan Description. If the claimant has complied with and exhausted the appropriate claims procedures and intends to pursue the claim further, the claimant must bring civil action under section 502(a) of ERISA, or if applicable, request arbitration or take other appropriate action within the later of (a) 90 days immediately following a final external adverse benefit determination; and (b) 125 days immediately following a deemed exhaustion of administrative remedies or a final determination in which to file suit in court. If the claimant does not bring such action within such period, the claimant will be barred from bringing an action under ERISA related to his claim.

Loss of Benefits

To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a covered Employee or other Covered Person might otherwise reasonably expect the Plan to provide based on the description of benefits:

- An Employee's cessation of Active Service for the Employer;
- A Covered Person's failure to pay their share of the cost of coverage, if any, in a timely manner;
- A Dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);
- A Covered Person is injured and expenses for treatment may be paid by or recovered from a third party;
- A claim for benefits is not filed within the time limits of the Plan; or
- A Covered Person's fraud or intentional misrepresentation of material fact related to the Plan.

Misuse of Identification Card

See "Termination for Fraud."

Non-Discrimination Due to Health Status

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- A medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- Claims experience
- Receipt of health care
- Medical history
- Evidence of insurability
- Disability
- Genetic information

Payment of Fees
Expenses required or permitted by law and otherwise to be paid by the Plan, are payable by the Plan from Plan assets.

Physical Examination
The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Purpose of the Plan
The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Reimbursements
Plan's Right to Reimburse Another Party – Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error – When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid including the Employee, or any other persons, insurance companies or other payees. The Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan of the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

A Covered Person, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or

Illnesses) under any other group benefits plan of the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability – The Plan Administrator may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefor from the Covered Person or the Provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Administrator or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to Employees or any of their Dependents.

Rescission of Coverage
The Plan may not Rescind an individual's coverage under the Plan (e.g., cancelling coverage after a Covered Person has submitted a claim). However, to the extent permitted by law, the Plan may Rescind coverage if a Covered Person commits fraud or makes an intentional misrepresentation of a material fact.

Rights Against the Plan Sponsor or Employer
Except for those rights expressly granted under ERISA §502, neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Termination for Cause
An individual's Plan coverage or eligibility may be terminated if the Plan Administrator determines that it should be terminated for Cause. Examples of "Cause" include but are not limited to, the submission of false claims or covering ineligible Dependents (e.g. a divorced spouse or overage Dependent children).

Termination for Fraud
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form, and found to be (i) fraudulent or (ii) an intentional misrepresentation of a material fact by the Plan Administrator, and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a fraud committed or intentional misrepresentation of such status or of a material fact with regard to an individual in an enrollment form or claims filing,

their eligibility, benefits or both, will be Rescinded, retroactively to the date thereof, to reflect their true status.

A fraudulent or intentional misrepresentation of marital status, Dependent status, age or other material fact will Rescind coverage, retroactively from the date thereof, not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

In the case of any fraud, or intentional misrepresentation of material fact, the Plan Administrator will provide at least 30 days advance written notice to each Covered Person who would be affected before coverage may be Rescinded.

Titles or Headings
Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Workers' Compensation
The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

No employment rights
The Plan does not provide confer employment rights upon any person. No person shall be entitled by virtue of the Plan to become or to remain in the employ of the Employer and nothing in the Plan shall restrict the right of the Employer to terminate the employment of any eligible employee or other person at any time.

Conflict with Plan document
In the event that there is a conflict between this SPD and the underlying Plan document, the Plan document will control.

STATEMENT OF RIGHTS

Covered Employees are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that a Covered Person shall be entitled to:

RECEIVE INFORMATION ABOUT THIS PLAN AND BENEFITS

This includes the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of a Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically; and
- Receive a summary of a Plan's annual financial report. The Plan Administrator is required by law to furnish each covered Employee with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

This includes:

The right to continue health care coverage for themselves, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The Employee or their Dependents may have to pay for such coverage. See the **COBRA Continuation Coverage** section for additional details about these rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for covered Employees, ERISA imposes duties upon the people who are responsible for the operation of a Plan (the Fiduciaries). Fiduciaries have a duty to operate a Plan prudently and in the interest of Covered Persons and beneficiaries. No one, including the Employer, may fire covered Employees or discriminate against them to prevent them from obtaining a welfare benefit or exercising rights under ERISA.

ENFORCEMENT OF RIGHTS

If an individual's claim for benefit is denied, in whole or in part, they must receive a written explanation of the reason for the denial. They has the right to obtain copies of documents relating to the decision without charge and have the Plan Administrator review and reconsider the claim, all within certain timeframes.

Under ERISA there are steps a covered Employee can take to enforce the above rights. For instance, if they request materials from a Plan and does not receive them within 30 days, they may file suit in a Federal Court. In such a case, the court may require the Plan Administrator

to provide the materials and pay them up to $110 a day until they receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If they have a claim for benefits which is denied or ignored, in whole or in part, they may resolve the claim through binding and confidential arbitration. In addition, if they disagree with the Plan decision or lack thereof, concerning the qualified status of a Medical Child Support Order (QMCSO), they may file suit in Federal court.

If it should happen that Plan Fiduciaries misuse the Plan's money, or if they are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or they may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If they are successful, the court may order the person they have sued to pay these costs and fees. If they lose, the court may order them to pay these costs and fees, for example, if it finds their claim is frivolous.

ASSISTANCE WITH QUESTIONS

If a Covered Person has any questions about the Plan, they should contact the Plan Administrator. If they have any questions about this statement or about their rights under ERISA, they should contact: (1) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in their telephone directory, or by calling EBSA at (866) 444-3272 or (2) the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. A Covered Person may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law, but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

Definitions – When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary – An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

EXCEPTION: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

NOTE: A PARTNER MAY NOT BE A QUALIFIED BENEFICIARY AND DOES NOT HAVE INDEPENDENT COBRA ELECTION RIGHTS.

Qualifying Event – Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

- Voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;
- Reduction in an Employee's Hours of Service to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on
- FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay their portion of the cost of Plan coverage during the FMLA leave;

- For an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that their Medicare coverage is in effect;
- For an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;
- For an Employee's spouse or child, the death of the covered Employee;
- For an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit).

Non-COBRA Beneficiary – An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

NOTICE OF RESPONSIBILITIES

If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in Hours of Service, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from their spouse. A Qualified Beneficiary is also responsible for other notifications. See the section entitled COBRA Notice Requirements for Covered Persons (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the

Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the latter of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. Failure to make a COBRA election within the 60-day period will result in the inability to elect COBRA continuation coverage.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable State law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights that allow Non-COBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of HIPAA extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a Provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the "Effect of the Trade Act" provision for information regarding a second 60-day election period allowance.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying

Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes their waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

LEVEL OF BENEFITS

COBRA continuation coverage will be equivalent to coverage provided to similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated Non-COBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to their deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

COST OF CONTINUATION OF COVERAGE

The cost of COBRA continuation coverage is fixed in advance for a 12-month determination period and will not exceed 102% of the Plan's full cost of coverage during the period for similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost that is paid by the Employer for Non-COBRA Beneficiaries. Qualified Beneficiaries will be charged 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. If payment is not made within such time period, the COBRA election is null and void. The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase during the Plan's 12-month determination period if:

- The cost previously charged was less than the maximum permitted by law;
- The increase occurs due to a Disability Extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage;

  -OR-

- The Qualified Beneficiary changes their coverage option(s) which results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than $50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTE: FOR QUALIFIED BENEFICIARIES WHO RESIDE IN A STATE WITH A HEALTH INSURANCE PREMIUM PAYMENT PROGRAM, THE STATE MAY PAY THE COST OF COBRA COVERAGE FOR A QUALIFIED BENEFICIARY WHO IS ELIGIBLE FOR HEALTH CARE BENEFITS FROM THE STATE THROUGH A PROGRAM FOR THE MEDICALLY-INDIGENT OR DUE TO A CERTAIN DISABILITY. THE EMPLOYER'S PERSONNEL OFFICES SHOULD BE CONTACTED FOR ADDITIONAL INFORMATION.

There may be other coverage options for the Qualified Beneficiaries. They will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, they could be eligible for a tax credit that lowers monthly premiums right away, and individuals can see what the premium, deductibles, and out-of-pocket costs will be before making a decision to enroll. Being eligible for COBRA does not limit a Qualified Beneficiary's eligibility for coverage for a tax credit through the Marketplace. Additionally, Qualified Beneficiaries may qualify for a special enrollment opportunity for another group health plan for which they are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if enrollment is requested within 30 days.

See the "Effect of the Trade Act" provision for additional cost of coverage information.

OTHER COVERAGE OPTIONS BESIDES COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options available through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. To learn more about many of these options please visit www.healthcare.gov.

MAXIMUM COVERAGE PERIODS

The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

- If the Qualifying Event is a termination of employment or reduction of Hours of Service of employment, the maximum coverage period is 18 months after the loss of coverage due to the Qualifying Event. With a Disability Extension (see "Disability Extension" information below), the 18 months is extended to 29 months;
- If the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;

- For any other Qualifying Event, the maximum coverage period ends 36 months after the loss of coverage due to the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of Hours of Service of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) – USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

DISABILITY EXTENSION

An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to be disabled in the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable period. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in their family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

TERMINATION OF CONTINUATION OF COVERAGE

Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the loss of coverage due to the Qualifying Event and ending on the earliest of the following dates:

- The last day of the applicable maximum coverage period – see "Maximum Coverage Periods" above;
- The date on which the Employer ceases to provide any group health plan to any Employee;
- The date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security

Administration and the individual has been notified that their Medicare coverage is in effect;

- In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  a) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension; or
  c) the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a Provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated Non-COBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

EFFECT OF THE TRADE ACT

In response to Public Law 107-210, referred to as the Trade Act of 2002 and the Trade Preferences Extension Act of 2015 (collectively, "TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended. These provisions will expire on December 31, 2019 unless extended by Congress.

Eligible Individuals – The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement or federal income tax filings. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

- Non-Electing TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.
- TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.
- TAA-Related Election Period – With respect to a TAA-Related Loss of Coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.
- TAA-Related Loss of Coverage – With respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Non-Electing TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period but only if such election is made not later than six (6) months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period.

Applicable Cost of Coverage Payments – Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in Treasury Regulation 54.4980B-8, the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise, the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

COBRA NOTICE REQUIREMENTS FOR COVERED PERSONS

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is:

- A Dependent child's ceasing to be eligible (e.g., due to reaching the maximum age limit);
- The divorce or legal separation of the Employee from their spouse;
- The occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to **COBRA Continuation Coverage** with a maximum duration of 18 (or 29) months;
- Where a Qualified Beneficiary entitled to receive **COBRA Continuation Coverage** with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled in the first 60 days of continuation coverage, or a Qualified Beneficiary has subsequently been determined by the Social Security Administration to no longer be disabled.

It is also important that the Plan Administrator be kept informed of the current addresses of all Covered Persons or beneficiaries who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. However, these procedures are current as of the date the document was prepared, and a Qualified Beneficiary should make certain that procedure changes have not occurred before relying on this information. The most current information should be included in the Employer's COBRA Initial General Notice that is provided to new hires.

Any individual who is the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any Authorized Representative acting on behalf of the Covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form, Content and Delivery – Notification of the Qualifying Event must be made to the Plan Administrator in care of the following office:

HR Simplified
5320 West 23rd Street, Ste. 350
Minneapolis, MN 55416
Phone: (888) 318-7472

Notification should include: (1) the name of the plan or plans under which coverage has been or will be lost, (2) the name and address of the Employee covered under the plan(s), (3) the name(s) and address(es) of the Qualified Beneficiary(ies), and the type of Qualifying Event and the date it happened.

TIME REQUIREMENTS FOR NOTIFICATION

In the case of a divorce, legal separation or a child losing Dependent status, Notice must be delivered within 60 days from the date of the Qualifying Event. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see "Effect of Trade Act" in the **COBRA Continuation Coverage** section."

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the date of the determination. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

IMPORTANT NOTICES

This is a self-funded employee benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

WHEN A PARTICIPANT RECEIVES EMERGENCY SERVICES CARE OR RECEIVES TREATED BY AN OUT-OF-NETWORK PROVIDER AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER, PARTICIPANTS ARE PROTECTED FROM SURPRISE BILLING OR BALANCE BILLING.

What is "Balance Billing" (sometimes called "surprise billing")?

When a Covered Person sees a doctor or other health care provider, they may owe certain out-of-pocket costs, such as a Copayment, Coinsurance and/or a Deductible Amount. They may have other costs or have to pay the entire bill if they see a Provider or visit a Health Care Facility that isn't in the Plan's Network.

"Non-Network" describes Providers and facilities that haven't signed a contract with the Plan. Non-Network Providers may be permitted to bill Covered Persons for the difference between what the Plan agreed to pay and the full amount charged for the service. This is called "**Balance Billing**." This amount is likely more than Network costs for the same service and might not count toward the annual Out-of-Pocket Maximum Amount.

"Surprise billing" is an unexpected Balance Bill. This can happen when a Covered Person can't control who is involved in their care – like when they have an emergency or when they schedule a visit at a Network Health Care Facility but are unexpectedly treated by a Non-Network Provider.

Covered Persons are protected from Balance Billing for:

Emergency Services

If a Covered Person has an Emergency Medical Condition and receives Emergency Services from a Non-Network Provider or facility, the most the Provider or facility may bill is the Covered Person's Network Cost Sharing amount (such as Copayments and Coinsurance). Covered Persons **can't** be Balance Billed for these Emergency Services. This includes services they may receive after they are in a stable condition, unless they give written consent and give up their protections not to be Balance Billed for these post-stabilization services.

Certain Services at A Health Care Facility

When Covered Persons receive services from a Network Health Care Facility such as a Hospital or Ambulatory Surgical Center, certain Providers there may be Non-Network. In these cases, the most those Providers may bill is the Plan's Network Cost Sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These Providers **can't** Balance Bill and may not ask Covered Persons to give up their protections not to be Balance Billed.

If Covered Persons receive other services at these Network facilities, Non-Network Providers **can't** Balance Bill unless given written consent that the Covered Person has given up their protections.

Covered Persons are never required to give up their protections from Balance Billing. They also aren't required to received Non-Network care. They can choose a Provider or facility in the Plan's Network.

When Balance Billing isn't allowed, Covered Persons also have the following protections:

- Covered Persons are responsible only for paying their share of the cost (like Copayments, Coinsurance and Deductible Amounts) that they would pay the Provider or facility as though the Provider or facility were in the Plan's Network. The Plan will pay Non-Network Providers and facilities directly.
- The Plan generally must:
  - Cover Emergency Services without requiring the Covered Person to obtain approval for services in advance (prior authorization).
  - Cover Emergency Services by Non-Network Providers.
  - Base what the Covered Person owes the Provider or facility (Cost Sharing) on what it would pay a Network Provider or facility and show that amount in the Covered Person's explanation of benefits.
  - Count any amount Covered Persons pay for Emergency Services or Non-Network services toward the Deductible Amount and Out-of-Pocket Maximum Amount.

If Covered Persons believe they have been wrongly billed, contact the HHS No Surprises Helpdesk at **(800) 985-3059, which is the** entity responsible for enforcing the federal and/or state balance or surprise billing protection laws.

Visit www.cms.gov/nosurprises/consumers for more information about rights under federal law.

MINIMUM ESSENTIAL COVERAGE (ACA)

This Plan offers to Employees, Children and, if not eligible for other group health coverage that provides minimum value (as defined in Code section 36B(c)(2)(C)(ii)), Spouses and Partners the opportunity to enroll in "minimum essential coverage" under an "eligible employer-sponsored plan" as those terms are defined in Code sections 5000A(f)(1) and 5000A(f)(2).

NONDISCRIMINATION

The Plan shall not discriminate against any Network Provider. This provision shall not require that the Plan contract with any Network Provider willing to abide by the terms and conditions for participation established by the Plan.

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A Covered Person can obtain additional information about coverage of a specific drug, treatment, procedure, Preventive Care Service, etc. from the office that handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

COBRA NOTICE PROCEDURES

In some circumstances, an Employee or a Qualified Beneficiary is the first to know that a COBRA Qualifying Event has occurred (e.g., in the case of a divorce or legal separation, or where a child reaches a maximum age limit and is no longer eligible). In such instances, it is the Employee's or the COBRA Qualified Beneficiary's responsibility to provide notice to the Plan that a COBRA Qualifying

Event has occurred.

The procedures for providing notice of a COBRA Qualifying Event are included in the Employer's COBRA notice communication piece that is provided to newly-hired Employees.

NOTE: It is important that the Plan Administrator be kept informed of the current addresses of all Covered Persons or beneficiaries who are or may become COBRA Qualified Beneficiaries.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, Federal law generally does not prohibit the mother's or newborn's attending Network Provider (see NOTE), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a Network Provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTE: AN "ATTENDING NETWORK PROVIDER" DOES NOT INCLUDE A PLAN, HOSPITAL, MANAGED CARE ORGANIZATION OR OTHER ISSUER.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending Physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Covered Persons must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the Women's Health and Cancer Rights Act (WHCRA).

GENETIC INFORMATION AND NON-DISCRIMINATION ACT

The Genetic Information and Non-discrimination Act (GINA) prohibits group health plans from collecting genetic information and discriminating in enrollment and cost of coverage based on an individual's genetic information – which includes family medical information.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Mental Health Parity and Addiction Equity Act was enacted to provide for parity in the application of Mental Health and Substance Use Disorder benefits with medical/surgical benefits. In general, a group health plan that provides medical/surgical benefits and benefits for Mental Health Conditions and Substance Use Disorders must offer benefits for Mental Health Conditions and Substance Use Disorders that are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits covered under a plan.

A Covered Person or Network Provider, upon request, has a right to receive the criteria for Medical Necessity relating to covered Mental Health Care and Substance Use Disorder Care by contacting the Prime Healthcare Utilization Management Department at (877) 234-5227.

HIPAA PRIVACY

As a Participant in the Plan, your "protected health information" is subject to safeguard under the privacy provisions of the Health Insurance Portability and Accountability Act ("HIPAA"). As a Participant, you will receive or have received a "privacy notice" that describes the important uses and disclosures of protected health information and your rights under HIPAA. If you need a copy of this notice, you should contact the Plan Administrator.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a qualifying State, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your Employer plan, your Employer must permit you to enroll in your Employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your Employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free (866) 444-EBSA (3272).

APPENDIX A

2022 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 http://www.uspreventiveservicestaskforce.org/uspstf/.

- 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 Copay.
- 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 Copay 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 Copay.

NEW

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.
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.

TOPIC	DESCRIPTION
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.
COVID-19 Over-the-Counter (OTC) Tests	COVID-19, at home OTC test kits, up to eight tests per Covered Person per month. Reimbursement is limited to up to $12.00 per at-home test kit. There is no limit on the number of tests, OTC COVID tests, that are covered if ordered or administered by a health care provider following an individualized clinical assessment.
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.
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.

TOPIC	DESCRIPTION
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.
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.

TOPIC	DESCRIPTION
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 childcare	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.
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.

2022-0125

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

UNITED STATES 2021

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®
	Hib (PRP-OMP)	PedvaxHIB®
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)	**LAIV4**	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®
	MenACWY-TT	MenQuadfi®
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®
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b, and hepatitis B vaccine	**DTaP-IPV-Hib-HepB**	Vaxelis®
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), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Assistants (www.aapa.org), and National Association of Pediatric Nurse Practitioners (www.napnap.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
- ACIP Shared Clinical Decision-Making Recommendations www.cdc.gov/vaccines/acip/acip-scdm-faqs.html

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, 2021

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 (LAIV4)											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, MenACWY-TT ≥2years)			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, 2021

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.**

Children age 4 months through 6 years					
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**
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 was 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 was 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 administered 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**	**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 2 years MenACWY-TT	**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, 2021

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/mm^3	≥15% and total CD4 cell count of ≥200/mm^3	Kidney failure, end-stage renal disease, or on hemodialysis	Heart disease or chronic lung disease	CSF leak or cochlear implant	Asplenia or persistent complement component deficiencies	Chronic liver disease	Diabetes
Hepatitis B										
Rotavirus		SCID[2]								
Diphtheria, tetanus, and acellular pertussis (DTaP)										
Haemophilus influenzae type b										
Pneumococcal conjugate										
Inactivated poliovirus										
Influenza (IIV)										
or										
Influenza (LAIV4)						Asthma, wheezing: 2–4yrs[3]				
Measles, mumps, rubella	*									
Varicella	*									
Hepatitis A										
Tetanus, diphtheria, and 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.

*Vaccinate after pregnancy.

Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction

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 LAIV4 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, 2021

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2021.

Additional information

COVID-19 Vaccination

ACIP recommends use of COVID-19 vaccines within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. Interim ACIP recommendations for the use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/hcp/acip-recs/.

- 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 vaccination 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 about 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 age 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.

Special situations

- Wound management in children less than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine: For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

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 age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) 8 weeks after dose 2.
- **2 doses of PedvaxHIB before age 12 months:** Administer dose 3 (final dose) at 12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 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 age 14 months) OR no doses (age 15 months or older)

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

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 age 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 age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix**®, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster 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 age 12–23 months.
  - **Unvaccinated age 12 months or 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 (whichever is earlier and even if weight is still <2,000 grams).
- **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 age 18 years or older may receive a 2-dose series of HepB **(Heplisav-B®)** at least 4 weeks apart.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster 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 9–14 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)
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted.
- No additional dose recommended after completing series with recommended dosing intervals using any HPV vaccine.

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 [LAIV4], 18 years [recombinant influenza vaccine, RIV4])

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, 2020, 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, 2020
  - 1 dose for **all persons age 9 years or older**
- For the 2021–22 season, see the 2021–22 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. If using an influenza vaccine other than Flublok or Flucelvax, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions.
- Severe allergic reactions to vaccines can occur even in the absence of a history of previous allergic reaction. All vaccination providers should be familiar with the office emergency plan and certified in cardiopulmonary resuscitation.
- A previous severe allergic reaction to influenza vaccine is a contraindication to future receipt of any influenza vaccine.
- **LAIV4 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
  - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
  - Pregnancy
  - Cochlear implant
  - Cerebrospinal fluid-oropharyngeal communication
  - Children less than age 2 years
  - Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours,. peramivir within the previous 5 days, or baloxavir within the previous 17 days

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

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 at age 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 or 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], 2 years [MenACWY-TT, MenQuadfi])

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 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 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.
- **MenQuadfi**
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

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 age 8 weeks: 4-dose series at 2, 4, 6, 12 months
    - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 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)
  - **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, Menactra, or MenQuadfi

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, Menactra,** or **MenQuadfi**

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.
- **Children for whom boosters are not recommended** (e.g., a healthy child 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 additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

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 additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

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
Underlying conditions below: When both PCV13 and PPSV23 are indicated, administer PCV13 first. PCV13 and PPSV23 should not be administered during 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 completing all recommended PCV13 doses)

Age 6–18 years
- • No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

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

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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 (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 on 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 on 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 age 18 years or 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_%20cid=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 age 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 the routine Tdap dose at age 11–12 years.
- **DTaP inadvertently administered on or after age 7 years:**
  - **Children age 7–9 years:** DTaP may count as part of catch-up series. Administer routine Tdap dose at age 11–12 years.
  - **Children age 10–18 years:** Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Table 2.

Special situations
- **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.
- For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.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 *MMWR* at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have a 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
2021

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)**

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	Gardasil 9®
Influenza vaccine (inactivated)	IIV	Many brands
Influenza vaccine (live, attenuated)	LAIV4	FluMist® Quadrivalent
Influenza vaccine (recombinant)	RIV4	Flublok® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R II®
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM MenACWY-TT	Menactra® Menveo® MenQuadfi®
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

*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.

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), American College of Nurse-Midwives (www.midwife.org), and American Academy of Physician Assistants (www.aapa.org).

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) 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, 2021: www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
- ACIP Shared Clinical Decision-Making Recommendations www.cdc.gov/vaccines/acip/acip-scdm-faqs.html

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

CS310021-B

Source: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html.

Table 2 Recommended Adult Immunization Schedule by Medical Condition and Other Indications, United States, 2021

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 count <200 mm³	HIV infection CD4 count ≥200 mm³	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 RIV4 or LAIV4	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*	Not Recommended	1 or 2 doses depending on indication								
VAR	Not Recommended*	Not Recommended			2 doses						
RZV					2 doses at age ≥50 years						
HPV	Not Recommended*	3 doses through age 26 years			2 or 3 doses through age 26 years depending on age at initial vaccination or condition						
PCV13					1 dose						
PPSV23					1, 2, or 3 doses depending on age and indication						
HepA							2 or 3 doses depending on vaccine				
HepB					2, 3, or 4 doses depending on vaccine or condition				<60 years		
MenACWY		1 or 2 doses depending on indication, see notes for booster recommendations							≥60 years		
MenB	Precaution	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations									
Hib		3 doses HSCT 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

Recommended vaccination based on shared clinical decision-making

Not recommended/ contraindicated—vaccine should not be administered.

*Vaccinate after pregnancy.

No recommendation/ Not applicable

1. Precaution for LAIV4 does not apply to alcoholism. **2.** See notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations. **3.** Hematopoietic stem cell transplant.

Source: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-conditions.html

Notes Recommended Adult Immunization Schedule for ages 19 years or older, United States, 2021

For vaccine recommendations for persons 18 years of age or younger, see the Recommended Child/ Adolescent Immunization Schedule.

Additional Information

COVID-19 Vaccination

ACIP recommends use of COVID-19 vaccines within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. Interim ACIP recommendations for the use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html

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

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: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])

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** (HepA-HepB [Twinrix] may be administered on an accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months)
  - **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)
  - **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 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: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])

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, shared clinical decision-making for persons 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 persons 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 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)
  - **Age 9–14 years at initial vaccination and received 1 dose or 2 doses less than 5 months apart:** 1 additional dose
  - **Age 9–14 years at initial vaccination and received 2 doses at least 5 months apart:** HPV vaccination series complete, no additional dose needed
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted
- **No additional dose recommended after completing series with recommended dosing intervals using any HPV vaccine**

Shared clinical decision-making

- **Some adults age 27–45 years: Based on shared clinical decision-making,** 2- or 3-dose series as above

Special situations

- **Age ranges recommended above for routine and catch-up vaccination or shared clinical decision-making also apply in special situations**

- **Immunocompromising conditions, including HIV infection**: 3-dose series as above, regardless of age at initial vaccination
- **Pregnancy**: HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

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–any symptom other than hives** (e.g., angioedema, respiratory distress): 1 dose any influenza vaccine appropriate for age and health status annually. If using an influenza vaccine other than RIV4 or ccIIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions.
- Severe allergic reactions to any vaccine can occur even in the absence of a history of previous allergic reaction. Therefore, all vaccine providers should be familiar with the office emergency plan and certified in cardiopulmonary resuscitation.
- A previous severe allergic reaction to any influenza vaccine is a contraindication to future receipt of the vaccine.
- **LAIV4 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
  - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
  - Pregnancy
  - Cranial CSF/oropharyngeal communications
  - Cochlear implant
  - Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days
  - Adults 50 years or older
- **History of Guillain-Barré syndrome within 6 weeks after 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/mm^3 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 for HIV infection with CD4 count <200 cells/mm^3
- **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-D (Menactra, Menveo or MenQuadfi) 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 or MenQuadfi) 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 or MenQuadfi)
- For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Shared clinical decision-making for MenB

- **Adolescents and young adults age 16–23 years (age 16–18 years preferred) not at increased risk for meningococcal disease:** Based on shared clinical decision-making, 2-dose series MenB-4C (Bexsero) at least 1 month apart or 2-dose series MenB-FHbp (Trumenba) 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 one month apart or

Notes Recommended Adult Immunization Schedule, United States, 2021

- 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
- For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

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 or older** (immunocompetent): 1 dose PCV13 based on **shared clinical decision-making** if previously not administered.
  - PCV13 and PPSV23 should not be administered during the same visit
  - 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

Special situations

(www.cdc.gov/mmwr/preview/mmwrhtml/mm6140a4.htm)

- **Age 19–64 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
- **Wound management:** Persons with 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant woman, use Tdap. For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.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/mm^3 with no evidence of immunity:** Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 count <200 cells/mm^3
- **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 zoster vaccine live (ZVL, Zostavax) vaccination (administer RZV at least 2 months after ZVL)

Special situations

- **Pregnancy:** Consider delaying RZV until after pregnancy if RZV is otherwise indicated.
- **Severe immunocompromising conditions (including HIV infection with CD4 count <200 cells/mm^3):** Recommended use of RZV under review

APPENDIX B

NOTICE OF PRIVACY PRACTICES

Prime Healthcare	***3480 E. Guasti Road, Ontario, CA 91761*** ***Clay Wombacher, Chief Compliance Officer*** ***cwombacher@primehealthcare.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, 2022

Clay Wombacher, Chief Compliance Officer
cwombacher@primehealthcare.com
(909) 638-0092.

APPENDIX C

COVERAGE RELATING TO COVID-19

"FAMILIES FIRST CORONAVIRUS RESPONSE ACT" ("FFFCRA") AND THE "CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT" ("CARES ACT")

This Appendix C reflects changes to the Plan resulting from the COVID-19 Public Health Emergency.

Effective March 1, 2020 and continuing for the length of the COVID-19 Public Health Emergency Period, the Plan will provide coverage for the collection of samples, testing and related services for the Corona Virus Disease 2019 ("COVID-19") without cost sharing as described herein.

IF PARTICIPATING IN A PPO —

Network Providers & Facilities (PPO): Copayments, Coinsurance and Deductibles for office visits (including telemedicine), Urgent Care, Emergency Services and related services for the purpose of collection, testing and related services for the diagnosis of COVID-19 are waived. Prior authorization requirements and other medical management techniques, if any, for such services are waived as well.

Non-Network Providers & Facilities (PPO): Copayments, Coinsurance and Deductibles for office visits (including telemedicine), Urgent Care, Emergency Services and non-traditional venues for the purpose of collection, testing and related services for the diagnosis of COVID-19 are waived. Prior authorization requirements and other medical management techniques, if any, for such services are waived as well. Non-Network Providers will be paid the cash price for such services as listed by the Provider on a public internet website. Otherwise, the Non-Network Provider will be reimbursed the Allowable Expense. However, Participants may be subject to balance billing for the difference between what the Plan pays and what the Non-Network Provider has billed.

Other benefits for the treatment of COVID-19 shall be the same as any other Illness.

IF PARTICIPATING IN AN EPO —

In-Network Providers & Facilities (EPO): Copayments, Coinsurance and Deductibles for physician office visits (including telemedicine), Urgent Care and Emergency Services for the purpose of collection, testing and other related services for the diagnosis of COVID-19 are waived. Prior authorization requirements and other medical management techniques, if any, for such services are waived as well.

Non-Network Providers & Facilities (EPO): Services for the purpose of collection, testing and other related services for the diagnosis of COVID-19 **ARE NOT COVERED.** Participants who receive Non-Network services, other than Emergency Services, will be responsible for the entire cost of those services.

Other benefits for the treatment of COVID-19 shall be the same as any other Illness.

EMERGENCY RELIEF RESPONSE TO COVID-19 —

Certain timeframes have been extended for the period commencing March 1, 2020 and ending on the earlier of (x) one year from the date the individual was first eligible for relief, and (y) 60 days after the announced end of the National Emergency. Please contact Human Resources regarding information about the extension of the following dates and time frames:

- COBRA elections;
- COBRA payments;
- Notification to the Plan of a qualifying event;
- COBRA election notice;

- Submission of claims or appeals; and
- Special enrollment rights.

TELEMEDICINE —

Network Providers and Facilities: Scheduled office visits for all services other than for services related to COVID-19 that are conducted via telemedicine (telephone, internet audio/visual, etc.) will be covered the same as any other office visit.

PREVENTIVE SERVICES —

Effective no later than 15 days after the date the USPSTF or ACIP makes an applicable recommendation regarding a qualifying coronavirus preventive service for COVID-19 vaccinations, all such COVID-19 vaccines shall be covered without cost sharing with respect to the individual and the administration thereof.

COVID-19 OVER-THE-COUNTER (OTC) TESTS —

On January 10, 2022, the Biden Administration announced new guidance that will require group health insurance plans and insurers to cover the cost of over-the-counter, at-home COVID-19 tests (OTC COVID tests) beginning on January 15, 2022. This guidance applies to both fully-insured and self-funded plans. Both the U.S. Department of Labor (DOL) and the Centers for Medicare and Medicaid Services (CMS) have issued Frequently Asked Question (FAQ) guidance regarding this requirement.

Under the guidance issued by the DOL and CMS (together, the Departments), individuals with private health insurance coverage or covered by a group health plan who purchase an OTC COVID test authorized, cleared or approved by the U.S. Food and Drug Administration will have the cost of those tests covered by their insurance without cost-sharing. Plans are required to cover up to 8 free OTC COVID tests per covered individual per 30-day period or per calendar month. (This requirement applies to individual tests. A package that contains 2 tests, counts as 2). Moreover, there is no limit on the number of tests, OTC COVID tests, that are covered if ordered or administered by a health care provider following an individualized clinical assessment.

PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

AMENDMENT 1
PRIME HEALTHCARE
PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION OF THE UNIFIED EPO PLAN AND PRESCRIPTION DRUG BENEFITS
EFFECTIVE JANUARY 1, 2023

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM AND A COPY OF THE SIGNED PLAN DOCUMENT TO:

Keenan & Associates
2355 Crenshaw Blvd. Suite 200
Torrance, CA 90501
Attention: Marcy Allen % dkong@keenan.com

The Plan Sponsor recognizes that it has full responsibility for the contents of the employee benefit document attached hereto and that, while Keenan & Associates, its employees and/or subcontractors, may have assisted in the preparation of the document, it is the Plan Sponsor who is responsible for the final text and meaning. The Plan Sponsor further certifies that the document has been fully read, understood, and describes its intent with regard to the employee benefit plan.

PLAN SPONSOR:

By: _____ Date: May 30, 2023
AUTHORIZED REPRESENTATIVE OF PLAN SPONSOR

THE ATTACHED EMPLOYEE BENEFIT DOCUMENT IS NOT INTENDED AS LEGAL ADVICE.

AMENDMENT 1

PRIME HEALTHCARE

PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION OF THE UNIFIED EPO PLAN AND PRESCRIPTION DRUG BENEFITS

Effective January 1, 2023, the Prime Healthcare Plan Document/Summary Plan Description of the Unified EPO Plan and Prescription Drug Benefits (the "Plan"), dated January 1, 2022, is hereby amended as follows:

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

There are no other changes to the Plan.

APPENDIX A
2023 PREVENTIVE CARE SERVICES

Preventive Care Services are based on recommendations of the U.S. Preventive Services 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 http://www.uspreventiveservicestaskforce.org/uspstf/.

- 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

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.
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.
Behavioral counseling interventions for healthy weight and weight gain: pregnant persons	The USPSTF recommends that clinicians offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
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.

TOPIC	DESCRIPTION
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 45 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. A colonoscopy conducted after a positive "non-invasive stool-based" screening test or direct visualization screening test (including prior consultation, bowel preparation meds, anesthesia services, etc.).
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.
COVID-19 Over-the-Counter (OTC) Tests	COVID-19, at home OTC test kits, up to eight tests per Covered Person per month. Reimbursement is limited to up to $12.00 per at-home test kit. There is no limit on the number of tests, OTC COVID tests, that are covered if ordered or administered by a health care provider following an individualized clinical assessment.
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. The USPSTF recommends primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.

TOPIC	DESCRIPTION
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.
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 persons at 24 weeks of gestation or after.
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.

TOPIC	DESCRIPTION
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.
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.
Hypertension screening: adults 18 years or older without known hypertension	The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement. The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
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: adults aged 50-80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 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.

TOPIC	DESCRIPTION
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.
Prediabetes and Type 2 Diabetes screening	The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.
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 nonpregnant adults who use tobacco.
Tobacco use counseling: pregnant persons	The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons 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.

TOPIC	DESCRIPTION
Well baby and well childcare	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, tuberculin testing.
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.

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

UNITED STATES
2022

Vaccines in the Child and Adolescent Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
Dengue vaccine	**DEN4CYD**	Dengvaxia®
Diphtheria, tetanus, and acellular pertussis vaccine	**DTaP**	Daptacel® Infanrix®
Diphtheria, tetanus vaccine	**DT**	No trade name
Haemophilus influenzae type b vaccine	**Hib (PRP-T)** **Hib (PRP-OMP)**	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	**HepA**	Havrix® Vaqta®
Hepatitis B vaccine	**HepB**	Engerix-B® Recombivax HB®
Human papillomavirus vaccine	**HPV**	Gardasil 9®
Influenza vaccine (inactivated)	**IIV4**	Multiple
Influenza vaccine (live, attenuated)	**LAIV4**	FluMist® Quadrivalent
Measles, mumps, and rubella vaccine	**MMR**	M-M-R II®
Meningococcal serogroups A, C, W, Y vaccine	**MenACWY-D** **MenACWY-CRM** **MenACWY-TT**	Menactra® Menveo® MenQuadfi®
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®
Poliovirus vaccine (inactivated)	**IPV**	IPOL®
Rotavirus vaccine	**RV1** **RV5**	Rotarix® 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®
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b, and hepatitis B vaccine	**DTaP-IPV-Hib-HepB**	Vaxelis®
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 and 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 or other indication **(Table 3)**

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

5 Review contraindications and precautions for vaccine types **(Appendix)**

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), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), and National Association of Pediatric Nurse Practitioners (www.napnap.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

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 Advisory Committee on Immunization Practices (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
- ACIP Shared Clinical Decision-Making Recommendations www.cdc.gov/vaccines/acip/acip-scdm-faqs.html

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

Scan QR code for access to online schedule

CS310020-A

Table 1 Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

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).

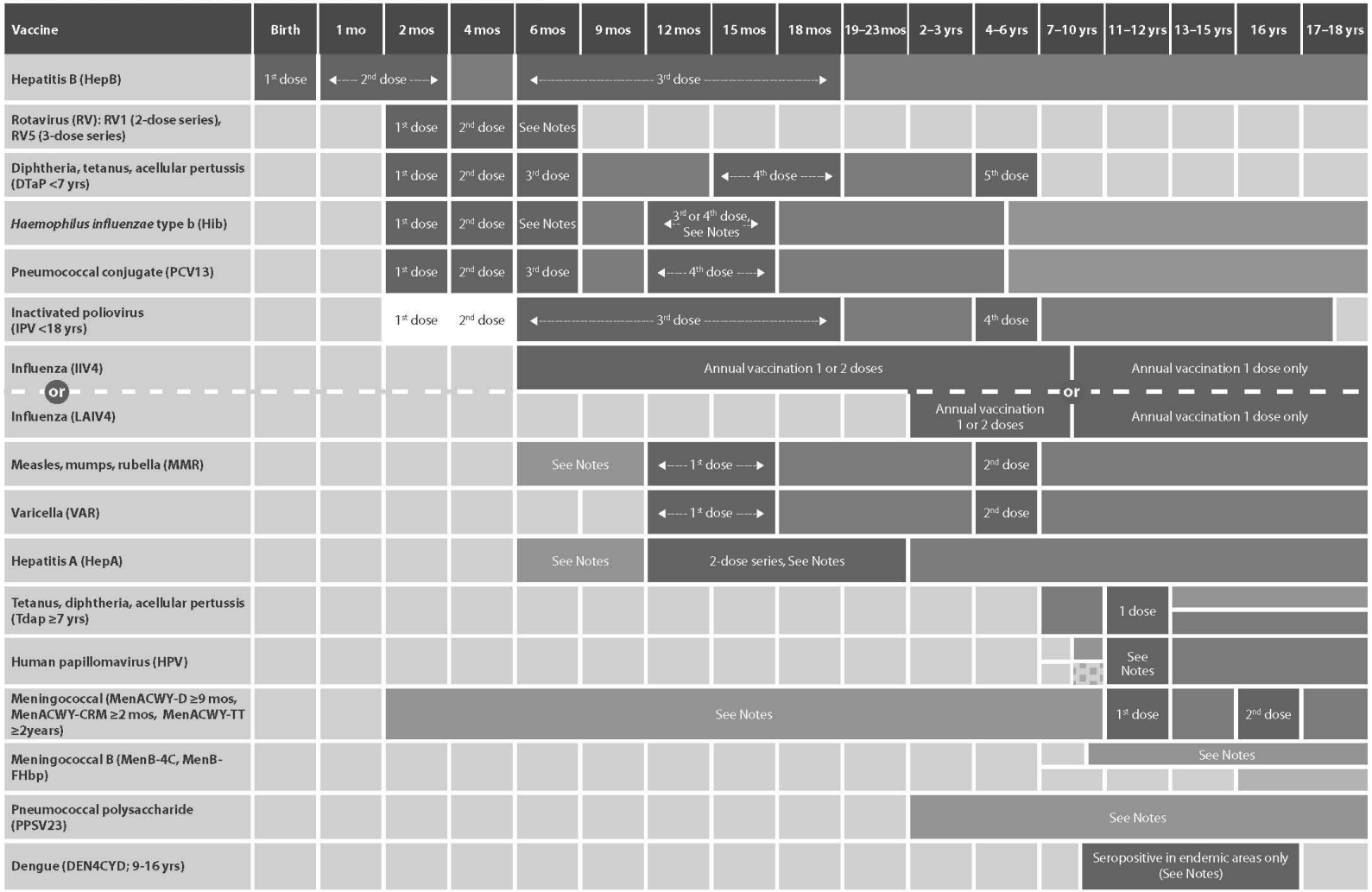


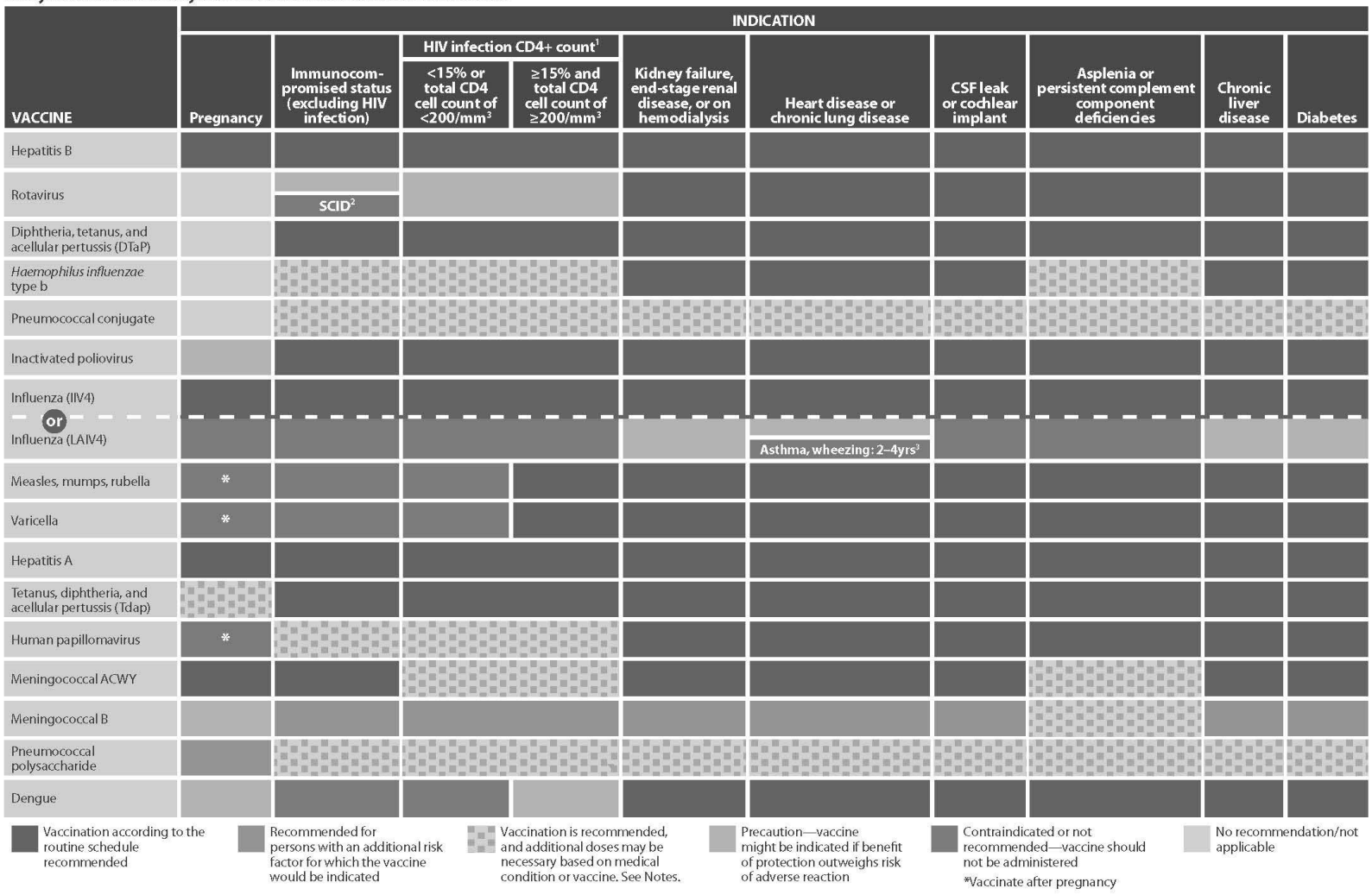
Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind, United States, 2022

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.**

Children age 4 months through 6 years					
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**
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®), Vaxelis® 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 was administered at younger than 15 months; OR if both doses were PedvaxHIB® 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 was 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 administered 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**	**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 2 years MenACWY-TT	**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			
Dengue	9 years	**6 months**	6 months		

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2022

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



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 J) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.
2 Severe Combined Immunodeficiency
3 LAIV4 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, 2022

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2022.

Additional information

COVID-19 Vaccination

COVID-19 vaccines are recommended for use within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. ACIP recommendations for the use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html.

CDC's interim clinical considerations for use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html.

- Consult relevant ACIP statements for detailed recommendations 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 vaccination 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 about 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.

Dengue vaccination (minimum age: 9 years)

Routine vaccination

- Age 9–16 years living in dengue endemic areas **AND** have laboratory confirmation of previous dengue infection
  - 3-dose series administered at 0, 6, and 12 months
- Endemic areas include Puerto Rico, American Samoa, US Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau. For updated guidance on dengue endemic areas and pre-vaccination laboratory testing see www.cdc.gov/mmwr/volumes/70/rr/rr7006a1.htm?s_cid=rr7006a1_w and www.cdc.gov/dengue/vaccine/hcp/index.html

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

Routine vaccination

- 5-dose series at age 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 age 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.

Special situations

- Wound management in children less than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine: For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

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

Routine vaccination

- **ActHIB®, Hiberix®, Pentacel®, or Vaxelis®:** 4-dose series (3 dose primary series at age 2, 4, and 6 months, followed by a booster dose* at age 12–15 months)
  - *Vaxelis® is not recommended for use as a booster dose. A different Hib-containing vaccine should be used for the booster dose.
- **PedvaxHIB®:** 3-dose series (2-dose primary series at age 2 and 4 months, followed by a booster dose at age 12–15 months)

Catch-up vaccination

- **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) at least 8 weeks after dose 2.
- **2 doses of PedvaxHIB® before age 12 months:** Administer dose 3 (final dose) at 12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 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. Vaxelis® can be used for catch-up vaccination in children less than age 5 years. Follow the catch-up schedule even if Vaxelis® is used for one or more doses. For detailed information on use of Vaxelis® see www.cdc.gov/mmwr/volumes/69/wr/mm6905a5.htm.

Special situations

- **Chemotherapy or radiation treatment:**
  Age 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):**
  Age 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:**
  Age 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:**
  Age 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 age 14 months) OR no doses (age 15 months or older)*

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

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

Routine vaccination
- 2-dose series (minimum interval: 6 months) at age 12–23 months

Catch-up vaccination
- Unvaccinated persons through age 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 age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix**®, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster 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 age 12–23 months.
  - **Unvaccinated age 12 months or 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:**
  - **All** medically stable infants ≥2,000 grams: 1 dose within 24 hours of birth
  - Infants <2,000 grams: Administer 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still <2,000 grams).
- **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 age 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 age 18 years or older may receive a 2-dose series of HepB **(Heplisav-B**®**)** at least 4 weeks apart.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix**®, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster 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.
- **Post-vaccination serology testing and revaccination** (if anti-HBs < 10mIU/mL) is 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 9–14 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)
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted.
- No additional dose recommended when any HPV vaccine series has been completed using the recommended dosing intervals.

Special situations
- **Immunocompromising conditions, including HIV infection:** 3-dose series, even for those who initiate vaccination at age 9 through 14 years.
- **History of sexual abuse or assault:** Start at age 9 years.
- **Pregnancy:** Pregnancy testing not needed before vaccination; HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant

Influenza vaccination
(minimum age: 6 months [IIV], 2 years [LAIV4], 18 years [recombinant influenza vaccine, RIV4])

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, 2021, 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, 2021
  - 1 dose for **all persons age 9 years or older**
- For the 2021-2022 season, see www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm.
- For the 2022–23 season, see the 2022–23 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) or required epinephrine or another emergency medical intervention: see Appendix listing contraindications and precautions
- **Severe allergic reaction (e.g., anaphylaxis) to a vaccine component or a previous dose of any influenza vaccine:** see Appendix listing contraindications and precautions

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

Routine vaccination
- 2-dose series at age 12–15 months, age 4–6 years
- MMR or MMRV may be administered

Note: For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV may be used if parents or caregivers express a preference.

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.
- Minimum interval between MMRV doses: 3 months

Special situations
International travel
- **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series at age 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 or older:** 2-dose series at least 4 weeks apart before departure

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

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

Routine vaccination

- 2-dose series at age 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 2 months: 4-dose series (additional 3 doses at age 4, 6 and 12 months)
  - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 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.
- **MenQuadfi®**
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

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 age 2 months: 4-dose series (additional 3 doses at age 4, 6 and 12 months)
    - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 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)
  - **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®, Menactra®, or MenQuadfi®

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®, Menactra®,** or **MenQuadfi®**

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.
- **Children for whom boosters are not recommended** (e.g., a healthy child 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. MenACWY vaccines may be administered simultaneously with MenB vaccines if indicated, but at a different anatomic site, if feasible.

For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

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

Note: 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 additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

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

Routine vaccination with PCV13

- 4-dose series at age 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

Underlying conditions below: When both PCV13 and PPSV23 are indicated, administer PCV13 first. PCV13 and PPSV23 should not be administered during 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 completing all recommended PCV13 doses)

Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

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

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 dose 2 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 dose 2 of PPSV23 administered 5 years after dose 1 of PPSV23 and at least 8 weeks after a dose of PCV13

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

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 (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 on 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 on 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 age 18 years or 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_%20cid=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 age 2 and 4 months
- **RotaTeq®:** 3-dose series at age 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 age 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 the routine Tdap dose at age 11–12 years.
- **DTaP inadvertently administered on or after age 7 years:**
  - **Children age 7–9 years:** DTaP may count as part of catch-up series. Administer routine Tdap dose at age 11–12 years.
  - **Children age 10–18 years:** Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Table 2.

Special situations
- **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.
- For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.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 age 12–15 months, 4–6 years
- VAR or MMRV may be administered*
- Dose 2 may be administered as early as 3 months after dose 1 (a dose inadvertently administered after at least 4weeks may be counted as valid)

***Note:** For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV may be used if parents or caregivers express a preference.

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

Appendix Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

Guide to Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4-1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: Contraindication and Precautions available at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html *and ACIP's Recommendations for the Prevention and Control of 2021-22 seasonal influenza with Vaccines available at* www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm.

Interim clinical considerations for use of COVID-19 vaccines including contraindications and precautions can be found at
www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

Vaccine	Contraindications[1]	Precautions[2]
Influenza, egg-based, inactivated injectable (IIV4)	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg)	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: Any influenza vaccine appropriate for age and health status may be administered. If using egg-based IIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable [(ccIIV4), Flucelvax® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component[3] of ccIIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, recombinant injectable [(RIV4), Flublok® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component[3] of RIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg- based IIV, ccIIV, or LAIV of any valency. If using RIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, live attenuated [LAIV4, Flumist® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg) • Children age 2 – 4 years with a history of asthma or wheezing • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear or any other cranial CSF leak • Children and adolescents receiving aspirin or salicylate-containing medications • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons aged 5 years old or older • Persons with egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: Any influenza vaccine appropriate for age and health status may be administered. If using LAIV4 (which is egg based), administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Persons with underlying medical conditions (other than those listed under contraindications) that might predispose to complications after wild-type influenza virus infection [e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus)] • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states

Appendix

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

Vaccine	Contraindications[1]	Precautions[2]
Dengue (DEN4CYD)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long- term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised)	• Pregnancy • HIV infection without evidence of severe immunosuppression • Moderate or severe acute illness with or without fever
Diphtheria, tetanus, pertussis (DTaP) Tetanus, diphtheria (DT)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For DTaP only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP or DTaP	• Guillain-Barré syndrome (GBS) within 6 weeks after previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid— containing or tetanus-toxoid– containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid- containing vaccine • For DTaP only: Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP until neurologic status clarified and stabilized • Moderate or severe acute illness with or without fever
Haemophilus influenzae type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Hiberix, ActHib, and PedvaxHIB only: History of severe allergic reaction to dry natural latex • Less than age 6 weeks	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including yeast • For Heplisav-B only: Pregnancy	• Moderate or severe acute illness with or without fever
Hepatitis A-Hepatitis B vaccine [HepA-HepB, (Twinrix®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing • Moderate or severe acute illness with or without fever
Meningococcal ACWY (MenACWY) [MenACWY-CRM (Menveo®); MenACWY-D (Menactra®); MenACWY-TT (MenQuadfi®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For MenACWY-D and Men ACWY-CRM only: severe allergic reaction to any diphtheria toxoid– or CRM197–containing vaccine • For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• For MenACWY-CRM only: Preterm birth if less than age 9 months • Moderate or severe acute illness with or without fever
Meningococcal B (MenB) [MenB-4C (Bexsero®); MenB-FHbp (Trumenba®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • For MenB-4C only: Latex sensitivity • Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV13)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid– containing vaccine or its component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Poliovirus vaccine, inactivated (IPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • Moderate or severe acute illness with or without fever
Rotavirus (RV) [RV1 (Rotarix®), RV5 (RotaTeq®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe combined immunodeficiency (SCID) • History of intussusception	• Altered immunocompetence other than SCID • Chronic gastrointestinal disease • RV1 only: Spina bifida or bladder exstrophy • Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP, DTaP, or Tdap	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid— containing or tetanus-toxoid– containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid– containing vaccine • For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized • Moderate or severe acute illness with or without fever
Varicella (VAR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long- term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.

Recommended Adult Immunization Schedule
for ages 19 years or older

UNITED STATES
2022

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 or other indication **(Table 2)**
3. Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**
4. Review contraindications and precautions for vaccine types **(Appendix)**

Vaccines in the Adult Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
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	Gardasil 9®
Influenza vaccine (inactivated)	IIV4	Many brands
Influenza vaccine (live, attenuated)	LAIV4	FluMist® Quadrivalent
Influenza vaccine (recombinant)	RIV4	Flublok® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R II®
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM MenACWY-TT	Menactra® Menveo® MenQuadfi®
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero® Trumenba®
Pneumococcal 15-valent conjugate vaccine	PCV15	Vaxneuvance™
Pneumococcal 20-valent conjugate vaccine	PCV20	Prevnar 20™
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

*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.

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), American College of Nurse-Midwives (www.midwife.org), and American Academy of Physician Associates (www.aapa.org), and Society for Healthcare Epidemiology of America (www.shea-online.org).

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) 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 Advisory Committee on Immunization Practices (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, 2022: www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/vaccines/acip/acip-scdm-faqs.html

Scan QR code for access to online schedule

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, 2022

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
Influenza inactivated (IIV4) or **Influenza recombinant** (RIV4)	1 dose annually			
or	or			
Influenza live, attenuated (LAIV4)	1 dose annually			
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management (see notes)			
	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)	2 doses for immunocompromising conditions (see notes)		2 doses	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
Pneumococcal (PCV15, PCV20, PPSV23)	1 dose PCV15 followed by PPSV23 OR 1 dose PCV20 (see notes)			1 dose PCV15 followed by PPSV23 OR 1 dose PCV20
Hepatitis A (HepA)	2 or 3 doses depending on vaccine			
Hepatitis B (HepB)	2, 3, or 4 doses depending on vaccine or condition			
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 or Other Indication, United States, 2022

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 percentage and count		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
			<15% or <200 mm³	≥15% and ≥200 mm³							
IIV4 or RIV4	1 dose annually										
or										or	
LAIV4	Contraindicated						Precaution			1 dose annually	
Tdap or Td	1 dose Tdap each pregnancy	1 dose Tdap, then Td or Tdap booster every 10 years									
MMR	Contraindicated*	Contraindicated	1 or 2 doses depending on indication								
VAR	Contraindicated*	Contraindicated		2 doses							
RZV		2 doses at age ≥19 years		2 doses at age ≥50 years							
HPV	Not Recommended*	3 doses through age 26 years		2 or 3 doses through age 26 years depending on age at initial vaccination or condition							
Pneumococcal (PCV15, PCV20, PPSV23)		1 dose PCV15 followed by PPSV23 OR 1 dose PCV20 (see notes)									
HepA				2 or 3 doses depending on vaccine							
HepB	3 doses (see notes)	2, 3, or 4 doses depending on vaccine or condition									
MenACWY	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
- Recommended vaccination based on shared clinical decision-making
- Precaution—vaccination might be indicated if benefit of protection outweighs risk of adverse reaction
- Contraindicated or not recommended—vaccine should not be administered.
  *Vaccinate after pregnancy.
- No recommendation/ Not applicable

1. Precaution for LAIV4 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 for ages 19 years or older, United States, 2022

For vaccine recommendations for persons 18 years of age or younger, see the Recommended Child and Adolescent Immunization Schedule.

COVID-19 Vaccination

COVID-19 vaccines are recommended within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. ACIP recommendations for the use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html.

CDC's interim clinical considerations for use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html.

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

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: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])

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** (HepA-HepB [Twinrix] may be administered on an accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months)
  - **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)
  - **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 B vaccination

Routine vaccination

- **Age 19 through 59 years:** complete a 2- or 3-, or 4-dose series
  - 2-dose series only applies when 2 doses of Heplisav-B* are used at least 4 weeks apart
  - 3-dose series Engerix-B or Recombivax HB at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks])
  - 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])
  - 4-dose series HepA-HepB (Twinrix) accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months
  - 4-dose series Engerix-B at 0, 1, 2, and 6 months for persons on adult hemodialysis (note: each dosage is double that of normal adult dose, i.e., 2 mL instead of 1 mL)

***Note:** Heplisav-B not recommended in pregnancy due to lack of safety data in pregnant women

Special situations

- **Age 60 years or older* and 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; patients with diabetes)
  - **Incarcerated persons**
  - **Travel in countries with high or intermediate endemic hepatitis B**

***Note:** Anyone age 60 years or older who does not meet risk-based recommendations may still receive Hepatitis B vaccination.

Human papillomavirus vaccination

Routine vaccination

- **HPV vaccination recommended for all persons 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 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)
  - **Age 9–14 years at initial vaccination and received 1 dose or 2 doses less than 5 months apart:** 1 additional dose
  - **Age 9–14 years at initial vaccination and received 2 doses at least 5 months apart:** HPV vaccination series complete, no additional dose needed

Notes Recommended Adult Immunization Schedule, United States, 2022

- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted
- **No additional dose recommended when any HPV vaccine series has been completed using the recommended dosing intervals.**

Shared clinical decision-making

- **Some adults age 27–45 years: Based on shared clinical decision-making,** 2- or 3-dose series as above

Special situations

- **Age ranges recommended above for routine and catch-up vaccination or shared clinical decision-making also apply in special situations**
  - **Immunocompromising conditions, including HIV infection**: 3-dose series, even for those who initiate vaccination at age 9 through 14 years.
  - **Pregnancy**: Pregnancy testing is not needed before vaccination; HPV vaccination is not recommended until after pregnancy; no intervention needed if inadvertently vaccinated while pregnant

Influenza vaccination

Routine vaccination

- **Age 19 years or older:** 1 dose any influenza vaccine appropriate for age and health status annually
- For the 2021–2022 season, see www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm
- For the 2022–23 season, see the 2022–23 ACIP influenza vaccine recommendations.

Special situations

- **Egg allergy, hives only:** any influenza vaccine appropriate for age and health status annually
- **Egg allergy–any symptom other than hives** (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: see Appendix listing contraindications and precautions
- **Severe allergic reaction (e.g., anaphylaxis) to a vaccine component or a previous dose of any influenza vaccine:** see Appendix listing contraindications and precautions
- **History of Guillain-Barré syndrome within 6 weeks after 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 percentages ≥15% and CD4 count ≥200 cells/mm^3 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 for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm^3
- **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 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
  - **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

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-D (Menactra, Menveo, or MenQuadfi) at least 8 weeks apart and revaccinate every 5 years if risk remains
- **Travel in countries with hyperendemic or epidemic meningococcal disease, or microbiologists routinely exposed to *Neisseria meningitidis*:** 1 dose MenACWY (Menactra, Menveo, or MenQuadfi) 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) or military recruits:** 1 dose MenACWY (Menactra, Menveo, or MenQuadfi)
- For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Shared clinical decision-making for MenB

- **Adolescents and young adults age 16–23 years (age 16–18 years preferred) not at increased risk for meningococcal disease:** Based on shared clinical decision-making, 2-dose series MenB-4C (Bexsero) at least 1 month apart or 2-dose series MenB-FHbp (Trumenba) 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, or 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

Notes Recommended Adult Immunization Schedule, United States, 2022

- **Pregnancy:** Delay MenB until after pregnancy unless at increased risk and vaccination benefits outweigh potential risks
- For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Note: MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, if feasible.

Pneumococcal vaccination

Routine vaccination

- **Age 65 years or older** who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown: 1 dose PCV15 or 1 dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak to minimize the risk of invasive pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups.
- For guidance for patients who have already received a previous dose of PCV13 and/or PPSV23, see www.cdc.gov/mmwr/volumes/71/wr/mm7104a1.htm.

Special situations

- **Age 19–64 years** with certain underlying medical conditions or other risk factors** who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown: 1 dose PCV15 or 1 dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak to minimize the risk of invasive pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups.
- For guidance for patients who have already received a previous dose of PCV13 and/or PPSV23, see www.cdc.gov/mmwr/volumes/71/wr/mm7104a1.htm.

***Note:** Immunocompromising conditions include chronic renal failure, nephrotic syndrome, immunodeficiency, iatrogenic immunosuppression, generalized malignancy, human immunodeficiency virus, Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplants, congenital or acquired asplenia, sickle cell disease, or other hemoglobinopathies.

****Note:** Underlying medical conditions or other risk factors include alcoholism, chronic heart/liver/lung disease, chronic renal failure, cigarette smoking, cochlear implant, congenital or acquired asplenia, CSF leak, diabetes mellitus, generalized malignancy, HIV, Hodgkin disease, immunodeficiency, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplants, or sickle cell disease or other hemoglobinopathies.

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:** 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
- **Wound management:** Persons with 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant woman, use Tdap. For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.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 percentages ≥15% and CD4 count ≥200 cells/mm³ with no evidence of immunity:** Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm³
- **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 zoster vaccine live (ZVL, Zostavax) vaccination (administer RZV at least 2 months after ZVL)

Special situations

- **Pregnancy:** There is currently no ACIP recommendation for RZV use in pregnancy. Consider delaying RZV until after pregnancy.
- **Immunocompromising conditions (including HIV):** RZV recommended for use in persons age 19 years or older who are or will be immunodeficient or immunosuppressed because of disease or therapy. For detailed information, see www.cdc.gov/mmwr/volumes/71/wr/mm7103a2.htm.

Appendix Recommended Adult Immunization Schedule, United States, 2022

Guide to Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4-1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: Contraindication and Precautions available at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html *and ACIP's Recommendations for the Prevention and Control of 2021-22 Seasonal Influenza with Vaccines available at www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm*

Interim clinical considerations for use of COVID-19 vaccines including contraindications and precautions can be found at
www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

Vaccine	Contraindications[1]	Precautions[2]
Influenza, egg-based, inactivated injectable (IIV4)	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg)	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: Any influenza vaccine appropriate for age and health status may be administered. If using egg-based IIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable [(ccIIV4), Flucelvax® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component[3] of ccIIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, recombinant injectable [(RIV4), Flublok® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component[3] of RIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, ccIIV, or LAIV of any valency. If using RIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, live attenuated [LAIV4, Flumist® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg) • Adults age 50 years or older • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear, or any other cranial CSF leak • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days.	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons aged 5 years old or older • Persons with egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: Any influenza vaccine appropriate for age and health status may be administered. If using LAIV4 (which is egg based), administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Persons with underlying medical conditions (other than those listed under contraindications) that might predispose to complications after wild-type influenza virus infection [e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus)] • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.

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Vaccine	Contraindications[1]	Precautions[2]
Haemophilus influenzae type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Hiberix, ActHib, and PedvaxHIB only: History of severe allergic reaction to dry natural latex	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including yeast • For Heplisav-B only: Pregnancy	• Moderate or severe acute illness with or without fever
Hepatitis A-Hepatitis B vaccine [HepA-HepB, (Twinrix®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing • Moderate or severe acute illness with or without fever
Meningococcal ACWY (MenACWY) [MenACWY-CRM (Menveo®); MenACWY-D (Menactra®); MenACWY-TT (MenQuadfi®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For MenACWY-D and Men ACWY-CRM only: severe allergic reaction to any diphtheria toxoid– or CRM197–containing vaccine • For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• Moderate or severe acute illness with or without fever
Meningococcal B (MenB) [MenB-4C (Bexsero); MenB-FHbp (Trumenba)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • For MenB-4C only: Latex sensitivity • Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV15)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid–containing vaccine or to its vaccine component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV20)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid– containing vaccine or to its vaccine component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP, DTaP, or Tdap	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid—containing or tetanus-toxoid– containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid–containing vaccine • Moderate or severe acute illness with or without fever • For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized
Varicella (VAR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long- term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • Moderate or severe acute illness with or without fever
Zoster recombinant vaccine (RZV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever • Current herpes zoster infection

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.

ADDENDUM 18

SCHEDULE OF MEDICAL BENEFITS

The Prime Healthcare entities included in the following schedule of medical benefits are:

- Shasta Regional Medical Center CNA

The percentages shown in the schedule reflect the amounts the Covered Person pays after any required Copay has been applied. The percentages apply to "Allowable Charges." See "Allowable Charges" in the **Definitions** section for more information. A "Copay" is a fixed amount the Covered Person must pay and is usually paid to the Provider at the time of service. All Services must be authorized by the Prime Healthcare Utilization Management Department for services to be obtained through a Blue Shield of CA Network Provider (unless otherwise noted in this SPD).

Eligible Dependent: A current Spouse or Registered Domestic Partner is NOT 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).

Primary Care Physician: At the time of enrollment, each Covered Person must select a Primary Care Physician (PCP) from the Tier 1 Prime Provider Directory of Network Providers. The Tier 1 Prime Provider Directory can be found on www.primehealthcare.com/EHP or by contacting Prime Customer Service at (877) 234-5227. For purposes of office visits only, Covered Persons may also select a Tier 2 Blue Shield of CA Network Primary Care Provider without prior approval from the Prime Healthcare Utilization Management Department.

Tier 1 Prime Healthcare Network	
Annual Deductible	None
Annual Out-of-Pocket Maximum	$1,350 Individual / $2,700 Family
Office Visit • Primary Care Physician (PCP) • Pediatrician • Specialist	 $10 Copay $10 Copay $10 Copay
Preventive Care Service	No charge
Chiropractic[1] (20 visit limit per calendar year)	$10 Copay
Lab and X-ray	No charge
Inpatient Hospital Services / Outpatient Hospital Services, Surgical Service	No charge
Urgent Care	$10 Copay
Emergency Room	$25 Copay (Copay waived if admitted)
Ambulance	$250 Copay per trip
Rehab Therapy[1] Physical, Occupational, Speech (30 visit combined limit per calendar year)	No charge at a Prime Hospital or Facility; or $10 Copay
Dialysis[1] 39 lifetime visits	No charge
Home Health Care[1] (100 visit limit per calendar year)	20% Coinsurance
Durable Medical Equipment	20% Coinsurance
Bariatric Procedure • Prime Facility / Physician Care	 Facility: $500 Copay plus 20% Coinsurance / Physician: 50% Coinsurance
Sleep Study • Home Study / Prime Sleep Lab • DME Supplies	 $100 Copay / $250 Copay 20% Coinsurance

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

Tier 2 Blue Shield of CA Network	
Annual Deductible	$1,500 Individual / $3,000 Family
Annual Out-of-Pocket Maximum	$7,750 Individual / $15,500 Family
Office Visit • Primary Care Physician (PCP) • Pediatrician • Specialist	 $40 Copay $10 Copay $60 Copay
Preventive Care Service	No charge
Chiropractic[1] (20 visit limit per calendar year)	$40 Copay, No Deductible
Lab and X-ray	Deductible plus 20% Coinsurance
Inpatient Hospital Services / **Outpatient Hospital Services,** Surgical Service	$500 Copay plus Deductible and 20% Coinsurance / $250 Copay plus Deductible and 20% Coinsurance
Urgent Care	$40 Copay, No Deductible
Emergency Room	$200 Copay plus 20% Coinsurance, No Deductible (Copay waived if admitted)
Ambulance	$250 Copay per trip, No Deductible
Rehab Therapy[1] Physical, Occupational, Speech (30 visit combined limit per calendar year)	$40 Copay, No Deductible
Dialysis[1] 39 lifetime visits	20% Coinsurance, No Deductible
Home Health Care[1] (100 visit limit per calendar year)	Deductible plus 20% Coinsurance
Durable Medical Equipment	20% Coinsurance, No Deductible
Bariatric Procedure	Not covered
Sleep Study • Home Study / Blue Shield of CA Sleep Lab • DME Supplies	 $200 Copay / $500 Copay 20% Coinsurance, No Deductible

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

THIS IS A SUMMARY ONLY. SEE THE ELIGIBLE MEDICAL EXPENSES AND MEDICAL LIMITATIONS AND EXCLUSIONS SECTIONS FOR MORE INFORMATION.

SCHEDULE OF PRESCRIPTION COPAYS

Prescription drug coverage is provided through separate agreement(s) between the Plan Sponsor and a prescription program vendor.

Prescription coverage includes a retail feature with participating retail pharmacies and a mail order option. A "participating pharmacy" has a contract with the prescription program vendor to dispense drugs to Covered Persons. The mail order option allows a Covered Person to receive a larger quantity of a prescription and is generally useful for long-term or maintenance-type drugs. Prescriptions filled at non-participating pharmacies will not be covered.

Express Scripts	
Annual Out-of-Pocket Maximum	**Combined with Tier 2 Medical Out-of-Pocket Maximum**
Retail Pharmacy • Generic • Formulary Brand	**Up to 30-day Supply** $10 Copay $30 Copay
Maintenance Drugs (After 2nd refill) • Generic • Formulary Brand	 $20 Copay $60 Copay
Specialty Drugs (Available through Accredo) • Generic • Formulary Brand	**Up to 30-day Supply** $200 Copay $300 Copay
Mail Order • Generic • Formulary Brand	**Up to 90-day Supply** $20 Copay $60 Copay
Prescription Drugs for the following conditions: • Asthma • Diabetes • High Blood Pressure • Heart Disease • High Cholesterol	**Up to 90-day Supply** Generic: $10 Copay Formulary Brand: $30 Copay

NOTE: RX COPAYS AND PERCENTAGES ARE THE COVERED PERSON'S RESPONSIBILITY. HOWEVER, THE ANCILLARY FEE (DIFFERENCE IN COST BETWEEN THE BRAND AND THE GENERIC) FOR A BRAND DRUG WILL NOT COUNT TOWARD THE OUT-OF-POCKET MAXIMUM IF A GENERIC DRUG IS AVAILABLE AND MEDICALLY APPROPRIATE (AS DETERMINED BY THE COVERED PERSON'S PERSONAL PHYSICIAN). BENEFITS UNDER THE PLAN, INCLUDING COST SHARING PROVISIONS SUCH AS COPAYS, ARE SUBJECT TO CHANGE.

PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

AMENDMENT 2
PRIME HEALTHCARE
PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION OF THE UNIFIED EPO PLAN AND PRESCRIPTION DRUG BENEFITS

EFFECTIVE MAY 1, 2023

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM AND A COPY OF THE SIGNED PLAN DOCUMENT TO:

Keenan & Associates
2355 Crenshaw Blvd. Suite 200
Torrance, CA 90501
Attention: Marcy Allen % dkong@keenan.com

The Plan Sponsor recognizes that it has full responsibility for the contents of the employee benefit document attached hereto and that, while Keenan & Associates, its employees and/or subcontractors, may have assisted in the preparation of the document, it is the Plan Sponsor who is responsible for the final text and meaning. The Plan Sponsor further certifies that the document has been fully read, understood, and describes its intent with regard to the employee benefit plan.

PLAN SPONSOR:

By: _____ Date: 6/12/2023
AUTHORIZED REPRESENTATIVE OF PLAN SPONSOR

THE ATTACHED EMPLOYEE BENEFIT DOCUMENT IS NOT INTENDED AS LEGAL ADVICE.

AMENDMENT 2

PRIME HEALTHCARE

PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION OF THE UNIFIED EPO PLAN AND PRESCRIPTION DRUG BENEFITS

Effective May 1, 2023, the Prime Healthcare Plan Document/Summary Plan Description of the Unified EPO Plan and Prescription Drug Benefits (the "Plan"), dated January 1, 2022, is hereby amended as follows:

The Section entitled "**PRESCRIPTION DRUG PROGRAM**" is deleted in its entirety and replaced with the following:

"PRESCRIPTION DRUG PROGRAM

Prescription drug coverage is provided through OptumRx – an independent prescription drug program Provider. The following is a summary of the program. See the attached addendum for Copay and additional details about the coverage provided through the prescription drug program.

Certain specialty drugs, such as injectables, must be obtained through OptumRx Specialty Pharmacy. In some cases, when a prescription drug is used for the first time, a one month's supply may be available from a retail pharmacy. For certain drugs, there is no opportunity for a one month's supply through a retail pharmacy.

HOW TO USE THE PRESCRIPTION DRUG PROGRAM

Using a Participating Pharmacy. To identify individuals as a Covered Persons for prescription drug benefits, individuals must present their ID Card to participating pharmacies when they have a prescription filled. Provided they have properly identified themselves as Covered Persons, a participating pharmacy will only charge them the Copay. Many participating pharmacies display an "Rx" decal with the OptumRx logo in their windows. For information on how to locate a participating pharmacy, a Covered Person should call (866) 339-3731.

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If a Covered Person presents a prescription to a participating pharmacy, and the participating pharmacy indicates that the prescription cannot be filled, or requires an additional Copay, this is not considered an Adverse Benefit Determination. If the Covered Person wants the prescription filled, they will have to pay either the full cost, or the additional Copay, for the prescription drug. If the Covered Person believes they are entitled to some Plan benefits in connection with the prescription drug, they should submit a claim for reimbursement to OptumRx at the address shown below:

OptumRx
PO Box 650334
Dallas, TX 75265-0334

Participating pharmacies usually have claims forms, but, if the participating pharmacy does not have claim forms, claim forms from customer service are available by calling (866) 339-3731. A Covered Person should mail their claim form, with the appropriate portion completed by the pharmacist, to

OptumRx within 180 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

Using a Non-Participating Pharmacy. The Plan does not provide any benefit for prescription drugs purchased at a non-participating pharmacy.

Out of State. If a Covered Person needs to purchase a prescription drug out of state, they may locate a participating pharmacy by calling (866) 339-3731.

When a Prescription is Ordered Through the Mail. Covered Persons can order their prescription through the mail service prescription drug program. Not all medications are available through the mail service pharmacy. The prescription must state the drug name, dosage, directions for use, quantity, the Physician's name and phone number, the Covered Person's name and address, and be signed by a Physician. The Covered Person must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. The Covered Person need only pay the cost of his Copay. A Covered Person's first mail service prescription must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number below. Covered Persons need only enclose the prescription or refill notice, and the appropriate payment for any subsequent mail service prescriptions or call the toll-free number. Copays can be paid by check, money order or credit card. Order forms can be obtained by contacting customer service at (866) 339-3731 or by accessing the website at Optum RX | Fast, Free Prescription Delivery.

Maintenance Medication Program. The prescription-drug benefit includes a maintenance medication program – for those medications taken regularly to treat ongoing conditions. This program can help Covered Persons save time, spend less and stay safe by getting these medications through Home Delivery. Covered Persons can receive two fills of each maintenance medication at his participating retail pharmacy. After that, they may order these prescriptions through Home Delivery from the OptumRx Pharmacy, or per the Plan, pay a higher Copay at the participating retail pharmacy.

- Mail the prescriptions – Request a Home Delivery order form by calling customer service at (866) 339-3731;

  OR

- Use the website or ask OptumRx to call the Covered Person's Physician – OptumRx will call the Covered Person's Physician to get a new prescription for Home Delivery. This process typically takes 10 business days from the time the Covered Person completes his online request. Just visit:

Optum RX | Fast, Free Prescription Delivery
If a Covered Person doesn't have Internet access, call: (866) 339-3731
24 hours/7 days per week

PRESCRIPTION DRUG UTILIZATION REVIEW

OptumRx prescription drug benefits include utilization review of prescription drug usage for its Covered Person's health and safety. Certain drugs may require prior authorization. If there are patterns of over-utilization or misuse of drugs, a medical consultant will notify the Covered Person's personal Physician and his pharmacist. The Plan reserves the right to limit benefits to prevent overutilization of drugs.

PRESCRIPTION DRUG FORMULARY

OptumRx uses a prescription drug formulary to help a Covered Person's doctor make prescribing decisions. The presence of a drug on the Plan's formulary list does not guarantee that the Covered Person will be prescribed that drug by their Physician. This list of Outpatient prescription drugs is developed by a committee of Physicians and pharmacists to determine which medications are sound, therapeutic and cost-effective choices. These medications, which include both generic and brand name drugs, are listed in the prescription drug formulary. The committee updates the formulary quarterly to ensure that the list includes drugs that are safe and effective. NOTE: The formulary drugs may change from time to time. Some drugs may require prior authorization. If a Covered Person has a question regarding whether a particular drug is on OptumRx formulary drug list or requires prior authorization, they should call OptumRx at (866) 339-3731.

Specialty drugs will be provided through OptumRx Specialty Pharmacy. If the Plan denies a request for prior authorization of a drug that is not part of the formulary, a Covered Person's Physician may file an appeal by following the procedures described in the OptumRx Claims Disclosure Notice detailing why the Physician believes an exception to the formulary should be made.

PRESCRIPTION DRUG CONDITIONS OF SERVICE

To be covered, the drug or medication must satisfy all of the following requirements:

- It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.
- It must be approved for general use by the Food and Drug Administration (FDA) or similar state agency.
- It must be for the direct care and treatment of a Covered Person's Illness, Injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However, formulas prescribed by a Physician for the treatment of phenylketonuria are covered.
- It must be dispensed from a licensed retail pharmacy, or through the mail service program.
- It must not be used while a Covered Person is an Inpatient in any facility. Also, it must not be dispensed in or administered by an Outpatient facility.
- For a retail pharmacy, the prescription must not exceed a 30-day supply.
- For the mail service program, the prescription must not exceed a 90-day supply.
- The drug will be covered only if it is not covered under another benefit of the Plan.

Step Therapy – Drugs in certain ongoing drug therapy categories could be subject to Step Therapy. Step Therapy is a program in which certain drug classes are organized in a set of "steps" with generic drugs being the first step and brand name drugs being the second step. Please call OptumRx at (866) 339-3731 for more information if you have a question regarding a specific medication.

COVERED PRESCRIPTION DRUGS

Covered drugs include most prescription drugs (i.e., federal legend drugs which are prescribed by a Physician and which require a prescription either by federal or state law – and including off-label drugs covered and dispensed by the prescription program vendor) and certain non-prescription items.

The following is a list of prescription and non-prescription drugs and supplies which are sometimes excluded by group health plans, but which are covered by this Plan:

Breast Cancer, Chemoprevention – see **Appendix A**.

Contraceptives – Subject to reasonable medical management techniques, the Plan will cover, without cost-sharing, all categories of Food and Drug Administration (FDA) approved contraceptive drugs for all individuals with reproductive capacity, as prescribed by a Network Provider and purchased through OptumRx. See **Appendix A**.

Abortifacient drugs are not covered except to the extent administered in the course of an Abortion covered under the Plan, and in such cases are not covered as Preventive Care.

Dermatology Drugs – Tretinoin agents used in the treatment of acne for Covered Persons through age 25.

NOTE: DEPIGMENTATION PRODUCTS USED FOR SKIN CONDITIONS REQUIRING A BLEACHING AGENT ARE NOT COVERED.

Diabetic Supplies – Insulin and diabetic supplies including syringes, needles, insulin injectable devices, pump supplies, swabs, blood glucose calibration solutions, and urine tests.

NOTE: THE PLAN WILL COVER ONE (1) DIABETIC TESTING MONITOR EVERY 365 DAYS AT NO COST TO THE COVERED PERSON.

Folic Acid, Fluoride, Aspirin, and Iron Supplements – see **Appendix A**.

Hormone Replacement Therapy – Continuous hormone replacement therapy for the treatment of Gender Dysphoria.

Hyperactivity (ADD, ADHD) Drugs – (i.e., Exubera, Dexedrine, Desoxyn, and Adderall)

Smoking Cessation/Deterrent Drugs – Any type of drug or supply for smoking cessation (e.g., Zyban, Nicotrol Inhaler).

EXPENSES NOT COVERED

Prescription Drug Expenses will not include any of the following:

Administration – Any charge for the administration of a drug.

Blood, Blood Plasma and Biological Sera

Cosmetic Products – Cosmetic-type drugs including photo-aged skin products such as Renova and Avage.

- Hair growth agents such as Propecia and Vaniqa.
- Injectable cosmetics such as Botox.

Equipment, Devices, Etc. – Devices of any type, even though such devices may require a prescription. These include but are not limited to:

- Peak flow meters;
- Non-insulin syringes; and
- Artificial appliances or braces.

Erectile Dysfunction Drugs – Erectile dysfunction drugs (e.g., Viagra, Levitra, Cialis, Muse, Caverject, or Edex).

Excess Refills – Refills which exceed the number of times specified by a Physician or which are dispensed more than one (1) year from the date of the Physician's prescription order.

Experimental and Non-FDA Approved Drugs – Experimental drugs and medicines, even though a charge is made to the Covered Person. Any drug not approved by the Food and Drug Administration. This exclusion does not apply to (i) off-label drugs covered and dispensed by the prescription program vendor, and (ii) covered drugs dispensed in connection with Clinical Trials.

Fertility Drugs – Except Oral/Vaginal drugs are covered.

Hair Loss Drugs – see "Cosmetic Products."

Homeopathic Drugs – Homeopathic drugs, legend or non-legend.

Immunization Agents – Serums, toxoids or vaccines, except those which are Preventive Care Services. See **Appendix A and Eligible Medical Expenses** Sections for more information on covered vaccinations.

Investigational Drugs – A drug or medicine labeled: "Caution – limited by federal law to investigational use."

No Charge – A prescribed drug which may be properly received without charge under a local, state or federal program or for which the cost is recoverable under any workers' compensation or occupational disease law.

Non-Home Use – Drugs intended for use in a Health Care Facility (Hospital, Skilled Nursing Facility, etc.) or in Physician's office or setting other than home use.

Non-Prescription Drugs – A drug or medicine that is bought without a written prescription. This does not apply to insulin.

Ostomy Supplies

OTC Equivalents – Except as provided herein or in the **Appendix A**, products obtained "over-the-counter" (i.e., without a prescription) that are identical to prescription drugs in active chemical ingredient, dosage form, strength and route of administration.

Vitamins – Legend and non-legend vitamins, except for prenatal vitamins and legend fluoride products.

Weight Management Drugs – Drugs used to suppress appetite and control fat absorption (e.g., Xenical, Meridia).

DISCLAIMER: THIS PRESCRIPTION INFORMATION IS ONLY A SUMMARY. IF THERE ARE ANY CONFLICTS BETWEEN THIS PRESCRIPTION INFORMATION AND THE TERMS OF AGREEMENT(S) BETWEEN THE PLAN SPONSOR AND THE PRESCRIPTION PROGRAM VENDOR, THE TERMS OF THE AGREEMENT(S) WILL GOVERN.

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, OptumRx 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 https://professionals.optumrx.com/prior-authorization.html.

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 it to:

OptumRx Prior Authorization Appeals
PO Box 2975
Mission, KS 66201

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) 711-4555 5am to 10pm PST Monday-Friday.

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 OptumRx. 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 and mail to:

  OptumRx Prior Authorization Appeals
  PO Box 2975
  Mission, KS 66201

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.

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, CA 91761
Attention: EHP

Administrative Review Requests:
Prime Healthcare Employee Benefits Plan
3480 East. Guasti Road
Ontario, CA 91761
Attention: EHP

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

Prime Healthcare Employee Benefits Plan
3480 East. Guasti Road
Ontario, CA 91761
Attention: EHP"

There are no other changes to the Plan.

Prime Healthcare Unified EPO 2023 – Amendment 1 to Addendum 18 changes effective May 1, 2023 are as follows:

> The Section entitled "**SCHEDULE OF PRESCRIPTION COPAYS**" is hereby amended by removing any reference to "Express Scripts" and replacing with "OptumRx" and any reference to "Accredo" is replaced with "OptumRx Specialty Pharmacy."

There are no other changes to this Addendum 18.

PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

AMENDMENT 3
PRIME HEALTHCARE
PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION OF THE UNIFIED EPO PLAN AND PRESCRIPTION DRUG BENEFITS

EFFECTIVE MAY 11, 2023

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM AND A COPY OF THE SIGNED PLAN DOCUMENT TO:

Keenan & Associates
2355 Crenshaw Blvd. Suite 200
Torrance, CA 90501
Attention: Marcy Allen % dkong@keenan.com

The Plan Sponsor recognizes that it has full responsibility for the contents of the employee benefit document attached hereto and that, while Keenan & Associates, its employees and/or subcontractors, may have assisted in the preparation of the document, it is the Plan Sponsor who is responsible for the final text and meaning. The Plan Sponsor further certifies that the document has been fully read, understood, and describes its intent with regard to the employee benefit plan.

PLAN SPONSOR: Prime Healthcare Services

By: _____ Date: 8/25/2023
AUTHORIZED REPRESENTATIVE OF PLAN SPONSOR

THE ATTACHED EMPLOYEE BENEFIT DOCUMENT IS NOT INTENDED AS LEGAL ADVICE.

AMENDMENT 3

PRIME HEALTHCARE

PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION OF THE UNIFIED EPO PLAN AND PRESCRIPTION DRUG BENEFITS

Effective May 11, 2023, the Prime Healthcare Plan Document/Summary Plan Description of the Unified EPO Plan and Prescription Drug Benefits (the "Plan"), dated January 1, 2022, is hereby amended as follows:

1. The Section entitled "**PRESCRIPTION DRUG PROGRAM**" is hereby amended by adding the following covered OTC drug under the subsection "**COVERED PRESCRIPTION DRUGS**":

   "**COVID-19 Test Kits (OTC)** – Limited to four tests per Participant per month."

2. Amend "**APPENDIX A – PREVENTIVE CARE SERVICES**" by removing the following line item:

COVID-19 Over-the-Counter (OTC) Tests	COVID-19, at home OTC test kits, up to eight tests per Covered Person per month. Reimbursement is limited to up to $12.00 per at-home test kit. There is no limit on the number of tests, OTC COVID tests, that are covered if ordered or administered by a health care provider following an individualized clinical assessment.

3. Remove **APPENDIX C** in its entirety.

There are no other changes to the Plan.

PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

AMENDMENT 4
PRIME HEALTHCARE
PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION OF THE UNIFIED EPO PLAN AND PRESCRIPTION DRUG BENEFITS
EFFECTIVE JANUARY 1, 2024

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM AND A COPY OF THE SIGNED PLAN DOCUMENT TO:

Keenan & Associates
2355 Crenshaw Blvd. Suite 200
Torrance, CA 90501
Attention: Marcy Allen mallen4@keenan.com

The Plan Sponsor recognizes that it has full responsibility for the contents of the employee benefit document attached hereto and that, while Keenan & Associates, its employees and/or subcontractors, may have assisted in the preparation of the document, it is the Plan Sponsor who is responsible for the final text and meaning. The Plan Sponsor further certifies that the document has been fully read, understood, and describes its intent with regard to the employee benefit plan.

PLAN SPONSOR:

By:_____ Date: 01/02/2024
AUTHORIZED REPRESENTATIVE OF PLAN SPONSOR

THE ATTACHED EMPLOYEE BENEFIT DOCUMENT IS NOT INTENDED AS LEGAL ADVICE.

AMENDMENT 4

PRIME HEALTHCARE

PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION OF THE UNIFIED EPO PLAN AND PRESCRIPTION DRUG BENEFITS

Effective January 1, 2024, the Prime Healthcare Plan Document/Summary Plan Description of the Unified EPO Plan and Prescription Drug Benefits (the "Plan"), dated January 1, 2022, is hereby amended as follows:

1. The Section entitled "**INTRODUCTION**" is hereby amended by replacing the first paragraph with the following:

   "The Plan is designed to provide Covered Medical Expenses and Covered Prescription Drugs to Employees of Prime Healthcare Services, Inc., Prime Healthcare Foundation, Inc., and the subsidiaries and affiliates of Prime Healthcare Services, Inc. and Prime Healthcare Foundation, Inc., as well as to the Employees' eligible Dependents."

2. The Section entitled **"ELIGIBLE MEDICAL EXPENSES"** is hereby amendment by adding the following note under the entry "**Ambulance**" at page 12:

   "NOTE: THE AMBULANCE COPAYMENT APPLIES PER TRIP EXCEPT WHEN DIRECTED BY PRIME UM AND TRANSFER IS INITIATED BY A PRIME FACILITY TO A NON-PRIME FACILITY FOR HIGHER LEVEL OF CARE OR REPATRIATED TO A PRIME FACILITY FROM A NON-PRIME FACILITY IN SUCH SCENARIOS, COPAYMENT WILL BE WAIVED."

3. The Section entitled "**ELIGIBILITY AND EFFECTIVE DATES**" is hereby amended by adding the following paragraph after the second paragraph under "**ELIGIBILITY REQUIREMENTS – EMPLOYEES**" at page 50:

   "Eligible Employees of an acquired company who are Active Service and were covered under the prior plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the waiting period of this plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition."

4. The Section entitled "**EXTENSION OF COVERAGE FOR HANDICAPPED DEPENDENT CHILDREN** at page 57 is hereby amended by removing this section and replacing it with the following:

   "EXTENSION OF COVERAGE FOR HANDICAPPED DEPENDENT CHILDREN ENROLLED PRIOR TO JANUARY 1, 2024

   NOTE: Newly hired and newly eligible Employees are not eligible for this extension of coverage if hired or newly eligible after December 31, 2023.

   If a Dependent child enrolled prior to January 1st, 2024, is incapable of self-support due to a mental or physical disability that began before the child attained the maximum age of 26 (regardless of current age), and such child is unable to be independent and is entirely

dependent upon the Employee for support and maintenance, coverage may continue past the maximum age.

The Employee must submit proof of the child's incapacity to the Plan Administrator within thirty-one (31) days of the child's attainment of the maximum age and as may reasonably be required thereafter, but not more frequently than once a year.

A child's coverage will cease on the earlier of the following: (1) cessation of the disability; (2) the child is no longer primarily dependent upon the Employee for support and maintenance; (3) Employee's failure to provide proof that the disability continues when such proof is requested; or (4) when the child ceases to be eligible for any reason other than reaching the maximum age."

5. The Section entitled "**ASSIGNMENT TO PROVIDERS**" at page 62 is hereby amended by removing first paragraph and replacing it with the following:

"No benefits will be subject to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void. This means, for example, you may not assign to anyone your right to file a lawsuit against the Plan. Benefits under the Plan may be subject to a Qualified Medical Child Support Order (QMCSO), however."

6. The Section entitled "**ADMINISTRATIVE PROVISION**" is hereby amended by removing the subsection "**Anticipation, Alienation, Sale or Transfer**" at page 101 and replacing it with the following:

"**Anticipation, Alienation, Sale or Transfer**
No benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims."

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

There are no other changes to the Plan.

APPENDIX A
2024 PREVENTIVE CARE SERVICES

Preventive Care Services are based on recommendations of the U.S. Preventive Services 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 http://www.uspreventiveservicestaskforce.org/uspstf/.

- 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	*REVISED*

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.
Anxiety in Children and Adolescents: Screening: children and adolescents aged 8 to 18 years	The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 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.
Behavioral counseling interventions for healthy weight and weight gain: pregnant persons	The USPSTF recommends that clinicians offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
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.

TOPIC	DESCRIPTION
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, including pregnant 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 45 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. A colonoscopy conducted after a positive "non-invasive stool-based" screening test or direct visualization screening test (including prior consultation, bowel preparation meds, anesthesia services, etc.).
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 primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. The USPSTF recommends primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.
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.
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.

TOPIC	DESCRIPTION
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.
Diabetes in Pregnancy Screening	WPSI recommends screening pregnant women for gestational diabetes mellitus after 24 weeks of gestation (preferably between 24 and 28 weeks of gestation) to prevent adverse birth outcomes. WPSI recommends screening pregnant women with risk factors for type 2 diabetes or GDM before 24 weeks of gestation—ideally at the first prenatal visit.
Diabetes **after** Pregnancy Screening	WPSI recommends screening for type 2 diabetes in women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes. Initial testing should ideally occur within the first year postpartum and can be conducted as early as 4–6 weeks postpartum. Women who were not screened in the first year postpartum or those with a negative initial postpartum screening test result should be screened at least every 3 years for a minimum of 10 years after pregnancy. For those with a positive screening test result in the early postpartum period, testing should be repeated at least 6 months postpartum to confirm the diagnosis of diabetes regardless of the type of initial test (e.g., fasting plasma glucose, hemoglobin A1c, oral glucose tolerance test). Repeat testing is also indicated for women screened with hemoglobin A1c in the first 6 months postpartum regardless of whether the test results are positive or negative because the hemoglobin A1c test is less accurate during the first 6 months postpartum.
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
Gonorrhea screening: women, including pregnant 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.

Topic	Description
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.
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.
Hypertension screening: adults 18 years or older without known hypertension	The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement. The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
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: adults aged 50-80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 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.

Topic	Description
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.
Prediabetes and Type 2 Diabetes screening	The USPSTF recommends screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.
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 clinicians prescribe a statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.
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 nonpregnant adults who use tobacco.
Tobacco use counseling: pregnant persons	The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.

Topic	Description
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 childcare	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, tuberculin testing.
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.

2024-01

See Addendum for new or updated ACIP vaccine recommendations

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

UNITED STATES 2023

Vaccines in the Child and Adolescent Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
COVID-19†	1vCOV-mRNA	Comirnaty®/Pfizer-BioNTech COVID-19 Vaccine
		SPIKEVAX®/Moderna COVID-19 Vaccine
	2vCOV-mRNA	Pfizer-BioNTech COVID-19 Vaccine, Bivalent
		Moderna COVID-19 Vaccine, Bivalent
	1vCOV-aPS	Novavax COVID-19 Vaccine
Dengue vaccine	DEN4CYD	Dengvaxia®
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®
	Hib (PRP-OMP)	PedvaxHIB®
Hepatitis A vaccine	HepA	Havrix®
		Vaqta®
Hepatitis B vaccine	HepB	Engerix-B®
		Recombivax HB®
Human papillomavirus vaccine	HPV	Gardasil 9®
Influenza vaccine (inactivated)†	IIV4	Multiple
Influenza vaccine (live, attenuated)†	LAIV4	FluMist® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R II®
		Priorix®
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D	Menactra®
	MenACWY-CRM	Menveo®
	MenACWY-TT	MenQuadfi®
Meningococcal serogroup B vaccine	MenB-4C	Bexsero®
	MenB-FHbp	Trumenba®
Pneumococcal conjugate vaccine†	PCV13	Prevnar 13®
	PCV15	Vaxneuvance™
Pneumococcal polysaccharide vaccine†	PPSV23	Pneumovax 23®
Poliovirus vaccine (inactivated)†	IPV	POL®
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 (If combination vaccine is not available or not indicated, administer component vaccines separately.)		
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®
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b, and hepatitis B vaccine	DTaP-IPV-Hib-HepB	Vaxelis®
Measles, mumps, rubella, and varicella vaccine	MMRV	ProQuad®
New Vaccines and Other Immunizing Agents added to the Schedule since February 2023 (see Addendum)		
RSV monoclonal antibody (Nirsevimab)	RSV-mAb	Beyfortus™
Pneumococcal conjugate vaccine	PCV20	Prevnar 20™

*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.
†COVID-19, Polio virus, Influenza, and Pneumococcal vaccines have new or updated ACIP recommendations. Please see Addendum for more details.

How to use the child and 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 or other indication (Table 3)
4. Review vaccine types, frequencies, intervals, and considerations for special situations (Notes)
5. Review contraindications and precautions for vaccine types (Appendix)
6. Review new or updated ACIP guidance (Addendum)

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), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), and National Association of Pediatric Nurse Practitioners (www.napnap.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

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 Advisory Committee on Immunization Practices (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
- ACIP Shared Clinical Decision-Making Recommendations www.cdc.gov/vaccines/acip/acip-scdm-faqsh.html

Scan QR code for access to online schedule

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

CS310200-C

See Addendum for new or updated ACIP vaccine recommendations

Table 1 Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2023

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).

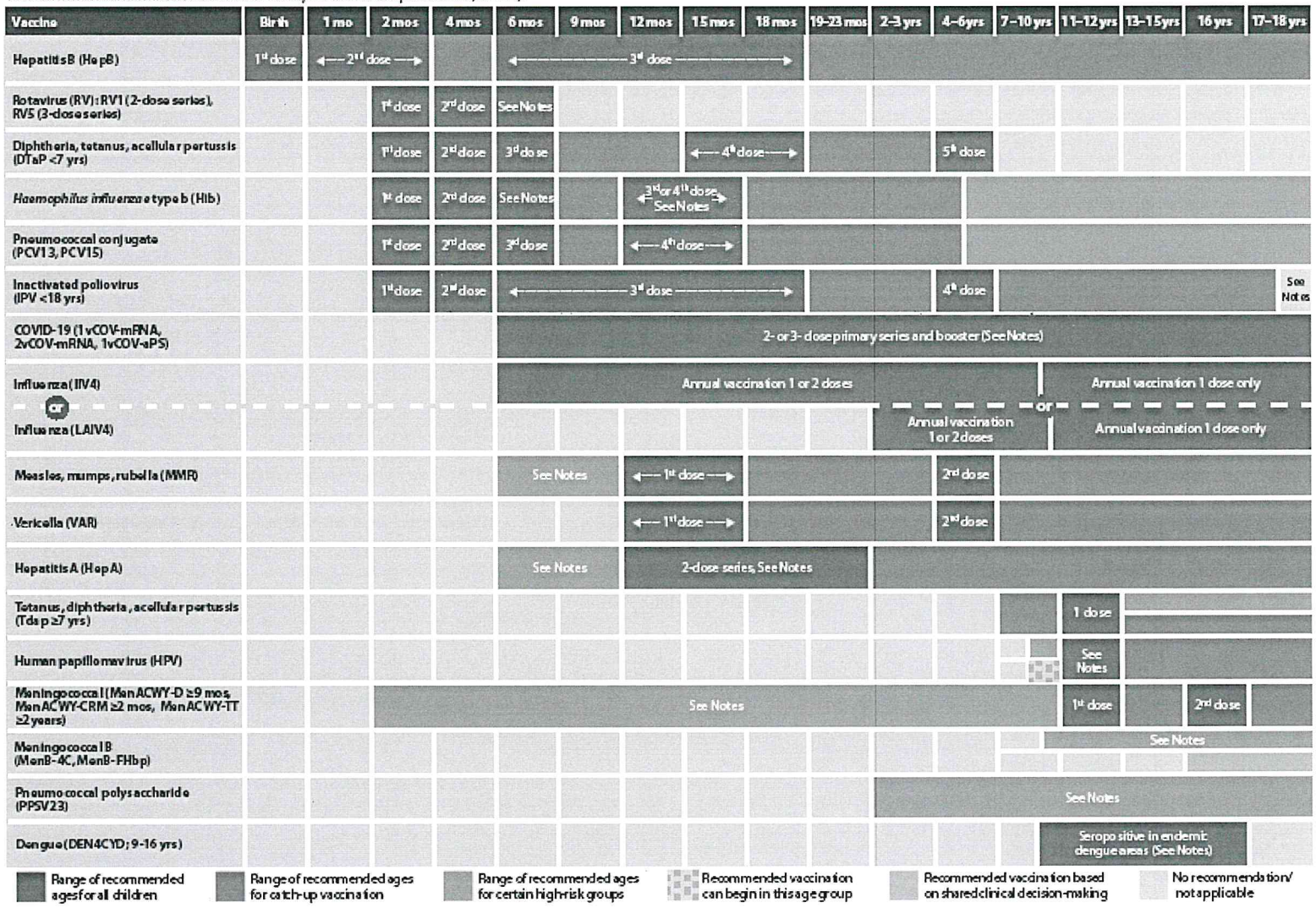


Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind, United States, 2023

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.**

Children age 4 months through 6 years

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
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®), Vaxelis® 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 was administered at younger than 15 months; OR If both doses were PedvaxHIB® 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 was 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 administered before age 12 months	**8 weeks (as final dose)** this dose is only necessary for children aged 12 through 59 months regardless of risk, or age 60 through 71 months with any risk, who received 3 doses before age 12 months.	
Inactivated poliovirus	6 weeks	4 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 2 years MenACWY-TT	8 weeks	See Notes	See Notes	

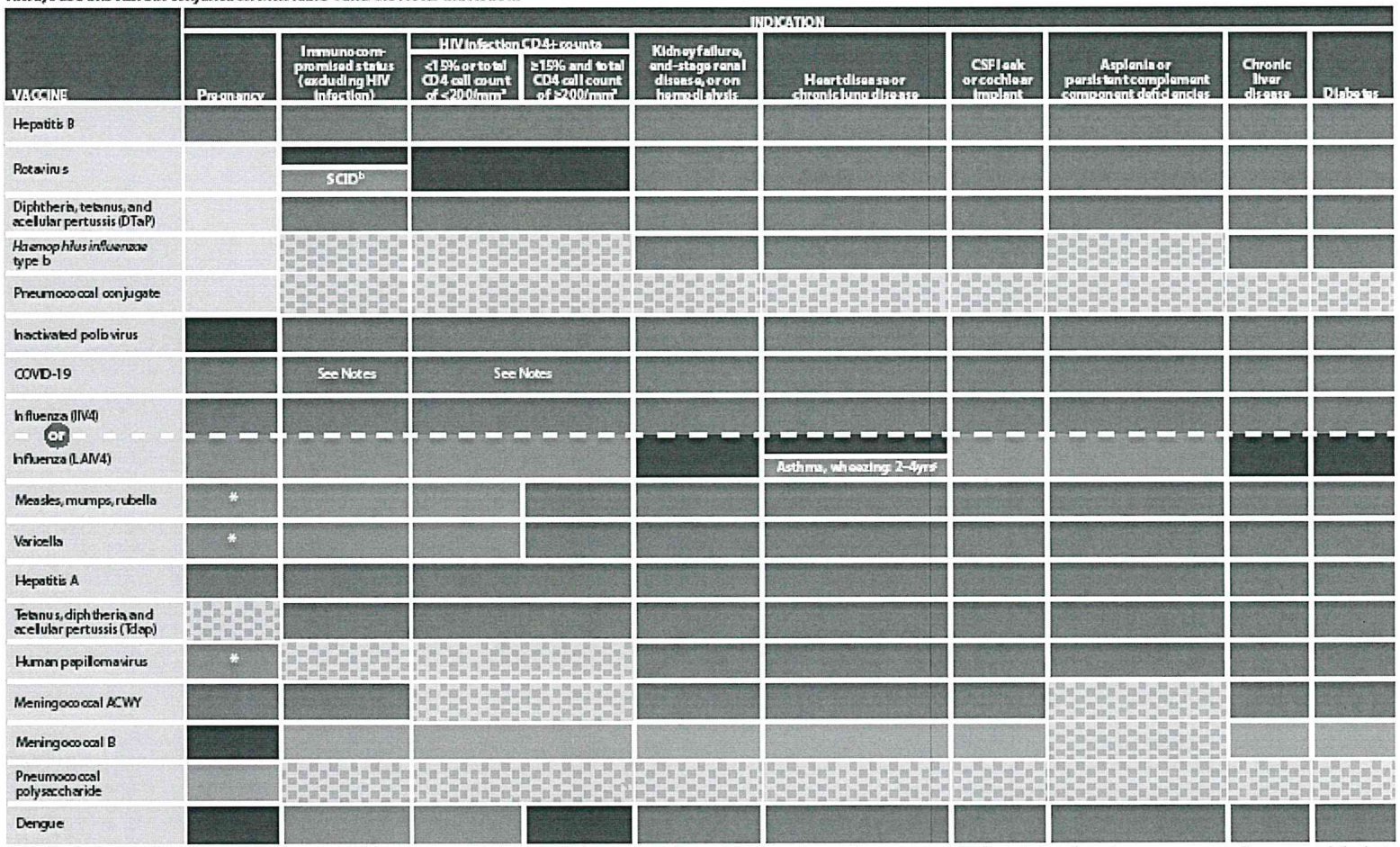
Children and adolescents age 7 through 18 years

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			
Dengue	9 years	6 months	6 months		

Table 3

Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2023

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



a. 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/adip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote J) at www.cdc.gov/vaccines/hcp/adip-recs/general-recs/contraindications.html.
b. Severe Combined Immunodeficiency
c. LAIV4 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

Notes

See Addendum for new or updated ACIP vaccine recommendations

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2023

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2023.

Additional information

- Consult relevant ACIP statements for detailed recommendations 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 3-2, 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 vaccination 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, Barnett ED, Lynfield Ruth, Sawyer MH, eds. *Red Book: 2021–2024 Report of the Committee on Infectious Diseases*. 32nd ed. Itasca, IL: American Academy of Pediatrics; 2021:72–86).
- For information about 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 vaccines included in the child and adolescent vaccine schedule are covered by VICP except dengue, PPSV23, and COVID-19 vaccines. COVID-19 vaccines that are authorized or approved by the FDA are covered by the Countermeasures Injury Compensation Program (CICP). For more information, see www.hrsa.gov/vaccinecompensation or www.hrsa.gov/cicp.

COVID-19 vaccination (minimum age: 6 months [Moderna and Pfizer-BioNTech COVID-19 vaccines], 12 years [Novavax COVID-19 Vaccine])

Routine vaccination

- **Primary series:**
  - **Age 6 months–4 years:** 2-dose series at 0, 4-8 weeks (Moderna) or 3-dose series at 0, 3-8, 11-16 weeks (Pfizer-BioNTech)
  - **Age 5–11 years:** 2-dose series at 0, 4-8 weeks (Moderna) or 2-dose series at 0, 3-8 weeks (Pfizer-BioNTech)
  - **Age 12–18 years:** 2-dose series at 0, 4-8 weeks (Moderna) or 2-dose series at 0, 3-8 weeks (Novavax, Pfizer-BioNTech)
- For **booster dose recommendations** see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html

Special situations

Persons who are moderately or severely immunocompromised

- **Primary series**
  - **Age 6 months–4 years:** 3-dose series at 0, 4, 8 weeks (Moderna) or 3-dose series at 0, 3, 11 weeks (Pfizer-BioNTech)
  - **Age 5–11 years:** 3-dose series at 0, 4, 8 weeks (Moderna) or 3-dose series at 0, 3, 7 weeks (Pfizer-BioNTech)
  - **Age 12–18 years:** 3-dose series at 0, 4, 8 weeks (Moderna) or 2-dose series at 0, 3 weeks (Novavax) or 3-dose series at 0, 3, 7 weeks (Pfizer-BioNTech)
- **Booster dose:** see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html
- **Pre-exposure prophylaxis** (monoclonal antibodies) may be considered to complement COVID-19 vaccination. See www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#Immunocompromised

For Janssen COVID-19 Vaccine recipients see COVID-19 schedule at www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html

Note: Administer an age-appropriate vaccine product for each dose. Current COVID-19 schedule and dosage formulation available at www.cdc.gov/vaccines/covid-19/downloads/COVID-19-Immunization-schedule-ages-6months-older.pdf. For more information on Emergency Use Authorization (EUA) indications for COVID-19 vaccines, see www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines.

Dengue vaccination (minimum age: 9 years)

Routine vaccination

- Age 9–16 years living in areas with endemic dengue **AND** have laboratory confirmation of previous dengue infection
  - 3-dose series administered at 0, 6, and 12 months
- Endemic areas include Puerto Rico, American Samoa, US Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau. For updated guidance on dengue endemic areas and pre-vaccination laboratory testing see www.cdc.gov/mmwr/volumes/70/rr/rr7006a1.htm?s_cid=rr7006a1_w and www.cdc.gov/dengue/vaccine/hcp/index.html
- Dengue vaccine should not be administered to children traveling to or visiting endemic dengue areas.

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

Routine vaccination

- 5-dose series at age 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 age 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.

Special situations

- **Wound management** in children less than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine: For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

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

Routine vaccination

- **ActHIB®, Hiberix®, Pentacel®, or Vaxelis®:** 4-dose series (3-dose primary series at age 2, 4, and 6 months, followed by a booster dose® at age 12–15 months)
  - "Vaxelis® is not recommended for use as a booster dose. A different Hib-containing vaccine should be used for the booster dose.
- **PedvaxHIB®:** 3-dose series (2-dose primary series at age 2 and 4 months, followed by a booster dose at age 12–15 months)

Catch-up vaccination

- **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) at least 8 weeks after dose 2.
- **2 doses of PedvaxHIB® before age 12 months:** Administer dose 3 (final dose) at age 12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 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. Vaxelis® can be used for catch-up vaccination in children less than age 5 years. Follow the catch-up schedule even if Vaxelis® is used for one or more doses. For detailed information on use of Vaxelis® see www.cdc.gov/mmwr/volumes/69/wr/mm6905a5.htm.

Special situations

- **Chemotherapy or radiation treatment:**
  Age 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):**
  Age 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:**
  Age 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:**
  Age 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 age 14 months) OR no doses (age 15 months or older)

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

Routine vaccination

- 2-dose series (minimum interval: 6 months) at age 12–23 months

Catch-up vaccination

- Unvaccinated persons through age 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 age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix®**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster 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 age 12–23 months.
  - **Unvaccinated age 12 months or older:** Administer dose 1 as soon as travel is considered.

Hepatitis B vaccination (minimum age: birth)

Routine vaccination

- 3-dose series at age 0, 1–2, 6–18 months **(use monovalent HepB vaccine for doses administered before age 6 weeks)**
  - Birth weight ≥2,000 grams: 1 dose within 24 hours of birth if medically stable
  - Birth weight <2,000 grams: 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still <2,000 grams).
- Infants who did not receive a birth dose should begin the series as soon as possible (see Table 2 for minimum intervals).
- Administration of 4 doses is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum intervals (see Table 2):** when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations
- **Final (3rd or 4th) dose:** age 6–18 months **(minimum age 24 weeks)**
- **Mother is HBsAg-positive**
  - **Birth dose (monovalent HepB vaccine only):** administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** (in separate limbs) within 12 hours of birth, regardless of birth weight.
  - **Birth weight <2000 grams:** administer 3 additional doses of HepB vaccine beginning at age 1 month (total of 4 doses)
  - **Final (3rd or 4th) dose:** administer at age 6 months **(minimum age 24 weeks)**
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.

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- **Mother is HBsAg-unknown**

If other evidences suggestive of maternal hepatitis B infection exists (e.g., presence of HBV DNA, HBeAg-positive, or mother known to have chronic hepatitis B infection), manage infant as if mother is HBsAg-positive

- **Birth dose (monovalent HepB vaccine only):**
  - Birth weight ≥2,000 grams: administer **HepB vaccine** within 12 hours of birth. Determine mother's HBsAg status as soon as possible. If mother is determined to be HBsAg-positive, administer **HBIG** as soon as possible (in separate limb), but no later than 7 days of age.
  - Birth weight <2,000 grams: administer **HepB vaccine** and **HBIG** (in separate limbs) within 12 hours of birth. Administer 3 additional doses of **HepB vaccine** beginning at age 1 month (total of 4 doses)
- **Final (3rd or 4th) dose:** administer at age 6 months **(minimum age 24 weeks)**
- If mother is determined to be HBsAg-positive or if status remains unknown, test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.

Catch-up vaccination

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months. See Table 2 for minimum intervals
- 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 age 18 years or older may receive:
  - **Heplisav-B®:** 2-dose series at least 4 weeks apart
  - **PreHevbrio®:** 3-dose series at 0, 1, and 6 months
  - Combined HepA and HepB vaccine, **Twinrix®:** 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

Special situations

- Revaccination is not generally recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Post-vaccination serology testing and revaccination** (if anti-HBs < 10 mIU/mL) is recommended for certain populations, including:
  - Infants born to HBsAg-positive mothers
  - Persons who are predialysis or on maintenance dialysis
  - Other immunocompromised persons
  - For detailed revaccination recommendations, see www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html.

Note: Heplisav-B and PreHevbrio are not recommended in pregnancy due to lack of safety data in pregnant persons

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 9–14 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)
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted.
- No additional dose recommended when any HPV vaccine series has been completed using the recommended dosing intervals.

Special situations

- **Immunocompromising conditions, including HIV infection:** 3-dose series, even for those who initiate vaccination at age 9 through 14 years.
- **History of sexual abuse or assault:** Start at age 9 years
- **Pregnancy:** Pregnancy testing not needed before vaccination; HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant

Influenza vaccination (minimum age: 6 months [IIV], 2 years [LAIV4], 18 years [recombinant influenza vaccine, RIV4])

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, 2022, 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, 2022
  - 1 dose for **all persons age 9 years or older**
- For the 2022-2023 season, see www.cdc.gov/mmwr/volumes/71/rr/rr7101a1.htm.
- For the 2023–24 season, see the 2023–24 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) or required epinephrine or another emergency medical intervention: Any influenza vaccine appropriate for age and health status may be administered. If using egg-based IIV4 or LAIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions.
- **Severe allergic reaction (e.g., anaphylaxis) to a vaccine component or a previous dose of any influenza vaccine:** see Appendix listing contraindications and precautions
- **Close contacts (e.g., caregivers, healthcare personnel) of severely immunosuppressed persons who require a protected environment:** these persons should not receive LAIV4. If LAIV4 is given, they should avoid contact with/caring for such immunosuppressed persons for 7 days after vaccination.

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

Routine vaccination

- 2-dose series at age 12–15 months, age 4–6 years
- MMR or MMRV may be administered

Note: For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV may be used if parents or caregivers express a preference.

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.
- Minimum interval between MMRV doses: 3 months

Notes

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Special situations

- **International travel**
  - **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series at age 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 or older:** 2-dose series at least 4 weeks apart before departure
- In mumps outbreak settings, for information about additional doses of MMR (including 3rd dose of MMR), see www.cdc.gov/mmwr/volumes/67/wr/mm6701a7.htm

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

Routine vaccination

- 2-dose series at age 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 2 months: 4-dose series (additional 3 doses at age 4, 6, and 12 months)
  - Dose 1 at age 3–6 months: 3- or 4-dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 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 PCV series.
- **MenQuadfi***
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

Travel to 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 age 2 months: 4-dose series (additional 3 doses at age 4, 6, and 12 months)
    - Dose 1 at age 3–6 months: 3- or 4-dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 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)
  - **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**, Menactra*, or MenQuadfi*

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**, Menactra*, or MenQuadfi***

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 component deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk.
- **Children for whom boosters are not recommended** (e.g., a healthy child 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.

**Menveo has two formulations: lyophilized and liquid. The liquid formulation should not be used before age 10 years.*

Note: Menactra* should be administered either before or at the same time as DTaP. MenACWY may be administered simultaneously with MenB vaccines if indicated, but at a different anatomic site, if feasible.

For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

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 (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed; if dose 3 is administered earlier than 4 months after dose 2, a 4th dose should be administered at least 4 months after dose 3)

Note: 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 additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

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Pneumococcal vaccination (minimum age: 6 weeks [PCV13], [PCV15], 2 years [PPSV23])

Routine vaccination with PCV

- 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV

- Healthy children age 24–59 months with any incomplete* PCV series: 1 dose PCV
- For other catch-up guidance, see Table 2.

Note: PCV13 and PCV15 can be used interchangeably for children who are healthy or have underlying conditions. PCV15 is not indicated for children who have received 4 doses of PCV13 or another age appropriate complete PCV13 series.

Special situations

Underlying conditions below: When both PCV and PPSV23 are indicated, administer PCV first. PCV 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 PCV doses: 1 dose PCV (at least 8 weeks after any prior PCV dose)
  - Less than 3 PCV doses: 2 doses PCV (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV doses)

Age 6–18 years

- Any incomplete* series with PCV: no further PCV doses needed
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV doses)

Cerebrospinal fluid leak, cochlear implant:

Age 2–5 years

- Any incomplete* series with:
  - 3 PCV doses: 1 dose PCV (at least 8 weeks after any prior PCV dose)
  - Less than 3 PCV doses: 2 doses PCV (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV doses)

Age 6–18 years

- No history of either PCV or PPSV23: 1 dose PCV, 1 dose PPSV23 at least 8 weeks later
- Any PCV but no PPSV23: 1 dose PPSV23 at least 8 weeks after the most recent dose of PCV
- PPSV23 but no PCV: 1 dose PCV at least 8 weeks after the most recent dose of PPSV23

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 PCV doses: 1 dose PCV (at least 8 weeks after any prior PCV dose)
  - Less than 3 PCV doses: 2 doses PCV (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV doses) and a dose 2 of PPSV23 5 years later

Age 6–18 years

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

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series see Table 2 in ACIP pneumococcal recommendations at www.cdc.gov/mmwr/volumes/71/wr/mm7137a3.htm

For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app, which can be downloaded here: www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumoapp.html

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 on 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 on 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 age 18 years or 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_%20cid=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.

Special situations

- **Adolescents aged 18 years at increased risk of exposure to poliovirus with:**
  - No evidence of a complete polio vaccination series (i.e., at least 3 doses): administer remaining doses (1, 2, or 3 doses) to complete a 3-dose series
  - Evidence of completed polio vaccination series (i.e., at least 3 doses): may administer one lifetime IPV booster

For detailed information, see: www.cdc.gov/vaccines/vpd/polio/hcp/recommendations.html

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2023

Rotavirus vaccination (minimum age: 6 weeks)

Routine vaccination

- **Rotarix®:** 2-dose series at age 2 and 4 months
- **RotaTeq®:** 3-dose series at age 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 age 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 the routine Tdap dose at age 11–12 years.
- **DTaP inadvertently administered on or after age 7 years:**
  - **Children age 7–9 years:** DTaP may count as part of catch-up series. Administer routine Tdap dose at age 11–12 years.
  - **Children age 10–18 years:** Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Table 2.

Special situations

- **Wound management** In persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.
- For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.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 age 12–15 months, 4–6 years
- VAR or MMRV may be administered*
- Dose 2 may be administered as early as 3 months after dose 1 (a dose inadvertently administered after at least 4 weeks may be counted as valid)

***Note:** For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV may be used if parents or caregivers express a preference.

Catch-up vaccination

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

Appendix Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2023

Guide to Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4-1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: Contraindication and Precautions available at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html *and ACIP's Recommendations for the Prevention and Control of 2022-23 seasonal influenza with Vaccines available at* www.cdc.gov/mmwr/volumes/71/rr/rr7101a1.htm.

For COVID-19 vaccine contraindications and precautions see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#contraindications

Vaccine	Contraindicated or Not Recommended[1]	Precautions[2]
Influenza, egg-based, inactivated injectable (IIV4)	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg)	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable [(ccIIV4), Flucelvax® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component[3] of ccIIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, recombinant injectable [(RIV4), Flublok® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component[3] of RIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, ccIIV, or LAIV of any valency. If using RIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, live attenuated [LAIV4, Flumist® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg) • Children age 2–4 years with a history of asthma or wheezing • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear or any other cranial CSF leak • Children and adolescents receiving aspirin or salicylate-containing medications • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons aged 5 years old or older • Persons with underlying medical conditions (other than those listed under contraindications) that might predispose to complications after wild-type influenza virus infection [e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus)] • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states

Appendix Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2023

Vaccine	Contraindicated or Not Recommended[1]	Precautions[2]
Dengue (DEN4CYD)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Lack of laboratory confirmation of a previous Dengue infection	• Pregnancy • HIV infection without evidence of severe immunosuppression • Moderate or severe acute illness with or without fever
Diphtheria, tetanus, pertussis (DTaP) Tetanus, diphtheria (DT)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For DTaP only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP or DTaP	• Guillain-Barré syndrome (GBS) within 6 weeks after previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid–containing or tetanus-toxoid–containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid–containing vaccine • For DTaP only: Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP until neurologic status clarified and stabilized • Moderate or severe acute illness with or without fever
Haemophilus influenzae type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Hiberix, ActHib, and Pedvax-HB only: History of severe allergic reaction to dry natural latex • Less than age 6 weeks	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including yeast • *Pregnancy: Heplisav-B and PreHevbrio are not recommended due to lack of safety data in pregnant persons. Use other hepatitis B vaccines if HepB is indicated[4].*	• Moderate or severe acute illness with or without fever
Hepatitis A-Hepatitis B vaccine (HepA-HepB), (Twinrix®[1])	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • *Pregnancy: HPV vaccination not recommended.*	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR) Measles, mumps, rubella, and varicella (MMRV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing • Moderate or severe acute illness with or without fever • For MMRV only: Personal or family (i.e., sibling or parent) history of seizures of any etiology
Meningococcal ACWY (MenACWY) [MenACWY-CRM (Menveo®) MenACWY-D (Menactra®); MenACWY-TT (MenQuadfi®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For MenACWY-D and MenACWY-CRM only: severe allergic reaction to any diphtheria toxoid– or CRM197–containing vaccine • For MenACWY-TT only: severe allergic reaction to a tetanus toxoid–containing vaccine	• For MenACWY-CRM only: Preterm birth if less than age 9 months • Moderate or severe acute illness with or without fever
Meningococcal B (MenB) [MenB-4C (Bexsero®); MenB-FHbp (Trumenba®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • For MenB-4C only: Latex sensitivity • Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid–containing vaccine or its component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Poliovirus vaccine, inactivated (IPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • Moderate or severe acute illness with or without fever
Rotavirus (RV) [RV1 (Rotarix®), RV5 (RotaTeq®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe combined immunodeficiency (SCID) • History of intussusception	• Altered immunocompetence other than SCID • Chronic gastrointestinal disease • RV1 only: Spina bifida or bladder exstrophy • Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP, DTaP, or Tdap	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid–containing or tetanus-toxoid–containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid–containing vaccine • For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized • Moderate or severe acute illness with or without fever
Varicella (VAR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • Moderate or severe acute illness with or without fever • If using MMRV, see MMR, MMRV for additional precautions

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.
4. For information on the pregnancy exposure registries for persons who were inadvertently vaccinated with Heplisav-B or PreHevbrio while pregnant, please visit heplisavbpregnancyregistry.com/ or www.prehevbrio.com/#safety.

Addendum Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2023

In addition to the recommendations presented in the previous sections of this Immunization Schedule, ACIP has approved the following recommendations by majority vote since October 20, 2022. The following recommendations have been adopted by the CDC Director and are now official. Links are provided if these recommendations have been published in *Morbidity and Mortality Weekly Report (MMWR)*.

Vaccines and Other Immunizing Agents	Recommendation	Effective Date of Recommendation*
Respiratory syncytial virus (RSV)	• Maternal Respiratory Syncytial Virus (RSV) vaccine (ABRYSVO™) is recommended for pregnant people during 32 through 36 weeks gestation, using seasonal administration, to prevent RSV lower respiratory tract infection in infants.	September 22, 2023
COVID-19 (Moderna, Pfizer-BioNTech)	• All persons ≥6 months of age should receive 2023–2024 (monovalent, XBB containing) COVID-19 vaccines as authorized under EUA or approved by BLA. • Bivalent mRNA COVID-19 vaccines are no longer recommended in the United States • For detailed information, see www.cdc.gov/covidschedule	September 12, 2023
Respiratory syncytial virus [RSV-mAb (Nirsevimab)]	• All infants younger than 8 months and born shortly before or during the RSV season should receive 1 dose of nirsevimab within 1 week of birth either in hospital or outpatient setting • Infants younger than age 8 months not born during RSV season and now entering their first RSV season should receive 1 dose of nirsevimab shortly before the start of RSV season • Infants aged 8–19 months with chronic lung disease of prematurity requiring medical support (e.g., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) any time during the 6-month period before start of the second RSV season; severe immunocompromise; cystic fibrosis with weight for length <10th percentile; or with manifestation of severe lung disease (e.g., previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable) should receive 1 dose of nirsevimab shortly before start of second RSV season • Infants 8–19 months who are American Indian or Alaska Native should receive 1 dose of nirsevimab before start of second RSV season • Infants who are age-eligible and undergoing cardiac surgery with cardiopulmonary bypass should receive 1 additional dose of nirsevimab after surgery • For detailed information, see: www.cdc.gov/mmwr/volumes/72/wr/mm7234a4.htm?s_cid=mm7234a4_w	August 3, 2023
Poliovirus (IPV)	• Adolescents age 18 years who are known or suspected to be unvaccinated or incompletely vaccinated against polio should complete a primary vaccination series with inactivated polio vaccine (IPV). • Adolescents age 18 years who have received a primary series of trivalent oral polio vaccine (tOPV) or IPV in any combination and who are at increased risk of poliovirus exposure may receive another dose of IPV. Available data do not indicate the need for more than a single lifetime booster dose with IPV for adults.	June 27, 2023
Influenza (IIV4, ccIV4, RIV4, LAIV4)	• All persons ages ≥6 months with egg allergy should receive influenza vaccine. Any influenza vaccine (egg based or non-egg based) that is otherwise appropriate for the recipient's age and health status can be used. • Affirm the updated *MMWR* Recommendations and Reports, "Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices—United States, 2023-24 Influenza Season" www.cdc.gov/mmwr/volumes/72/rr/rr7202a1.htm	June 27, 2023
Pneumococcal (PCV15, PCV20)	• Use of either pneumococcal conjugate vaccines (PCV) PCV15 or PCV20 is recommended for all children aged 2–23 months according to currently recommended PCV dosing and schedules. • For children with an incomplete PCV vaccination status, use of either PCV15 or PCV20 according to currently recommended PCV dosing and schedules is recommended for: – Healthy children aged 24–59 months – Children with specified risk conditions* aged 24 through 71 months • For children aged 2–18 years with any risk condition who have received all recommended doses of PCV before age 6 years – Using ≥1 dose(s) of PCV20: No additional doses of any pneumococcal vaccine are indicated. This recommendation may be updated as additional data become available. – Using PCV13 or PCV15 (no PCV20): A dose of PCV20 or PPSV23 using previously recommended dosing and schedules is recommended. • For children aged 6–18 years with any risk condition who have not received any dose of PCV13, PCV15, or PCV20, a single dose of PCV15 or PCV20 is recommended. When PCV15 is used, it should be followed by a dose of PPSV23 at least 8 weeks later if not previously given. *Risk conditions include: cerebrospinal fluid leak; chronic heart disease; chronic kidney disease (excluding maintenance dialysis and nephrotic syndrome, which are included in immunocompromising conditions); chronic liver disease; chronic lung disease (including moderate persistent or severe persistent asthma); cochlear implant; diabetes mellitus; immunocompromising conditions (on maintenance dialysis or with nephrotic syndrome; congenital or acquired asplenia or splenic dysfunction; congenital or acquired immunodeficiencies; diseases and conditions treated with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and solid organ transplant; HIV infection; and sickle cell disease and other hemoglobinopathies).	June 27, 2023

*The effective date is the date when the CDC director adopted the recommendation and when the ACIP recommendation became official

See Addendum for new or updated ACIP vaccine recommendations

Recommended Adult Immunization Schedule for ages 19 years or older 2023

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 or other indication (Table 2)
3. Review vaccine types, dosing frequencies and intervals, and considerations for special situations (Notes)
4. Review contraindications and precautions for vaccine types (Appendix)
5. Review new or updated ACIP guidance (Addendum)

Vaccines in the Adult Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
COVID-19 vaccine†	1vCOV-mRNA	Comirnaty®/Pfizer-BioNTech COVID-19 Vaccine SPIKEVAX®/Moderna COVID-19 Vaccine
	2vCOV-mRNA	Pfizer-BioNTech COVID-19 Vaccine, Bivalent Moderna COVID-19 Vaccine, Bivalent
	1vCOV-aPS	Novavax COVID-19 Vaccine
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® Heplisav-B® PreHevbrio® Recombivax HB®
Human papillomavirus vaccine	HPV	Gardasil 9®
Influenza vaccine (inactivated)†	IIV4	Many brands
Influenza vaccine (live, attenuated)†	LAIV4	FluMist® Quadrivalent
Influenza vaccine (recombinant)†	RIV4	Flublok® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R II® Priorix®
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM MenACWY-TT	Menactra® Menveo® MenQuadfi®
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero® Trumenba®
Pneumococcal conjugate vaccine	PCV15 PCV20	Vaxneuvance™ Prevnar 20™
Pneumococcal polysaccharide vaccine	PPSV23	Pneumovax 23®
Poliovirus vaccine†	IPV	IPOL®
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
New vaccines added to the Schedule since February 2022 (see Addendum)		
Respiratory Syncytial Virus vaccine	RSV	Arexvy® ABRYSVO™

*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.

†COVID-19, Poliovirus, and Influenza vaccines have new or updated ACIP recommendations. Please see Addendum for more details.

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), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), American Pharmacists Association (www.pharmacist.com), and Society for Healthcare Epidemiology of America (www.shea-online.org).

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 PPSV23, RZV, and COVID-19 vaccines are covered by the National Vaccine Injury Compensation Program (VICP). COVID-19 vaccines that are authorized or approved by the FDA are covered by the Countermeasures Injury Compensation Program (CICP). For more information, see www.hrsa.gov/vaccinecompensation or www.hrsa.gov/cicp.

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 Advisory Committee on Immunization Practices (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, 2023: www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/vaccines/acip/acip-scdm-faqs.html

Scan QR code for access to online schedule

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Centers for Disease Control and Prevention

CS310021-C

See Addendum for new or updated ACIP vaccine recommendations

Table 1 Recommended Adult Immunization Schedule for ages 19 years or older, United States, 2023

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
COVID-19	2- or 3- dose primary series and booster (See Notes)			
Influenza inactivated (IIV4) or Influenza recombinant (RIV4)	1 dose annually			
or	or			
Influenza live, attenuated (LAIV4)	1 dose annually			
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management (see notes)			
	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)			For healthcare personnel, see notes
Varicella (VAR)	2 doses (if born in 1980 or later)	2 doses		
Zoster recombinant (RZV)	2 doses for immunocompromising conditions (see notes)		2 doses	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
Pneumococcal (PCV15, PCV20, PPSV23)	1 dose PCV15 followed by PPSV23 OR 1 dose PCV20 (see notes)			See Notes
				See Notes
Hepatitis A (HepA)	2, 3, or 4 doses depending on vaccine			
Hepatitis B (HepB)	2, 3, or 4 doses depending on vaccine or condition			
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 or Other Indication, United States, 2023

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 percentage and count		Asplenia, complement deficiencies	End-stage renal disease, or on hemodialysis	Heart or lung disease; alcoholism[a]	Chronic liver disease	Diabetes	Health care personnel[b]	Men who have sex with men
			<15% or <200 mm³	≥15% and ≥200 mm³							
COVID-19		See Notes									
IIV4 or RIV4 or LAIV4	1 dose annually										
	Contraindicated						Precaution			or 1 dose annually	
Tdap or Td	1 dose Tdap each pregnancy	1 dose Tdap, then Td or Tdap booster every 10 years									
MMR	Contraindicated*	Contraindicated	1 or 2 doses depending on indication								
VAR	Contraindicated*	Contraindicated		2 doses							
RZV		2 doses at age ≥19 years		2 doses at age ≥50 years							
HPV	Not Recommended*	3 doses through age 26 years		2 or 3 doses through age 26 years depending on age at initial vaccination or condition							
Pneumococcal (PCV15, PCV20, PPSV23)		1 dose PCV15 followed by PPSV23 OR 1 dose PCV20 (see notes)									
HepA			2, 3, or 4 doses depending on vaccine								
HepB	3 doses (see notes)	2, 3, or 4 doses depending on vaccine or condition									
MenACWY		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[c] 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
- Recommended vaccination based on shared clinical decision-making
- Precaution–vaccination might be indicated if benefit of protection outweighs risk of adverse reaction
- Contraindicated or not recommended–vaccine should not be administered.
- No recommendation/ Not applicable

*Vaccinate after pregnancy

a. Precaution for LAIV4 does not apply to alcoholism. b. See notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations. c. Hematopoietic stem cell transplant.

Notes

See Addendum for new or updated ACIP vaccine recommendations

Recommended Adult Immunization Schedule for ages 19 years or older, United States, 2023

For vaccine recommendations for persons 18 years of age or younger, see the Recommended Child and Adolescent Immunization Schedule.

COVID-19 vaccination

Routine vaccination

- **Primary series:** 2-dose series at 0, 4-8 weeks (Moderna) or 2-dose series at 0, 3-8 weeks (Novavax, Pfizer-BioNTech)
- **Booster dose:** see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html

Special situations

Persons who are moderately or severely immunocompromised

- **Primary series**
  - 3-dose series at 0, 4, 8 weeks (Moderna) or 3-dose series at 0, 3, 7 weeks (Pfizer-BioNTech)
  - 2-dose series at 0, 3 weeks (Novavax)
- **Booster dose:** see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html
- **Pre-exposure prophylaxis (e.g., monoclonal antibodies)** may be considered to complement COVID-19 vaccination. See www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#immunocompromised

For Janssen COVID-19 Vaccine recipients see COVID-19 schedule at www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html.

Note: Current COVID-19 schedule available at www.cdc.gov/vaccines/covid-19/downloads/COVID-19-immunization-schedule-ages-6months-older.pdf. For more information on Emergency Use Authorization (EUA) indications for COVID-19 vaccines, please visit www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines

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

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: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])

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** (HepA-HepB [Twinrix] may be administered on an accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months)
  - **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)
  - **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 B vaccination

Routine vaccination

- **Age 19 through 59 years: complete a 2- or 3- or 4-dose series**
  - 2-dose series only applies when 2 doses of Heplisav-B* are used at least 4 weeks apart
  - 3-dose series Engerix-B, PreHevbrio*, or Recombivax HB at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks])
  - 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])
  - 4-dose series HepA-HepB (Twinrix) accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months

***Note:** Heplisav-B and PreHevbrio are not recommended in pregnancy due to lack of safety data in pregnant persons.

Notes Recommended Adult Immunization Schedule, United States, 2023

- **Age 60 years or older with** known risk factors for hepatitis B virus infection **should** complete a HepB vaccine series.
- **Age 60 years or older without** known risk factors for hepatitis B virus infection **may** complete a HepB vaccine series.

- **Risk factors for hepatitis B virus infection include:**
  - **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; persons on maintenance dialysis, including in-center or home hemodialysis and peritoneal dialysis, and persons who are predialysis; patients with diabetes)
  - **Incarceration**
  - **Travel in countries with high or intermediate endemic hepatitis B**

Special situations

- **Patients on dialysis:** complete a 3- or 4-dose series
  - 3-dose series Recombivax HB at 0, 1, 6 months (note: use Dialysis Formulation 1 mL = 40 mcg)
  - 4-dose series Engerix-B at 0, 1, 2, and 6 months (note: use 2 mL dose instead of the normal adult dose of 1 mL)

Human papillomavirus vaccination

Routine vaccination

- **HPV vaccination recommended for all persons 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 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)
  - **Age 9–14 years at initial vaccination and received 1 dose or 2 doses less than 5 months apart:** 1 additional dose
  - **Age 9–14 years at initial vaccination and received 2 doses at least 5 months apart:** HPV vaccination series complete, no additional dose needed
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted
- **No additional dose recommended when any HPV vaccine series has been completed using the recommended dosing intervals.**

Shared clinical decision-making

- **Some adults age 27–45 years:** Based on shared clinical decision-making, 2- or 3-dose series as above

Special situations

- **Age ranges recommended above for routine and catch-up vaccination or shared clinical decision-making also apply in special situations**
  - **Immunocompromising conditions, including HIV infection:** 3-dose series, even for those who initiate vaccination at age 9 through 14 years.
  - **Pregnancy:** Pregnancy testing is not needed before vaccination; HPV vaccination is not recommended until after pregnancy; no intervention needed if inadvertently vaccinated while pregnant

Influenza vaccination

Routine vaccination

- **Age 19 years or older:** 1 dose any influenza vaccine appropriate for age and health status annually.
  - **Age 65 years or older:** Any one of quadrivalent high-dose inactivated influenza vaccine (HD-IIV4), quadrivalent recombinant influenza vaccine (RIV4), or quadrivalent adjuvanted inactivated influenza vaccine (aIIV4) is preferred. If none of these three vaccines is available, then any other age-appropriate influenza vaccine should be used.
- For the 2022–2023 season, see www.cdc.gov/mmwr/volumes/71/rr/rr7101a1.htm
- For the 2023–2024 season, see the 2023–2024 ACIP influenza vaccine recommendations.

Special situations

- **Egg allergy, hives only:** any influenza vaccine appropriate for age and health status annually
- **Egg allergy–any symptom other than hives** (e.g., angioedema, respiratory distress or required epinephrine or another emergency medical intervention): Any influenza vaccine appropriate for age and health status may be administered. If using egg-based IIV4 or LAIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions.
- **Close contacts (e.g., caregivers, healthcare workers) of severely immunosuppressed persons who require a protected environment:** these persons should not receive LAIV4. If LAIV4 is given, they should avoid contact with/caring for such immunosuppressed persons for 7 days after vaccination.
- **Severe allergic reaction (e.g., anaphylaxis) to a vaccine component or a previous dose of any influenza vaccine:** see Appendix listing contraindications and precautions

Notes

- **History of Guillain-Barré syndrome within 6 weeks after 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 persons of childbearing age with no evidence of immunity to rubella:** 1 dose
- **HIV infection with CD4 percentages ≥15% and CD4 count ≥200 cells/mm³ 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 for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm³
- **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
- **In mumps outbreak settings,** for information about additional doses of MMR (including 3rd dose of MMR), see www.cdc.gov/mmwr/volumes/67/wr/mm6701a7.htm
- **Health care personnel:**
  - **Born before 1957 with no evidence of immunity to measles, mumps, or rubella:** Consider 2-dose series at least 4 weeks apart for protection against measles or mumps or 1 dose for protection against rubella
  - **Born in 1957 or later with no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart for protection against measles or mumps or at least 1 dose for protection against 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-D (Menactra, Menveo, or MenQuadfi) at least 8 weeks apart and revaccinate every 5 years if risk remains
- **Travel in countries with hyperendemic or epidemic meningococcal disease, or microbiologists routinely exposed to *Neisseria meningitidis*:** 1 dose MenACWY (Menactra, Menveo, or MenQuadfi) 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) or military recruits:** 1 dose MenACWY (Menactra, Menveo, or MenQuadfi)
- For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Shared clinical decision-making for MenB

- **Adolescents and young adults age 16–23 years (age 16–18 years preferred) not at increased risk for meningococcal disease:** Based on shared clinical decision-making, 2-dose series MenB-4C (Bexsero) at least 1 month apart or 2-dose series MenB-FHbp (Trumenba) 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, or 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; if dose 3 is administered earlier than 4 months after dose 2, a fourth dose should be administered at least 4 months after dose 3); 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
- For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Note: MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, if feasible.

Notes

Pneumococcal vaccination

Routine vaccination

- **Age 65 years or older who have:**
  - **Not previously received a dose of PCV13, PCV15, or PCV20 or whose previous vaccination history is unknown:** 1 dose PCV15 OR 1 dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak to minimize the risk of invasive pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups.
  - **Previously received only PCV7:** follow the recommendation above.
  - **Previously received only PCV13:** 1 dose PCV20 at least 1 year after the PCV13 dose OR complete the recommended PPSV23 series as described here www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf.
  - **Previously received only PPSV23:** 1 dose PCV15 OR 1 dose PCV20 at least 1 year after the PPSV23 dose. If PCV15 is used, it need not be followed by another dose of PPSV23.
  - **Previously received both PCV13 and PPSV23 but NO PPSV23 was received at age 65 years or older:** 1 dose PCV20 at least 5 years after their last pneumococcal vaccine dose OR complete the recommended PPSV23 series as described here www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf.
  - **Previously received both PCV13 and PPSV23, AND PPSV23 was received at age 65 years or older:** Based on shared clinical decision-making, 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine dose.
- For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app which can be downloaded here: www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumoapp.html

Special situations

- **Age 19–64 years with certain underlying medical conditions or other risk factors** who have**
  - **Not previously received a PCV13, PCV15, or PCV20 or whose previous vaccination history is unknown:** 1 dose PCV15 OR 1 dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak
  - **Previously received only PCV7:** follow the recommendation above.
  - **Previously received only PCV13:** 1 dose PCV20 at least 1 year after the PCV13 dose OR complete the recommended PPSV23 series as described here www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf.
  - **Previously received only PPSV23:** 1 dose PCV15 OR 1 dose PCV20 at least 1 year after the PPSV23 dose. If PCV15 is used, it need not be followed by another dose of PPSV23.
  - **Previously received both PCV13 and PPSV23 but have not completed the recommended series:** 1 dose PCV20 at least 5 years after their last pneumococcal vaccine dose OR complete the recommended PPSV23 series as described here www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf.
- For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app which can be downloaded here: www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumoapp.html

***Note:** Immunocompromising conditions include chronic renal failure, nephrotic syndrome, immunodeficiency, iatrogenic immunosuppression, generalized malignancy, human immunodeficiency virus, Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplants, congenital or acquired asplenia, sickle cell disease, or other hemoglobinopathies.

****Note:** Underlying medical conditions or other risk factors include alcoholism, chronic heart/liver/lung disease, chronic renal failure, cigarette smoking, cochlear implant, congenital or acquired asplenia, CSF leak, diabetes mellitus, generalized malignancy, HIV, Hodgkin disease, immunodeficiency, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplants, or sickle cell disease or other hemoglobinopathies.

Polio vaccination

Routine vaccination

Routine poliovirus vaccination of adults residing in the United States is not necessary.

Special situations

- **Adults at increased risk of exposure to poliovirus with:**
  - No evidence of a complete polio vaccination series (i.e., at least 3 doses): administer remaining doses (1, 2, or 3 doses) to complete a 3-dose series
  - Evidence of completed polio vaccination series (i.e., at least 3 doses): may administer one lifetime IPV booster

For detailed information, see: www.cdc.gov/vaccines/vpd/polio/hcp/recommendations.html

Notes Recommended Adult Immunization Schedule, United States, 2023

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:** 1 dose Tdap followed by 1 dose Td or Tdap at least 4 weeks later, and a third dose of Td or Tdap 6–12 months later (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
- **Wound management:** Persons with 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant woman, use Tdap. For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.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 persons 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 percentages ≥15% and CD4 count ≥200 cells/mm³ with no evidence of immunity:** Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm³
- **Severe immunocompromising conditions:** VAR contraindicated

Zoster vaccination

Routine vaccination

- **Age 50 years or older*:** 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon), regardless of previous herpes zoster or history of zoster vaccine live (ZVL, Zostavax) vaccination.

***Note:** Serologic evidence of prior varicella is not necessary for zoster vaccination. However, if serologic evidence of varicella susceptibility becomes available, providers should follow ACIP guidelines for varicella vaccination first. RZV is not indicated for the prevention of varicella, and there are limited data on the use of RZV in persons without a history of varicella or varicella vaccination.

Special situations

- **Pregnancy:** There is currently no ACIP recommendation for RZV use in pregnancy. Consider delaying RZV until after pregnancy.
- **Immunocompromising conditions (including persons with HIV regardless of CD4 count)**:** 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon). For detailed information, see www.cdc.gov/shingles/vaccination/immunocompromised-adults.html

****Note:** If there is no documented history of varicella, varicella vaccination, or herpes zoster, providers should refer to the clinical considerations for use of RZV in immunocompromised adults aged ≥19 years and the ACIP varicella vaccine recommendations for further guidance: www.cdc.gov/mmwr/volumes/71/wr/mm7103a2.htm

Appendix Recommended Adult Immunization Schedule, United States, 2023

Guide to Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4-1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: Contraindication and Precautions available at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html *and ACIP's Recommendations for the Prevention and Control of 2022-23 Seasonal Influenza with Vaccines available at www.cdc.gov/mmwr/volumes/71/rr/rr7101a1.htm*

For COVID-19 vaccine contraindications and precautions see
www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#contraindications

Vaccine	Contraindicated or Not Recommended[1]	Precautions[2]
Influenza, egg-based, inactivated injectable (IIV4)	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg)	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable [(ccIIV4), Flucelvax® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component[3] of ccIIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, recombinant injectable [(RIV4), Flublok® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component[3] of RIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, ccIIV, or LAIV of any valency. If using RIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, live attenuated [LAIV4, Flumist® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg) • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear, or any other cranial CSF leak • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days.	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons aged 5 years old or older • Persons with underlying medical conditions (other than those listed under contraindications) that might predispose to complications after wild-type influenza virus infection [e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus)] • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.

Appendix Recommended Adult Immunization Schedule, United States, 2023

Vaccine	Contraindicated or Not Recommended[1]	Precautions[2]
Haemophilus influenzae type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Hiberix, ActHib, and PedvaxHB only: History of severe allergic reaction to dry natural latex	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including yeast • *Pregnancy: Heplisav-B and PreHevbrio are not recommended due to lack of safety data in pregnant persons. Use other hepatitis B vaccines if HepB is indicated*[4]	• Moderate or severe acute illness with or without fever
Hepatitis A + Hepatitis B vaccine (HepA+HepB, [Twinrix®])	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • *Pregnancy: HPV vaccination not recommended*	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (eg., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing • Moderate or severe acute illness with or without fever
Meningococcal ACWY (MenACWY) [MenACWY-CRM (Menveo®); MenACWY-D (Menactra®); MenACWY-TT (MenQuadfi®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For MenACWY-D and MenACWY-CRM only: severe allergic reaction to any diphtheria toxoid- or CRM197–containing vaccine • For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• Moderate or severe acute illness with or without fever
Meningococcal B (MenB) [MenB-4C (Bexsero); MenB-FHbp (Trumenba)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • For MenB-4C only: Latex sensitivity • Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV15, PCV20)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria toxoid-containing vaccine or to its vaccine component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP, DTaP, or Tdap	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria toxoid–containing or tetanus toxoid–containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus toxoid–containing vaccine • Moderate or severe acute illness with or without fever • For Tdap only: Progressive or unstable neurologic all disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized
Varicella (VAR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (eg., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • Moderate or severe acute illness with or without fever
Zoster recombinant vaccine (RZV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever • Current herpes zoster infection

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.
4. For information on the pregnancy exposure registries for persons who were inadvertently vaccinated with Heplisav-B or PreHevbrio while pregnant, please visit heplisavbpregnancyregistry.com/ or www.prehevbrio.com/#safety.

Addendum Recommended Adult Immunization Schedule, United States, 2023

In addition to the recommendations presented in the previous sections of this Immunization Schedule, ACIP has approved the following recommendations by majority vote since October 20, 2022. The following recommendations have been adopted by the CDC Director and are now official. Links are provided if these recommendations have been published in *Morbidity and Mortality Weekly Report (MMWR)*.

Vaccines	Recommendations	Effective Date of Recommendation*
Respiratory syncytial virus (RSV)	• Maternal Respiratory Syncytial Virus (RSV) vaccine (ABRYSVO™) is recommended for pregnant people during 32 through 36 weeks gestation, using seasonal administration, to prevent RSV lower respiratory tract infection in infants.	September 22, 2023
COVID-19 (Moderna, Pfizer-BioNTech)	• All persons ≥6 months of age should receive 2023–2024 (monovalent, XBB containing) COVID-19 vaccines as authorized under EUA or approved by BLA. • Bivalent mRNA COVID-19 vaccines are no longer recommended in the United States • For detailed information, see: www.cdc.gov/covidschedule	September 12, 2023
Respiratory syncytial virus (RSV)	• Adults 60 years of age and older may receive a single dose of Respiratory Syncytial Virus (RSV) vaccine, using shared clinical decision-making. • For detailed information, see: www.cdc.gov/mmwr/volumes/72/wr/mm7229a4.htm?s_cid=mm7229a4_w	June 27, 2023
Poliovirus (IPV)	• Adults who are known or suspected to be unvaccinated or incompletely vaccinated against polio should complete a primary vaccination series with inactivated polio vaccine (IPV). • Adults who have received a primary series of trivalent oral polio vaccine (tOPV) or IPV in any combination and who are at increased risk of poliovirus exposure may receive another dose of IPV. Available data do not indicate the need for more than a single lifetime booster dose with IPV for adults.	June 27, 2023
Influenza (IIV4, ccIV4, RIV4, LAIV4)	• All persons ages ≥6 months with egg allergy should receive influenza vaccine. Any influenza vaccine (egg based or non-egg based) that is otherwise appropriate for the recipient's age and health status can be used. • Affirm the updated *MMWR* Recommendations and Reports, "Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices—United States, 2023–24 Influenza Season" www.cdc.gov/mmwr/volumes/72/rr/rr7202a1.htm	June 27, 2023

*The effective date is the date when the CDC director adopted the recommendation and when the ACIP recommendation became official

Prime Healthcare Unified EPO 2024 – Amendment 2 to Addendum 18 change effective January 1, 2024 is as follows:

The Section entitled "**The Prime Healthcare entities included in the following schedule of medical benefits are**" is hereby amended by adding the following entity:

- Shasta Regional Medical Center CHEU

There are no other changes to this Addendum 18.