

PRIME HEALTHCARE

SUMMARY PLAN DESCRIPTION

OF THE

SHASTA REGIONAL MEDICAL CENTER

EPO 4 MEDICAL 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.

IMPORTANT NOTICES

This is a self-funded benefit 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.

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 Registered Domestic 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 Covered Provider. This provision shall not require that the Plan contract with any Covered Provider willing to abide by the terms and conditions for participation established by the Plan or issuer.

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A participant 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. The procedures are also included herein and are located immediately following the **COBRA Continuation Coverage** section (see the **COBRA Notice Procedures for Covered Persons** section). Please review that section for additional details or contact the Plan Administrator for the most current notice procedures.

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 and health insurance issuers 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 Covered 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 and issuers may not, under Federal

law, require that a Covered Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTE: An “attending Covered 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.

Plan participants 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 Review Department at (877) 234-5227.

DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the **Definitions** section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

If an Employee and/or an Employee’s Children are eligible for Medicaid or CHIP and are eligible for health coverage in the Plan, there may be a state premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If an Employee and/or an Employee’s Children aren’t eligible for Medicaid or CHIP, there won’t be eligibility for these premium assistance programs but may be eligible to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If an Employee and/or an Employee's Children are already enrolled in Medicaid or CHIP and live in a State listed in Appendix A, contact the State Medicaid or CHIP office to find out if premium assistance is available.

If an Employee and/or an Employee's Children are NOT currently enrolled in Medicaid or CHIP, and think there might be eligibility for either of these programs, contact the State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If qualified, ask the state if it has a program that might help pay the premiums for this Employer-sponsored plan.

If an Employee and/or an Employee's Children are eligible for premium assistance under Medicaid or CHIP, as well as eligible under this Plan, the Employer must allow enrollment in the Employer Plan if an Employee and/or Children aren't already enrolled. This is called a "special enrollment" opportunity, and **request for coverage must be received within 60 days of being determined eligible for premium assistance**. For questions enrolling in the Employer Plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**. See **Appendix A** for more information.

CHOICE OF PRIMARY CARE PROVIDER ACCESS TO OBSTETRIC OR GYNECOLOGICAL CARE

The Prime Healthcare Services Shasta Regional Medical Center EPO 4 Medical and Prescription Drug Benefits Plan generally requires the designation of a Primary Care Provider. You have the right to designate any Primary Care Provider who participates in the Prime Healthcare network and BCBS BlueCard/Blue Shield of CA Network and who is available to accept you or your family members. Until you make this designation, Prime Healthcare designates one for you. For assistance on how to select a Primary Care Provider, and for a list of the participating Primary Care Providers, contact Prime Healthcare Customer Service at (877) 234-5227.

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

You do not need prior authorization for the Annual Well Woman exam from Prime Healthcare Services Utilization Management Review Department or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a Covered Provider in the Prime Healthcare Services EPO network and the BCBS BlueCard/Blue Shield of CA Network who specializes in obstetrics or gynecology. The Covered 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 a participating Network Providers who specialize in obstetrics or gynecology, contact Prime Healthcare Customer Service at (877) 234-5227.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

COVERED PERSONS ARE PROTECTED FROM SURPRISE BILLING OR BALANCE BILLING WHEN THEY GET EMERGENCY CARE OR GET TREATED BY A NON-NETWORK PROVIDER AT A NETWORK HEALTH CARE FACILITY SUCH AS A NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER.

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 Copay, 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 Copays 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 Copays, 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.

- o 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.
- o 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 balance or surprise billing protection laws.

Visit www.cms.gov/nosurprises/consumers for more information about Participants rights under federal law.

UTILIZATION MANAGEMENT PROGRAM

The Plan includes a **Utilization Management Program** as described below. The purpose of the program is to encourage Covered Persons to obtain quality medical care while utilizing the most cost efficient sources.

PRE-SERVICE REVIEW REQUIREMENTS

The Plan Sponsor requires pre-service review. The name and phone number of the organization that is providing pre-service review is shown on the Member's Prime Healthcare Services identification card.

When a Prime Healthcare Physician or service is not available within 50 miles of the Employee's Hospital, Covered Persons will be referred to a BCBS BlueCard/Blue Shield of CA Network Provider. Copays and/or Deductibles for this visit or service will be paid at the Prime Healthcare Network Allowable Charge. BCBS BlueCard/Blue Shield of CA Network facility and specialty Physician services require prior approval from the Prime Healthcare Utilization Management Review Department.

Compliance Procedures – The procedures outlined below must be followed to avoid a possible penalty:

HOW TO OBTAIN PRE-SERVICE REVIEWS

Remember, it is always your responsibility to confirm that the review has been performed. If the review is not performed benefits will not be payable.

Utilization Management Organization (UMO) – Prime Healthcare Utilization Management Review Department must authorize any elective or non-Emergency Services which are rendered in the Prime Healthcare Network or BCBS BlueCard/Blue Shield of CA Network.

Pre-Service Reviews. Pre-service review, before receiving scheduled services, is required as follows:

- For all scheduled services that are subject to utilization review, you or your Physician must initiate the pre-service review at least five working days prior to when you are scheduled to receive services.
- You must tell your Physician that this Plan requires pre-service review. The toll-free number for pre-service review is printed on your identification card.
- If you do not receive the reviewed service within 45 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

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

Inpatient Admission – Except as noted, at least five (5) business days prior to any non-emergency Inpatient admission to a Covered Provider facility (Hospital, Convalescent Facility, Inpatient mental health/substance abuse facility, etc.), the Covered Person or someone acting on his behalf must contact the Prime Healthcare Services Utilization Management Review Department for authorization. For an emergency admission, the Prime Healthcare Services Utilization Management Review Department must be notified within one (1) working day of the admission unless Extraordinary Circumstances* prevent such notification with that time period. If contact is not made prior to

discharge, the admitting facility will have to file a “Retrospective Review” request with the Prime Healthcare Services Utilization Management Review Department.

***Extraordinary Circumstances** – In determining “extraordinary circumstances,” the Review Center may take into account whether or not the condition was severe enough to prevent the Covered Person from notifying the Prime Healthcare Services Utilization Management Review Department, or whether or not a member of the Covered Person’s family was available to notify the Prime Healthcare Services Utilization Management Review Department. The Covered Person may have to prove that such “extraordinary circumstances” were present at the time of the Emergency Services.

If, in the opinion of the patient’s Physician, it is necessary for the patient to be confined for a longer time than initially authorized, the Physician may request that additional days be authorized by contacting the Prime Healthcare Services Utilization Management Review Department no later than the last authorized day.

All Covered Services must be performed at Shasta Regional Medical Center in order to be considered Covered Medical Expenses, **except for those not available**.

Members wishing to seek ANY services through providers within the BCBS BlueCard/Blue Shield of CA Network must obtain prior authorization through the Prime Healthcare Services Utilization Management Review Department. Be advised that failure to obtain prior authorization may result in denied claims for services rendered through the BCBS BlueCard/Blue Shield of CA Network of Providers.

Exception – the plan will allow direct access to the BCBS BlueCard/Blue Shield of CA Network for some services, including all Pediatric care, OB-GYN, Lab, Radiology and/or Emergency services. In addition, you will be allowed to select a Prime or BCBS BlueCard/Blue Shield of CA Network Provider as your PCP. If you select a BCBS BlueCard/Blue Shield of CA Network PCP, you will only be allowed to use them to access Physician office services. Any Inpatient or Outpatient services (including those directed by a BCBS BlueCard/Blue Shield of CA Network PCP) must be approved by Prime Healthcare Services Utilization Management Review Department or claims will be denied.

NOTE: Pre-service review will not be required for an Inpatient admission for Pregnancy delivery which does not exceed 48 hours following a normal 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.

Specified Outpatient Services and Supplies – Prior to receipt of the following services, the Covered Person or someone acting on his behalf must contact the Prime Healthcare Services Utilization Management Review Department for authorization:

- Ambulatory Surgery Center (for certain services)
- Home health care
- Home infusion (IV) therapy
- Potentially cosmetic/investigative services

Transplant Procedures – The Prime Healthcare Services Utilization Management Review Department must be contacted for authorization prior to the performance of any transplant procedure.

Penalty for Non-Compliance – If the above pre-service review requirements are not completed, benefits will not be payable.

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 reduction) under this program.

NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would constitute an Emergency Medical Condition.

MORE INFORMATION ABOUT PRE-SERVICE REVIEW

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of noncompliance, an Employee should contact the review organization 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 or not 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.

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.

Pre-service review and authorization is **not a guarantee of coverage**. The **Utilization Management Program** is designed ONLY to determine whether or not 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.

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.

CASE MANAGEMENT SERVICES

The Utilization Management Organization (UMO) provides case management for catastrophically ill or injured Covered Persons who require extensive medical services and who have exceptional or complex needs. Case Managers are responsible for evaluating and monitoring the efficiency, appropriateness and quality of all aspects of health care for Covered Persons who have been accepted into the case management program. To achieve this objective, the case management program works in collaboration with the Covered Person's team of Covered Providers to provide feedback, support and assistance during the utilization and case management process.

Once a Covered Person is identified for potential case management, the Covered Person is contacted for program enrollment. The case manager will introduce and describe the program. The Covered Person can ask questions and agree or decline to participate. If the Covered Person declines to participate, a case manager may work with the health care treatment team to monitor progress through the healthcare continuum.

The Plan Sponsor expressly reserves the right to make modifications to Plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services.

NOTE: Case Management Programs are voluntary. There are no reductions of benefits or penalties if the patient chooses not to participate. Also, each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

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 Healthcare Provider Directory of Network Providers. The Tier 1 Prime Healthcare's 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 Healthcare 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 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 Prime Healthcare Customer Service for instructions on how to request pre-service review to determine if a Tier 2 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 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. 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.

LIMITED CHOICE OF COVERED PROVIDERS IN CALIFORNIA

WARNING: This option provides coverage only when certain providers are used. Please read the following information to know from whom or what group of providers health care may be obtained.

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 explained below, in order to receive the benefits of the Plan ALL HEALTH CARE must be provided or ordered by Network Providers and authorized by the Prime Healthcare Utilization Management Review Department.

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

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

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION

Tier 2 BCBS BlueCard Network Providers, Outside of California – Facilities, Physicians and non-Physician Licensed Covered Providers who have signed agreements to participate in the BCBS BlueCard Network.

Network Providers have agreed to provide services to Covered Persons at negotiated rates. Except in limited situations that are explained below, in order to receive the benefits of this option, ALL HEALTH CARE must be provided, authorized or ordered by Covered Providers who are participating in one of the Networks and authorized by the Prime Healthcare Services Utilization Management Review Department.

The Plan Sponsor will automatically provide a Plan participant with information about how he can access directories of Network Providers.

Although there may be circumstances when a Network Covered Provider cannot be used, Non-Network Provider services will not be covered. However, in the following limited circumstances, Non-Network Provider expenses will be covered at the BCBS BlueCard/Blue Shield of CA Network benefit levels. The benefit levels will be applied to Allowable Charges (see “Allowable Charges” in the **Definitions** section):

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 – Covered items or services received from a Non-Network Provider during a Non-Emergency Visit at a Network Provider 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).

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION

LIMITED CHOICE OF COVERED PROVIDERS OUTSIDE OF CALIFORNIA

Out-of-California Emergency and Urgent Care – If a Covered Person is outside of California and has an Emergency Medical Condition (Accidental Injury or Sickness) requiring immediate care, benefits will be provided if BCBS BlueCard Network providers are used. Contact information for BCBS BlueCard is on the back of the Covered Person’s Blue Shield of CA Network ID card. If the Covered Person is admitted to a Hospital, the Prime Healthcare Services Utilization Management Review Department must be contacted. See the **Utilization Management Program** section for additional information. The benefit levels will be applied to Allowable Charges (see “Allowable Charges” in the **Definitions** section).

If a Covered Person requires care for an Emergency Medical Condition and is unable to access a BCBS BlueCard Provider, benefits for Non-Network Provider services will be paid at the BCBS BlueCard Network benefit levels as shown in the Schedule of Medical Benefits. The Non-Network Provider may bill for the difference between the Provider’s charge and the Allowable Charge.

Continuing or follow-up treatment will be covered at the BCBS BlueCard Network benefit levels, but coverage is limited to services required before the Covered Person be Transferred to the BCBS BlueCard/Blue Shield of CA Network service area. Authorization for continued out-of-area care may be granted by the Prime Utilization Management Organization if continued treatment is deemed to be Medically Necessary and in the best interest of both the Covered Person and the Plan. In some instances, the Plan may cover medical transportation costs to return the Covered Person to California, but the Plan must authorize such services in advance.

NOTE: Coverage will not be provided for a Covered Person who chooses to leave the BCBS BlueCard/Blue Shield of CA Network service area for the purpose of receiving Medically Necessary elective (i.e., non-emergency/non-urgent) treatment.

Out-of-Area and Out-of-California Residents – Covered Persons who reside out-of-area from the Prime Healthcare Services Network Provider can use BCBS BlueCard/Blue Shield of CA Network Providers. Benefits will be provided at the BCBS BlueCard/Blue Shield of CA Network benefit levels as shown in the Schedule of Medical Benefits. The Covered Person must notify and receive approval from the Prime Healthcare Services Utilization Management Review Department if residing out of the Prime Healthcare network service area or out of California. Covered Persons must provide proof of out-of-area residency.

INTER-PLAN AGREEMENT

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

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION

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:

- The billed charges for covered services; or
- 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.

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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.

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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.

SCHEDULE OF MEDICAL BENEFITS

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.

MAXIMUM DOLLAR LIFETIME BENEFIT	Unlimited	
There is no lifetime dollar limit to the total benefits payable for all eligible medical expenses that are Essential Health Benefits for each Covered Person. However, annual and lifetime dollar limits may apply to Plan coverage or to certain conditions or types or levels of care that are not essential health benefits. Such limits are included in this summary.		
OUT-OF-POCKET MAXIMUMS	Tier 1 Prime Healthcare Network	Tier 2 BCBS BlueCard/Blue Shield of CA Network & Rx
Individual Out-of-Pocket Maximum	\$1,500	\$5,350
Family Out-of-Pocket Maximum	\$3,000	\$10,700

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Individual Out-of-Pocket Maximum – Except as noted, a Covered Person will not be required to pay more than the amounts shown above in any Plan Year toward his percentage share of Eligible Expenses that are not paid by the Plan. Once he has paid his Out-of-Pocket Maximum, his Eligible Expenses will be paid at 100% for the balance of the Plan Year.

Family Out-of-Pocket Maximum – An individual family member will not be required to pay more than \$1,500 toward his percentage share using the Prime Healthcare Network, not including Rx, and \$5,350 for services using the BCBS BlueCard/Blue Shield of CA Network, including Rx, of Eligible Expenses that are not paid by the Plan. Except as noted, a covered family (Employee and his Dependents) will not be required to pay more than the amounts shown above in any Plan Year toward their percentage share of Eligible Expenses. Once the family has paid their Out-of-Pocket Maximum, their Eligible Expenses will be paid at 100% for the balance of the Plan Year.

Prime Healthcare Out-of-Pocket Maximums do not cross-apply to the BCBS BlueCard/Blue Shield of CA Network and Rx Out-of-Pocket Maximum.

NOTE: The Out-of-Pocket Maximums include amounts applied or paid to satisfy any Copay or Coinsurance requirements but do not include non-covered items, premiums, balance billing or penalties for non-compliance of Pre-Service Review requirements.

ELIGIBLE MEDICAL EXPENSES	Tier 1 Prime Healthcare Network	Tier 2 BCBS BlueCard/Blue Shield of CA Network
Allergy Testing and Treatment , per visit	\$10 Copay	\$45 Copay
Ambulance , per trip	\$250 Copay	\$250 Copay
Bariatric Surgery Facility Physician	-0- 50%	Not Covered Not Covered
Chiropractic Care , per visit	\$10 Copay	\$30 Copay
Limited to 20 visits per Calendar Year. See allowable services in the Definitions section		
Contraception	-0-	-0-
Subject to reasonable medical management techniques, “Contraception” includes all FDA-approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity as prescribed by a Covered Provider. Diaphragms are limited to 1 per 365-day period or as Medically Necessary.		
Convalescent Facility / Rehab. Facility	-0-	20%
Inpatient room and board is limited to a semi-private room accommodation. A private room accommodation will be covered at 90% of the lowest charge by the facility for a single room and board accommodation only when isolation of the patient is Medically Necessary and is ordered by the attending Physician.		
Diagnostic X-ray, Lab and Radiology Outpatient	-0-	20%
* 20% Coinsurance will apply for analysis of services performed outside a Prime Healthcare Services facility. See “Physician and Specialist Office Visits” for diagnostic services performed as part of a Physician’s office visit.		
Dialysis Dialysis treatments have a lifetime limit of 39 visits.	-0-	20%
Durable Medical Equipment	20%	20%
Gender Dysphoria Services	-0-	20%
Home Health Care	20%	20%
Up to 100 visits per calendar year.		
Hospice Care Inpatient Outpatient	-0- -0-	20% -0-
Hospital Services Inpatient Care Emergency Room Use: for an Emergency Medical Condition – see * if not an Emergency Medical Condition Other Outpatient Services and Supplies	-0- \$25 Copay \$25 Copay -0-	20% \$100 Copay* + 10% Not Covered 20%
Inpatient room and board is limited to a semi-private room accommodation. A private room accommodation will be covered at 90% of the lowest charge by the facility for a single room and board accommodation only when isolation of the patient is Medically Necessary and is ordered by the attending Physician.		
* The emergency room Copay is waived if a Covered Person is admitted to the Hospital directly from the emergency room. The Copay for Emergency Services from Non-Network Providers (i.e. outside the BCBS BlueCard/Blue Shield of CA Network) is the same as the Network Copay for Network Providers (i.e. \$100 Copay + 10%) until the patient is Stabilized and can be Transferred to a Network facility.		

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION

ELIGIBLE MEDICAL EXPENSES	Tier 1 Prime Healthcare Network	Tier 2 BCBS BlueCard/Blue Shield of CA Network
Mental Health Care Inpatient Care including Physician Services Outpatient Visits including Physician Services	-0- \$10 Copay	20% \$30 Copay
Mental Health Care is “covered same as Sickness” which means that the Plan’s <u>treatment limitations</u> and <u>financial requirements</u> that apply to covered mental health care (see “Mental Health Care” in the Eligible Medical Expenses section) may not be any more restrictive than the most common or frequent limitations that apply to substantially all medical and surgical benefits provided hereunder. “Treatment limitations” include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. “Financial requirements” includes deductibles, Copays, percentage sharing provisions and out-of-pocket expenses. Nonquantitative treatment limitations, such as preauthorization requirements, imposed on Mental Health Care benefits will be comparable to, and not applied more strictly than, the nonquantitative treatment limits imposed on medical and surgical benefits, unless justified by reference to recognized clinically appropriate standards of care.		
Physical, Occupational and Speech Therapy	(see “Therapy, Outpatient / Short-Term”)	
Physician and Specialist Office Visits Primary Care Physician Pediatric Primary Care Physician Specialist	\$10 Copay \$10 Copay \$10 Copay	\$30 Copay \$10 Copay \$45 Copay
An “office visit” includes diagnostic procedures performed during the visit. Lab services performed outside of a Prime Healthcare facility by a Network Provider are subject to the applicable Coinsurance amount.		
Preventive Care (see Note and Appendix B) Federally-Required Services Other Preventive Care Services, per visit or service	-0- \$10 Copay	-0- \$30 Copay
Preventive Care Services (Appendix B) shall be covered without cost-sharing: To the extent the services described in Appendix B exceed the above-described Preventive Care Services, preventive care is covered in full (i.e., no cost sharing) when Network Providers are used. See Eligible Medical Expenses and Appendix B for more details. <u>For particular Preventive Care Services, the Plan may use reasonable medical management techniques to determine any coverage limitations and rely on established techniques and the relevant evidence base to determine the frequency, method, treatment, or setting for which a Preventive Care Service will be available without cost-sharing when not specified in a recommendation or guideline.</u>		
Note: <ul style="list-style-type: none"> • When a particular Preventive Care Service is not offered by a Prime Healthcare Services or BCBS BlueCard/Blue Shield of CA Network Provider, the item or service when performed by a Non-Network Provider will be covered with no cost-sharing. • If a preventive item or service is billed separately (or is tracked as individual encounter data separately) from the office visit, then Copays with respect to the office visit will apply. • If a preventive item or service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then there is no Copay with respect to the office visit. If a preventive item or service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then Copays with respect to the office visit will apply.		
Sleep Study Supplies	20%	Not Covered
Sleep Study Testing	\$100 Copay per study	Not Covered
Substance Use Disorder Care - Detox and Rehab Inpatient Care including Physician Services Outpatient Visits including Physician Services	-0- \$10 Copay	20% \$30 Copay
Substance Use Disorder Care is “covered same as Sickness” which means that the Plan’s <u>treatment limitations</u> and <u>financial requirements</u> that apply to covered substance use disorders may not be any more restrictive than the most common or frequent limitations that apply to substantially all medical and surgical benefits provided hereunder. “Treatment limitations” include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. “Financial requirements” includes deductibles, Copays, percentage sharing provisions and out-of-pocket expenses. Nonquantitative treatment limitations, such as preauthorization requirements, imposed on Substance Use Disorder benefits will be comparable to, and not applied more strictly than, the nonquantitative treatment limits imposed on medical and surgical benefits, unless justified by reference to recognized clinically appropriate standards of care.		
Surgeon and Assistant Surgeon Services	-0-	20%

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ELIGIBLE MEDICAL EXPENSES	Tier 1 Prime Healthcare Network	Tier 2 BCBS BlueCard/Blue Shield of CA Network
Therapy, Outpatient / Short-Term, per visit	\$10 Copay Limited to the following modalities: PT Evaluation 97110 - Therapeutic; 97140 - Manual Therapy	\$30 Copay
Coverage is limited to a combined maximum of 30 visits per Calendar Year		
Transplant-Related Expenses	N/A	20%
Urgent Care Facility	\$10 Copay	\$30 Copay
An authorization from the Prime Healthcare Services Utilization Management Review Department is not required to access Urgent Care facilities at either Prime or BCBS BlueCard/Blue Shield of CA Network facilities.		
All Other Eligible Medical Expenses	-0-	20%

THIS IS A SUMMARY ONLY. SEE THE **ELIGIBLE MEDICAL EXPENSES** AND **MEDICAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

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SCHEDULE OF PRESCRIPTION COPAYS

Prescription drug coverage is provided through separate agreement(s) between the Plan Sponsor and Express Scripts, Inc.

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.

PRESCRIPTION PROGRAM	Covered Person Pays
Retail Pharmacy Feature Generic Formulary Brand Smoking Cessation/Deterrent Drugs (See Covered Drugs and Appendix B) Folic acid, fluoride, Aspirin, iron supplements (See Covered Drugs and Appendix B)	\$10 Copay \$30 Copay -0- -0-
To use the Retail Pharmacy Feature, a Covered Person takes his Medical/Rx ID card to a participating pharmacy to fill his prescription order. A retail prescription can be purchased in up to a 30-day supply for the Copays shown.	
Maintenance Drugs – After second refill at a Retail Pharmacy (up to 30-day supply) Generic Formulary Brand	\$20 Copay \$60 Copay
Specialty Medications through Accredo Generic Formulary Brand SaveOnSP Specialty Drugs	\$100 Copay \$200 Copay -0-
Mail Order Option Generic Formulary Brand Smoking Cessation/Deterrent Drugs (See Covered Drugs and Appendix B) Folic acid, fluoride, Aspirin, iron supplements (See Covered Drugs and Appendix B)	\$20 Copay \$60 Copay -0- -0-
Other Covered Services Generic Rx for Asthma, Diabetes, High Blood Pressure, Heart Disease and High Cholesterol Formulary Brand Rx for Asthma, Diabetes, High Blood Pressure, Heart Disease and High Cholesterol Oral and Injectable Contraceptives (Retail and Mail Order)	\$10 Copay \$30 Copay -0- for Generic Drugs only
The Mail Order Option is for maintenance (longer-term) drugs. A mail order prescription can be purchased in up to a 90-day supply for the Copays shown.	

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).

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION

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.

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 (CRNA) for the administration of anesthesia.

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 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) are considered medically necessary when required for the management of behaviors, especially where there is the potential for individuals to harm themselves or others, or when such treatment would otherwise be considered medically necessary.

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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 Surgery – Bariatric Surgery when Medically Necessary for the treatment of morbid obesity as defined by CMS Guidelines for Bariatric Surgery.

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

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

Documented cumulative history of 2 years previously unsuccessful with medical treatment for obesity, with at least 6 months of consecutive participation. Bariatric procedure is limited to one per lifetime. Benefit excludes but not limited to:

- Post operative adjustments if not in compliance with the program.
- Procedure(s) after weight loss (ex: panniculectomy, breast lift).

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;
- Initiated within twelve (12) weeks after treatment for the medical condition ends; and
- Provided in a covered medical care facility as defined by the Plan.

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 a Sickness.

Radium and radioactive isotope therapy when provided for treatment or control of a Sickness.

Chiropractic Care – Musculoskeletal manipulation and modalities provided by a chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain. Extrapinal manipulation also known as Extrapinal Manipulative Therapy (EMT) is not a covered benefit.

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Circumcision – Expenses incurred for circumcision of a child under age one when performed in a facility setting. Expenses for circumcision of an adult may be covered with prior authorization from the Prime Healthcare Services Utilization Management Review Department.

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

Clinical Trials – routine Covered Person’s costs for items and services furnished in connection with the participation of a Qualified Individual in a Clinical Trial. Further, the Plan may not discriminate against a Qualified Individual on the basis of his or her participation in the Clinical Trial.

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 Covered Provider.

The administration of contraceptives by a Network Physician 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 Physician or Covered 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 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 Covered Provider.

Convalescent Facility /Rehabilitation Center – Inpatient care in Convalescent Facility/ 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.

Dental Care – Facility services and supplies, including general anesthesia, when provided in connection with a dental procedure where Hospital confinement 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.

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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 his 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. Treatments have a lifetime limit of 39 visits.

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 Sickness or Accidental 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 and Hearing Aids – 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

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Physician during the period of home health care. Also, the attending Physician in conjunction with the Prime Healthcare Services Utilization Management Review Department must certify that the condition would require Inpatient confinement in a Hospital or Convalescent Facility / Rehabilitation Center 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 (RN) or services by a licensed vocational nurse (LVN) if an RN 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 Convalescent Facility/Rehabilitation 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.

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

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

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION

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:
 - 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;
 - The child displays one of the following: psychotic features: risk of suicide or risk of violence due to a mental disorder.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION

- 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 sick or injured.

Also see “Pregnancy Care” for newborn expenses.

Nursing Services – Nursing services by a Registered Nurse (RN) 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 Services UM 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 Accidental Injury.

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

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.

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.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION

Pregnancy Care – Pregnancy-related expenses of a covered Employee or a covered dependent (including spouse; Registered Domestic Partner, or dependent children) are covered. Eligible Pregnancy-related expenses are covered in the same manner as expenses for a Sickness 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 Registered Domestic 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 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.

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. Also, the **Utilization Management Program** requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

If a Hospital stay is shorter than the above minimums, a follow-up visit for the mother and newborn within 48 hours of discharge will be covered when prescribed by the treating Physician. The visit must be provided by a Network Provider whose scope of practice includes postpartum and newborn care. The treating Physician, in consultation with the mother, shall determine whether this visit shall occur at home, at the facility or in the Physician's office.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION

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.

Prescription Drugs – 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.

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

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

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 “Convalescent Facility/Rehabilitation Center.”

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.

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 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.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION

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.

Sleep Study Testing – Testing and treatment for diagnosis of sleep disorders, with clinical signs and symptoms of obstructive sleep apnea, including the treatment or supplies (i.e., CPAP machines, etc.). Services not available at a Prime Healthcare Network facility are not covered.

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 – Alcoholism or drug abuse therapy that is prescribed and supervised by a Physician and that either: (1) has a follow-up therapy program directed by a Physician, or (2) includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

Surgeon and Assistant Surgeon Services – Assistant surgeon’s expenses not to exceed twenty percent (20%) of the Allowable Charge of the surgical procedure.

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 Accidental Injury, Sickness 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.”

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 or investigational in nature:

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

A transplant must be ordered by a Network Physician and services must be performed at a Network-designated Center of Excellence (COE) facility.

Eligible expenses for the medical and surgical expenses of a live donor, but only to the extent he is not covered by another plan or program, received from a Network-designated Center of Excellence (COE) facility.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION

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.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION

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/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.

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.

Cancer Clinical Trials – Any and all charges (other than routine expenses that would ordinarily be covered by the Plan) for services and supplies that are associated with a cancer Clinical Trial, other than Qualifying Clinical Trials, including a Clinical Trial that is provided only to test toxicity.

Carbon Dioxide Therapy

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

Complications of Non-Covered Treatment – Care, services or treatments that are required to treat complications resulting from a treatment or surgery that is not or would not be covered hereunder, unless expressly stated otherwise.

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.

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 an Illness or Injury;
- 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.

Criminal Activities/Illegal Acts – see **General Exclusions** section.

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;
- Cutting procedures to alter the jaw, jaw joints, or bite relationships when appliance therapy alone cannot result in functional improvement;
- Repair or prosthetic replacement of sound natural teeth that are damaged in an Accidental 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 Accidental 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 Accidental Injury or Sickness, 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 or the use of advanced reproductive technologies (e.g., in vitro fertilization (IVF or egg donation);
- Reversal of a sterilization procedure; or
- Elective abortion, except when the mother’s life is in immediate danger if the Pregnancy were allowed to continue to term or 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 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 or otherwise, used to eliminate baldness.

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.”

Marriage and Family Counseling – Counseling for marital or family problems.

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

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.

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.

Nutritional 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 sickness 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, myofascial 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.

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 (2) tetanus or rabies vaccinations administered in connection with an Accidental 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 a Sickness or Accidental 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 **Schedule of Prescription Copays** at the bottom of the **Medical and Prescription Drug Benefits** section 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 an individual as a member covered for prescription drug benefits, the member must present his ID card to participating pharmacies when he has a prescription filled. Provided he has properly identified himself as a member, a participating pharmacy will only charge him the Copay. Many participating pharmacies display an "Rx" decal with the Express Scripts logo in their window. For information on how to locate a participating pharmacy in his area, a member 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 member 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 claim decision. If the member wants the prescription filled, he will have to pay either the full cost, or the additional Copay, for the prescription drug. If the member believes he is entitled to some Plan benefits in connection with the prescription drug, he 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 and customer service are available by calling (866) 718-7955. A Covered Person should mail his claim, 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. If a Covered Person purchases a Prescription Drug from a non-participating pharmacy, benefits are not payable, and he will have to pay the full cost of the drug.

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

When a Prescription is Ordered Through the Mail. A Covered Person can order his 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 patient'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 Person 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.express-scripts.com.

Maintenance Medication Program. The prescription-drug benefit includes a Preferred 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. A Covered Person can receive two fills of each maintenance medication at his participating pharmacy. After that, he 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 doctor – Express Scripts will call the member's doctor to get a new prescription for Home Delivery. This process typically takes 2 to 3 weeks from the time the member completes his online request. Just visit:

www.StartHomeDelivery.com

If a member 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 Persons' 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 prescription drug formulary list does not guarantee that the Covered Person will be prescribed that drug by his 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, he 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 State of California Department of Health Services or the Food and Drug Administration (FDA).
- It must be for the direct care and treatment of a member'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 member 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, if necessary, 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 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 B**.

Contraceptives – Subject to reasonable medical management techniques, the Plan will cover, without cost-sharing, all Food and Drug Administration (FDA) approved contraceptive drugs for all women with reproductive capacity, as prescribed by a Covered Provider and purchased through Express Scripts. See the **Appendix B**.

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.

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

NOTE: Yohimbine is not covered.

Estrogen Replacement Drugs

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

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

Hyperactivity (ADD, ADHD) Drugs – (i.e., Exuber, Dexedrine, Desoxyn, and Adderall) Prior authorization is required.

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

EXPENSES NOT COVERED

Prescription drug coverage 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.

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 drug 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 B 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, Convalescent 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 **Appendix B**, 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 to

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

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

Supporting Information. For an initial coverage review request (prior authorization by Provider) or an administrative coverage administrative coverage request (Covered Person's request) supporting information must be submitted.

Timeframes. The initial determination and notification to patient and Provider will be made within the specified timeframes indicated in the Section called "Claims and Appeals Procedures."

FIRST AND SECOND APPEALS OF DENIED INITIAL REVIEW

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

- Name of Patient;
- Participant ID Card Number;
- Phone Number;
- The name of the drug for which benefit coverage has been denied;

- Brief description of why the Claimant disagrees with the initial Adverse Benefit Determination; and
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents.

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

Clinical Review Requests (Prior Authorization):

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

Administrative Review Requests:

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

EXTERNAL REVIEW

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

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

MCMC LLC
Prime Healthcare Employee Benefits Plan
3480 East. Guasti Road
Ontario, CA91761
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 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 Calendar 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 trustee 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 his 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 Calendar 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 or separated, 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, 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, then the order in which benefits are paid will be as follows:
 - The plan which covers the child as a dependent of the parent with custody.
 - The plan which covers the child as a dependent of the stepparent (married to the parent with custody).
 - The plan which covers the child as a dependent of the parent without custody.
 - The plan which covers the child as a dependent of the stepparent (married/Registered Domestic Partner) to the parent without custody.
 - When a dependent child who has coverage under either or both parents' plans and also has coverage as a dependent under a spouse's plan, the Longer vs. Shorter Length of Coverage rule is used.

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.

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 other than a laid off or retired Employee or 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, member, 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:

- Medicare coverage for end-stage renal disease, up to the Plan limits, generally begins on the first day of the fourth month of treatment,
- A Claimant is entitled to Medicare benefits as a disabled person, unless he has a current employment status as determined by Medicare rules through a group plan of 100 or more employees (according to federal OBRA 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, sickness, disease or disability 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, the 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 Copayee 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 sole, 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 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

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

To participate as an Employee in the Plan coverages that are described herein, an individual must be in active employment for the Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel) and must be 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 employment” on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in “active employment” on any day on which he is absent from work during an approved FMLA leave or solely due to his 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 his first scheduled workday, he will not be considered as having commenced active employment.

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 eligibility.

EFFECTIVE DATE – EMPLOYEES

An Employee’s coverage is effective, subject to timely enrollment, on the first day of the month following commencement of active employment in an eligible status.

If an Employee fails to enroll within thirty-one (31) days after completion of the waiting period, his 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

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:

- A legally married spouse whether same-sex or opposite-sex, in a marriage entered into under the laws of a U.S. or foreign jurisdiction having the authority to sanction marriages, but will not include a common law spouse;
- A Registered Domestic Partner who resides with the Employee at the same address in a committed relationship and who has resided with the Employee continuously for not less than one (1) year, provided both the Employee and Registered Domestic Partner: (1) are unmarried and mentally competent and of legal age to consent, (2) have no other Registered Domestic Partners and have not signed a Registered Domestic Partner declaration with any other person within the past twelve months, (3) are not related by blood in a way that would

prohibit legal marriage in their state, (4) are financially interdependent, and (5) sign such affidavits and other documents as may be required by the Employer; or

- A child who is under age 26 (i.e., through age 25);
- A ward under a legal guardianship through age 18 (or such other time upon termination of the legal guardianship).

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, a child who is placed with the Employee for legal adoption, or a child with whom the Employee has legal guardianship. An eligible child also includes one for whom coverage is required due to an administrative or court order or a National Medical Support Notice.

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 Registered Domestic Partner following dissolution of the partnership;
- A spouse or Registered Domestic Partner who is eligible for coverage under another group medical plan;
- Any person who is on active duty in any military service, except where eligibility is required by U.S. law;
- Any person who is eligible to be enrolled as an Employee;
- 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, parents, in-laws, etc.;
- Any child born to a Covered Member resulting from an assisted reproduction agreement under California Family Code Sections 7960-7962;
- 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

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:

- He 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 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 Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;
- The individual lost the other coverage as a result of a certain event 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:
 - Loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;
 - 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);
 - 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;
 - 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;
 - 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;
 - Loss of eligibility when COBRA continuation coverage is exhausted; and
 - Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP) or the date the individual becomes eligible for State premium assistance under Medicaid or CHIP.

If the above conditions are met, Plan coverage will be effective on the date of the Qualifying event.

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 Drop Due to CHIP Eligibility – If an Employee’s child(ren) become eligible for CHIP (known as “Healthy Families” in California), Employee has the ability to drop the child(ren) from the group health coverage.

Entitlement to Enroll Due to Acquiring New Dependent(s) – If an Employee acquires one (1) or more new eligible Dependents through marriage, Registered Domestic Partnership, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty-one (31) days of the date the new Dependent or Dependents are acquired (the “triggering event”) and Plan coverage will be effective as follows – see NOTE:

- Where Employee’s marriage or Registered Domestic Partnership is the “triggering event” – the spouse’s or partner’s coverage (and the coverage of any newly eligible children) will be effective on the date of event. The children of Registered Domestic Partners are not eligible for coverage;
- Where acquisition of a child is the “triggering event” – the child’s coverage will be effective on the date of the event (i.e., concurrent with the child’s date of birth, date of placement or date of adoption). The “triggering event” date for a newborn adoptive child is the child’s date of birth if the child is placed with the Employee within 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 or an Employee’s spouse is required to provide coverage for a child under a Medical Child Support Order, coverage for the child shall be effective as of the date specified in such order provided that such order is qualified according to the Plan Sponsor’s written procedures and provided that a request for coverage is made on a form acceptable to the Plan Sponsor within 31 days from the date such order is determined to be qualified (QMCSO). A request to enroll the child may be made by the Employee, the Employee’s spouse, the child’s other parent, or by a State Agency on the child’s behalf.

If the Employee is not enrolled when the Plan is presented with an 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.

If a court has ordered that coverage be provided for a covered Employee’s spouse or minor child (non-QMCSO), Employee may enroll such Dependent(s) hereunder.

OPEN ENROLLMENT

If an individual 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. Any benefits paid while an individual was covered under one option will be carried forward and applied against the benefit maximums of the newly-elected option.

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 and the Family and Medical Leave Act (FMLA), and during the leave Employee discontinued paying his 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 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 Armed Forces, will be reinstated to coverage hereunder immediately upon returning from military service. See "Extension of Coverage During U.S. Military Service" in the **Extensions of Coverage** section for more information.

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.

Benefits for any Employee or Dependent who is covered hereunder, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

TRANSFER OF COVERAGE

If a husband and wife are both Employees and are covered as Employees under this Plan and one of their employment terminates, the terminating spouse and any of his 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 IRC 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 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.

An Employee otherwise eligible and validly enrolled hereunder shall not be terminated solely due to his 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 on the last day of the month in which the dependent ceases to meet 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: A Dependent otherwise eligible and validly enrolled hereunder shall not be terminated solely due to his 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 age 26 (regardless of current age), and such child is primarily 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 a limiting 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 employment 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.), he may be permitted to continue health care coverages for himself and his Dependents though he 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) and/or the California Pregnancy Disability Leave (PDL) law may apply, 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, it intends to comply to the fullest extent required. Continued coverage under PDL shall run concurrently with coverage under FMLA. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty (50) employees within a 75-mile radius.

Except as noted, continued coverage under the FMLA is allowed for up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

- The birth of an Employee's child and in order to care for the child;
- The placement of a child with the Employee for adoption or foster care;
- To care for a spouse, child or parent of the Employee where such relative has a serious health condition;
- Employee's own serious health condition that makes him unable to perform the functions of his or her job;
- The Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions which are found to conflict with the FMLA 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 his or her duties).

EXTENSION OF COVERAGE DURING LABOR DISPUTE

If an Employee fails to continue in active employment due to a labor dispute, 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 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 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 military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. 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 his military service. Notice may be written or oral, or may be given by an appropriate officer of the military 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 military 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 his 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 military 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 military 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 military 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 military 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 military 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 military leave must notify their employer of their intent to return to work. Notification (application for re-employment) must be made:

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

No re-employment application is required if the military 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 military 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 his 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 are received, and Covered Provider name, address, phone number and tax identification number.

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

- **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.

- **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within one (1) year from the date of service.

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

All Eligible Expenses reimbursable hereunder will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other Covered Providers of service will be honored, (2) the Plan may pay benefits directly to Covered Providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network Covered Provider will be considered "assigned" to such Covered Provider and will be paid directly to such Covered Provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due hereunder, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

In the event the Plan fails to pay benefits to a Covered Provider in respect of a claim incurred by a Covered Person, the Employee or Covered Person will be responsible for paying the Covered Provider any amounts due for the services received.

No covered Employee or Dependent may, at any time, either while covered hereunder or following termination of coverage, assign his right to sue to recover Plan benefits or to enforce rights hereunder or any other causes of action that he may have against the Plan or its fiduciaries.

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 OR HIS BENEFICIARY 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 <u>Incomplete</u> 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.
Plan Receives <u>Completing</u> 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.
Claimant Makes Initial <u>Complete</u> Claim Request	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), 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 urgency of the medical situation), after receipt of Claimant's appeal.
<p>An "urgent claim" is an oral or written request for 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.</p> <p>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.</p>	
Concurrent Care Claim - defined below	
Plan Wants to Reduce or Terminate Already Approved Care	Plan notifies Claimant of intent to reduce or deny benefits <u>before</u> any reduction or termination of benefits is made and provides enough time 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	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.
<p>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.</p>	
Non-Urgent Claim	
Claimant Makes Initial <u>Incomplete</u> Claim Request	Within 5 days of receipt of the incomplete claim request, Plan notifies Claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification.
Plan Receives <u>Completing</u> 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.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial <u>Complete</u> Claim Request	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 (or where Plan requires 2 mandatory levels of appeal, within 15 days for each 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 <u>Incomplete</u> 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 <u>Completing</u> 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 <u>Complete</u> 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 Appeal	Within a reasonable period of time but not later than 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).
"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. The Claimant may be required to provide reasonable proof of such authorization. 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. "Health care professional" means a Covered Provider.

WRITTEN OR ELECTRONIC NOTICES

The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

FULL AND FAIR REVIEW

During the internal claims and review process, the Claimant is entitled to a full and fair review of the claim and Adverse Benefit Determination and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating

to the claim, without regard to whether the information was submitted or considered in the initial benefit determination. A full and fair review does not afford deference to the previous Adverse Benefit Determination and is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

A Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

A Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

During the internal claims and appeals process, the Claimant may review the claim file and present evidence and testimony as part of the process. The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan, or new rationale used in making its determination in connection with the claim, sufficiently in advance of the notice of Final Internal Adverse Benefit Determination in order to give the Claimant a reasonable opportunity to respond prior to that date.

ADVERSE BENEFIT DETERMINATION

An adverse benefit determination means a denial in benefits; reduction in benefits; rescission of coverage, even if the rescission does not impact a current claim for benefits; termination of benefits; 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 Claimant's eligibility to participate in the Plan; denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review; or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate. A final internal adverse benefit determination" shall mean an adverse benefit determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an adverse benefit determination with respect to which the internal claims and appeals process has been deemed exhausted.

The Plan must ensure that any notice of an internal adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care Provider, and the claim amount (if applicable)).

The Plan must ensure that the reason or reasons for the internal adverse benefit determination or final internal adverse benefit determination includes a description of the Plan's standard, if any, that was

used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.

The Plan must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

The Plan must disclose the availability of, and contact information for, any applicable office of health coverage consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes.

INTERNAL CLAIMS REVIEW PROCEDURES

Filing an Internal Appeal

Within 180 days of receiving notice of an Adverse Benefit Determination, an individual may appeal his claim, in writing, to a new decision-maker and he may submit new information (e.g., comments, documents and records) in support of his appeal. Appeals should be submitted to:

Keenan HealthCare
P. O. Box 2744
Torrance, CA 90509

Deemed Exhaustion of Internal Claims and Appeals Process

Claimant may not take legal action on a denied claim until he has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures.

Decision on Internal Appeal

A decision with regard to the claim appeal will be made within the allowed time frame. In the case of a pre-service urgent care claim, a decision must be made as soon as possible consistent with the medical exigencies involved (but in no event later than 72 hours), provided that the Plan defers to the attending Provider with respect to the decision as to whether the claim constitutes "urgent care."

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

- The specific reason(s) for the decision;
- Reference to the pertinent Plan provisions on which the decision is based;
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;
- Identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;
- A statement about the provision of language services, if applicable;
- A statement about the availability of diagnostic and treatment codes and their descriptions;
- A statement describing any voluntary appeal procedures offered by the Plan, the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under ERISA section 502(a); and
- Information about the external appeals process.

A Covered Person and the Plan may have other voluntary alternative dispute resolutions options, such as mediation. One way to find out what may be available is to contact the Local U.S. Department of Labor Office and the State insurance regulatory agency.

Any New Evidence During the Appeal Process

If any new evidence is considered, relied upon or is generated during the appeal process, or a determination is based on a new rationale, the Claimant must be furnished with the new evidence or rationale as soon as possible and free of charge. This documentation must be provided sufficiently in advance of the final determination so that the Claimant has a reasonable opportunity to respond before the final determination is made.

Avoidance of Conflicts of Interest

Claims and appeals will be adjudicated by individuals who are independent and impartial. This means that the fiduciary deciding an appeal will be different from (and not subordinate to) the individual who decided the initial claim, and that any medical expert consulted regarding an appeal will be different from (and not subordinate to) the expert consulted in connection with the initial claim. Moreover, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to a claims adjudicator or medical expert cannot be based upon the likelihood such individual will deny a claim. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim will be provided, even if the Plan did not rely upon their advice.

Continued Coverage Pending Appeals Outcome

Coverage for concurrent care must continue during the appeal process, pending the outcome of the review. This requirement is intended to be consistent with applicable regulations for claims involving concurrent care (i.e., where the Plan has previously approved an ongoing course of treatment for a specified period of time or number of treatments, it cannot reduce the period/number without first providing the Claimant advance notice and an opportunity to appeal).

EXTERNAL CLAIMS REVIEW PROCEDURES

Filing an External Review

An individual may file a request for an external review if the request is 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 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. The request is filed as described in the notice.

Preliminary Review

Within five (5) business days after the date of the receipt of the external review request, a preliminary review must be completed to determine whether:

- The Claimant is or was covered by the Plan at the time the health care service was requested;
- The Adverse Benefit Determination or Final Internal Adverse Benefit Determination relates to a question of medical judgment or a Rescission;
- The Claimant has exhausted the Plan's internal appeal process, unless the Claimant is not required to exhaust the internal appeals process; and

- The Claimant has provided all of the information and forms required to process an external review.

Within one (1) business day after completing the preliminary review, a written notification must be issued to the Claimant, if applicable, the Covered Person's authorized representative and the Plan. 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).

If the request is not complete, the notification must describe the information needed to make the request complete, and the Plan must let a Claimant perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

External Review Process

The external review process is independent and without bias and may be assigned to and conducted by an independent review organization (an "IRO") that is accredited by a nationally recognized accrediting organization or may be conducted in another manner that ensures an independent and unbiased external review. An IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO shall notify the Claimant, in a timely manner, of its acceptance of the review and inform the Claimant of the deadlines for submissions of additional information which shall be no later than ten business days following receipt of this notice.

Within five business days of assignment of the external review to the IRO, the Plan shall provide to the IRO any documents and information it used in making its Adverse Benefit Determination or Final Internal Adverse Benefit Determination.

Notice of Final Review Decision

The IRO must provide written notice of the Final External Review Decision within 45 days after receiving the request for the external review. The notice must be delivered to the Claimant and to the Plan.

Expedited External Review

External review procedures may be expedited for cases where completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or would jeopardize his or her ability to regain maximum function, an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility. For an expedited 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 non-written 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 arbitration 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.

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 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, 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.

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

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

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.

Bariatric Services – 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 section, “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 Covered Provider is a participating Provider and has concluded that the individual’s participation in such trial would be appropriate; or (2) the Covered Participant or beneficiary 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 – Your share of the costs of a covered health care service, calculated as a percent of the Allowable Charges for the service.

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.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits hereunder.

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/Plan Participant – An individual who meets the eligibility requirements as contained herein (e.g., a covered Employee, a covered Dependent, or a Qualified Beneficiary [COBRA]). 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 Expense(s) – Expense that is covered by a specific benefit provision of the Benefit Document.

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.

Employer(s) – The Employer or Employers participating in these Plan benefits as reflected in the **General Plan Information** section.

Essential Health Benefits – Items and services covered within the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and 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:

- 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;
- It is not covered under Medicare reimbursement laws, regulations or interpretations;
- It is not commonly and customarily recognized by the medical profession or appropriate for the condition being treated; or

- “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”) was created by the Affordable Care Act, which created a new mechanism for purchasing coverage called Exchanges, which are entities that will be set up in states to create a more organized and competitive market for health insurance by offering a choice of health plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them. In California, the applicable Exchange is “Covered California.” See <http://www.coveredca.com/> for more information.

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 (RN) 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 patient;
- 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 that:

- Mainly provides Inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons;
- Is supervised by a staff of Physicians;
- Provider 24-hour-a-day services by Registered Nurses (RNs);
- Is not mainly a place for rest for aged, for drug addicts, for alcoholics, or a nursing home; and
- Makes charges.

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 a Medical/Rx ID card to a Covered Person for purposes of identifying him/her to a Covered Provider.

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.

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

Inpatient – A person physically occupying a room and being charged for room and board in a facility (e.g., Hospital, or Convalescent Facility) 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 – 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 a Sickness or Accidental 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 his or her license; and
 - It must not be maintenance therapy or maintenance treatment;
 - Its purpose must be to restore health;
 - It must not be primarily custodial in nature;
 - It must not be a listed item or treatment not allowed for reimbursement by Medicare;
 - 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 covered 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 89-98 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 Services as “Prime Providers” or Prime Healthcare Services Network Providers, Blue Shield of CA Network Providers and BCBS BlueCard providers for out-of-California services. For Emergency Services not received at a Prime Healthcare Network facility, BCBS BlueCard/Blue Shield of CA Network is deemed to be the Network Provider.

Non-Network Provider – A facility, Physician, or other licensed health care professional who does not have a Network provider agreement with Prime Healthcare Services, BCBS BlueCard/Blue Shield of CA Network.

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.

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:

- 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) & 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.

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).

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 THE COVERED PERSON HIMSELF, HIS RELATIVES (SEE **GENERAL EXCLUSIONS**) OR INTERNS, RESIDENTS, FELLOWS OR OTHERS ENROLLED IN A GRADUATE MEDICAL EDUCATION PROGRAM.

Plan – The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator – see “Plan Sponsor.”

Plan Document – A formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments.

Plan Sponsor – The entity sponsoring the Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

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 B**.

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

Provider – An individual who is:

- Licensed in the state to perform certain health care services that are covered hereunder and who is acting within the scope of his 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 his license;
- Facilities as are defined herein including, but not limited to, Hospitals, Residential Treatment Facilities, Ambulatory Surgical Facilities, 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.

NOTE: A NETWORK PROVIDER DOES NOT INCLUDE: (1) A COVERED PERSON TREATING HIMSELF 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 HIS 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.

Registered Domestic Partner – A relationship established under California Family Code Sections 297-297.5 An individual, who has filed, along with the Employee, a Declaration of Registered Domestic Partnership with the Secretary of State of California, or a similar declaration issued by another state, and at the time of enrollment in the Plan meets all the following requirements: (1) both Persons have a common residence; (2) neither person is married to someone else or is a member of another Registered Domestic Partnership with someone else that has not been terminated, dissolved or adjudicated a nullity; (3) the two persons are not related by blood in a way that would prevent them from being married to each other in the state of California; (4) both persons are at least 18 years of age; and (5) both persons are either members of the same sex or else one or both of the persons are 62 years of age or older and are entitled to Medicare or Social Security.

Rehabilitation Center – See “Skilled Nursing Facility.”

Registered Domestic Partner – A relationship established under California Family Code Sections 297-297.5 or other similar applicable State law.

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 abuse 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 (RN) 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) – Prime Healthcare Utilization Management Review Department must authorize any elective or non-Emergency Services which are rendered in the Prime Healthcare Network or BlueShield of California PPO Network.

GENERAL PLAN INFORMATION

Name of Plan: Prime Healthcare Services, Inc.
Welfare Benefits Plan

Plan Sponsor / Plan Administrator: Prime Healthcare Services, Inc.
Address: 3480 East Guasti Road
Ontario, CA 91761
Business Phone Number: (909) 235-4400

Plan Sponsor ID Number (EIN): 33-0943449

Plan Number: 501
Plan Year: January 1 through December 31

Named Fiduciary: Prime Healthcare Services, Inc.
Address: 3480 East Guasti Road
Ontario, CA 91761
(See also definition of “Fiduciary”)

Agent for Service of Legal Process: General Counsel
Prime Healthcare Services, Inc.
Address: 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 Section 125 pre-tax premium plan.

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

ADMINISTRATIVE PROVISIONS

Administration (type of)

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. The Contract Administrator is not an insurance company.

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 Sponsor 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 Sponsor'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 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 done by written amendment that is signed by at least one Fiduciary of the Plan. 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 Employer or Plan Sponsor 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 Summary Plan Description and any other document or communication, this Summary Plan Description 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.

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 he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife 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, 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 Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciary Responsibility and Authority

Fiduciaries will serve at the discretion of the Plan Administrator and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan Administrator and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to Provider Networks or Utilization Management Organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

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.

Indemnification

Except as otherwise provided in ERISA, no Director, Officer or Employee of the Plan Sponsor shall incur any personal liability for the breach of any responsibility, obligation or duty in connection with any act done or omitted to be done in good faith in the administration or management of the Plan and shall be indemnified and held harmless by the Plan Sponsor from and against any such personal

liability, including all expenses reasonably incurred in their defense if the Plan Sponsor fails to provide such defense.

The Plan Sponsor may purchase insurance to cover the potential liability of Directors, Officers and employees serving in a Fiduciary capacity with respect to the Plan and the Plan itself, at its expense, may insure itself against loss by misdeeds or omissions of Plan Fiduciaries. The company may also purchase insurance to cover the exposure of its Directors, Officers and employees by reason of such right or recourse.

Legal Actions

Until the Plan Sponsor has issued its final decision on a claim, no legal action can be brought to recover under this Plan. No such action may be brought at all unless it is brought within three (3) years from the deadline for filing a 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 Person or beneficiary 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 his 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.

Material Modification

In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) increases premiums, deductibles, Coinsurance, Copays, or other amounts to be paid by a Plan participant or beneficiary, or (3) establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

Misstatement/Misrepresentation

If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form 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 with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be rescinded to reflect his true status.

A fraudulent or intentional misrepresentation of marital status, Dependent status or age will rescind coverage 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.

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, including but not limited to the Transitional Reinsurance Program Fee as required by the Affordable Care Act. Such fees 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.

Privacy Rules, Security Standards and Breach Notification Rules

To the extent required by law, the Plan is amended and will comply with: (1) the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA), and (2) the HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

The 2009 breach notification regulations and the Health Information Technology for Economic and Clinical Health (HITECH) Act, require HIPAA covered entities and their business associates to provide notification to an affected individual following a breach of unsecured protected health information. Such individual notification must be provided within a reasonable period of time and in no case later than 60 days following the discovery of a breach. To the extent possible, such affected individual must also be provided with a description of the breach, a description of the types of information that were involved in the breach, the steps the individual should take to protect themselves from potential harm, a brief description of what the covered entity is doing to investigate the breach, mitigate the harm, and prevent further breaches, as well as contact information for the covered entity. More information is available on the U.S. Department of Health and Human Services' website.

NOTES: The Privacy Rules requirements do not apply to “summary health information” which is provided only for the purpose of obtaining premium bids or for modifying or terminating the Plan. “Summary health information” is health-related information that is in a form that excludes individual identifiers such as names, addresses, social security numbers or other unique patient-identifying numbers or characteristics.

Please refer to the Prime Healthcare Services Group Welfare Benefits Plan Summary Plan Description Wrap Supplement for a complete description of your privacy rights under HIPAA.

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 maintained by 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 maintained by 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 therefore 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 Sponsor 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 the Employee or any of his Dependents.

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 Sponsor 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, his eligibility, benefits or both, will be Rescinded, retroactively to the date thereof, to reflect his 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 Plan Participant 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.

STATEMENT OF RIGHTS

Covered Persons 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 participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

This includes:

The right to continue health care coverage for himself, spouse or dependents if there is a loss of coverage under a Plan as a result of a Qualifying Event. The Employee or his dependents may have to pay for such coverage. See the **COBRA Continuation Coverage** section for additional details about these rights. An individual should be provided a certificate of creditable coverage, free of charge, from his group health plan or health insurance issuer when he loses coverage under a plan, when he becomes entitled to elect COBRA continuation coverage, when his COBRA continuation coverage ceases, if he requests it before losing coverage or if he requests it up to 24 months after losing coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, 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 Plan participants and beneficiaries. No one, including the employer, may fire a Covered Person or discriminate against him to prevent him from obtaining a welfare benefit or exercising rights under ERISA.

ENFORCEMENT OF RIGHTS

If an individual's claim for a welfare benefit is denied in whole or in part, he must receive a written explanation of the reason for the denial. He has the right to have the Plan Administrator review and reconsider his claim.

Under ERISA there are steps a Covered Person can take to enforce the above rights. For instance, if he requests materials from a Plan and does not receive them within 30 days, he may file suit in a Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay him up to \$110 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If he has a claim for benefits which is denied or ignored, in whole or in part, he may file suit in a state or Federal Court. In addition, if he disagrees with the Plan decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), he may file suit in Federal Court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if he is discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor, or he may file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If he is successful, the court may order the person he has sued to pay these costs and fees. If he loses, the court may order him to pay these costs and fees, for example, if it finds his claim is frivolous.

ASSISTANCE WITH HIS QUESTIONS

If a Covered Person has any questions about a Plan, he should contact the Plan Administrator. If he has any questions about this statement or about his rights under ERISA, he should contact: (1) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in his telephone directory, 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 his 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 coverage 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 Registered Domestic Partner is not 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 employment 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 his 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 his or her 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 RESPONSIBILITIES

If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, 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 his 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 later 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 the Health Insurance Portability and Accountability Act (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 Healthcare Provider regarding a Qualified Beneficiary's right to coverage during the election period.

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 his 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 his 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 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 his 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. When key parts of the health care law take effect, they will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, they could be eligible for a new kind of 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.

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 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 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 his or her 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 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 his or her Medicare coverage is in effect;
- In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - 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

- o The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;
- o 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 Healthcare 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.

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 his 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 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.

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.

APPENDIX A

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15, 2021. Contact your State for more information on eligibility –

ALABAMA – MEDICAID

Website: <http://myalhipp.com>
Phone: 855.692.5447

ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 866.251.4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
<http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS – MEDICAID

Website: <http://myarhipp.com/>
Phone: 855.MyARHIPP (855.692.7447)

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program Website:
<http://dhcs.ca.gov/hipp>
Phone: 916.445.8322
Email: hipp@dhcs.ca.gov

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website:
<https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
800.221.3943 | State Relay 711
CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>
CHP+ Customer Service: 800.359.1991 | State Relay 711
Health Insurance Buy-In Program (HIBI):
<https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>
HIBI Customer Service: 855.692.6442

FLORIDA – MEDICAID

Website:
<http://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 877.357.3268

GEORGIA – MEDICAID

Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678.564.1162, ext. 2131

INDIANA – MEDICAID

Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov./fssa/hip/>
Phone: 877.438.4479
All other Medicaid
Website: <https://www.in.gov/medicaid/>
Phone: 800.457.4584

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website: <https://dhs.iowa.gov/ime/members>
Medicaid Phone: 800.338.8366
Hawki Website: <http://dhs.iowa.gov/Hawki>
Hawki Phone: 800.257.8563
HIPP Website:
<https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
HIPP Phone: 888.346.9562

KANSAS – MEDICAID

Website: <https://www.kancare.ks.gov/>
Phone: 800.792.4884

KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
Phone: 855.459.6328
Email: KIHIPPPROGRAM@ky.gov
KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>
Phone: 877.524.4718
Kentucky Medicaid Website: <https://chfs.ky.gov>

LOUISIANA – MEDICAID

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

MAINE – MEDICAID

Enrollment Website:
<https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: 800.442.6003 | State Relay 711
Private Health Insurance Premium Webpage:
<https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: 800.977.6740 | State Relay 711

MASSACHUSETTS – MEDICAID AND CHIP

Website: <https://www.mass.gov/info-details/masshealth-premium-assistance-pa>
Phone: 800.862.4840

MINNESOTA – MEDICAID

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
Phone: 800.657.3739

MISSOURI – MEDICAID

Website:
<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573.751.2005

MONTANA – MEDICAID

Website:
<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 800.694.3084

NEBRASKA – MEDICAID

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – MEDICAID

Medicaid Website: <https://dhcfp.nv.gov>
Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – MEDICAID

Website: <https://www.dhhs.nh.gov/oi/hipp.htm>
Phone: 603.271.5218
HIPP Program Toll-Free Phone: 800.852.3345, ext. 5218

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website:
<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 609.631.2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 800.701.0710

NEW YORK – MEDICAID

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800.541.2831

NORTH CAROLINA – MEDICAID

Website: <https://medicaid.ncdhhs.gov/>
Phone: 919.855.4100

NORTH DAKOTA – MEDICAID

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 844.854.4825

OKLAHOMA – MEDICAID AND CHIP

Website: <http://www.insureoklahoma.org>
Phone: 888.365.3742

OREGON – MEDICAID

Websites: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
Phone: 800.699.9075

PENNSYLVANIA – MEDICAID

Website:
<https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>
Phone: 800.692.7462

RHODE ISLAND – MEDICAID AND CHIP

Website: <http://www.eohhs.ri.gov>
Phone: 855.697.4347 or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID

Website: <https://www.scdhhs.gov>
Phone: 888.549.0820

SOUTH DAKOTA – MEDICAID

Website: <http://dss.sd.gov>
Phone: 888.828.0059

TEXAS – MEDICAID

Website: <http://gethipptexas.com/>
Phone: 800.440.0493

UTAH – MEDICAID AND CHIP

Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website: <http://health.utah.gov/chip>
Phone: 877.543.7669

VERMONT – MEDICAID

Website: <http://www.greenmountaincare.org/>
Phone: 800.250.8427

VIRGINIA – MEDICAID AND CHIP

Website: <https://www.coverva.org/en/famis-select>
<https://www.coverva.org/en/hipp/>
Medicaid Phone: 800.432.5924
CHIP Phone: 800.432.5924

WASHINGTON – MEDICAID

Website: <https://www.hca.wa.gov/>
Phone: 800.562.3022

WEST VIRGINIA – MEDICAID

Website: <http://mywvhipp.com/>
Toll-Free Phone: 855.MyWVHIPP (855.699.8447)

WISCONSIN – MEDICAID AND CHIP

Website:
<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 800.362.3002

WYOMING – MEDICAID

Website:
<https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
Phone: 800.251.1269

To see if any other states have added a premium assistance program since October 15, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, menu option 4, ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

APPENDIX B

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 persons.
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 delay.
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
Hypothyroidism 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, 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
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
<i>Haemophilus influenzae</i> type b vaccine	Hib (PRP-T) Hib (PRP-OMP)	Act-Hib® 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)	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 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® Tdva™
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 <i>Haemophilus influenzae</i> type b vaccine	DTap-IPV/Hib	Pentacel®
DTap and inactivated poliovirus vaccine	DTap-IPV	Kinrix® Quadriacel®
DTap, inactivated poliovirus, <i>Haemophilus influenzae</i> 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



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)	1 st dose	← 2 nd dose →					← 3 rd dose →										
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)		1 st dose	2 nd dose	See Notes													
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)		1 st dose	2 nd dose	3 rd dose	See Notes		← 4 th dose →				5 th dose						
<i>Haemophilus influenzae</i> type b (Hib)		1 st dose	2 nd dose	3 rd or 4 th dose	See Notes												
Pneumococcal conjugate (PCV13)		1 st dose	2 nd dose	3 rd dose	See Notes		← 4 th dose →										
Inactivated poliovirus (IPV <18 yrs)		1 st dose	2 nd dose	3 rd dose	See Notes		← 4 th dose →										
Influenza (IV) or Influenza (LAIV4)				Annual vaccination 1 or 2 doses									Annual vaccination 1 or 2 doses				
Measles, mumps, rubella (MMR)					See Notes		← 1 st dose →						2 nd dose				
Varicella (VAR)							← 1 st dose →						2 nd 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 ≥2 years)																	1 st dose
Meningococcal B																	2 nd dose
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.**

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	
<i>Haemophilus influenzae</i> 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 1 st 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 PIP-T (Acellular Pertussis, Hib, Polio) 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 1 st birthday and second dose was administered at younger than 15 months; OR if both doses were PIP-OMP (Pneumococcal, Comvax) and were administered before the 1 st birthday.	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1 st 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 1 st birthday. 8 weeks (as final dose for healthy children) if first dose was administered at the 1 st 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, and acellular pertussis	7 years	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1 st birthday. 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1 st birthday.		6 months if first dose of DTaP/DT was administered before the 1 st 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									
	Pregnancy	Immunocompromised status (excluding HIV infection)	HIV infection total CD4 cell count of <200/mm ³	HIV infection CD4+ count ¹ ≥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 deficiencies	Chronic liver disease	Diabetes
Hepatitis B										
Rotavirus		SCID ²								
Diphtheria, tetanus, and acellular pertussis (DTaP)										
<i>Haemophilus influenzae</i> type b										
Pneumococcal conjugate										
Inactivated poliovirus										
Influenza (IV) OR Influenza (LAIV4)										
Measles, mumps, rubella	*									
Varicella	*									
Hepatitis A										
Tetanus, diphtheria, and acellular pertussis (Tdap)										
Human papillomavirus	*									
Meningococcal ACWY										
Meningococcal B										
Pneumococcal polysaccharide										

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

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; 2018:867–111).
- 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.

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

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

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, Hibberix, 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 $\geq 2,000$ 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 $\geq 2,000$ 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.

Influenza vaccination

(minimum age: 6 months [IV], 2 years [LAIV])
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 vaccination 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 Flucevax, 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.
- **LAIV should not be used** in persons with the following conditions or situations:
 - History of severe allergic reaction to a previous dose of any influenza vaccine or to any vaccine component (excluding egg; see details above)
 - Receiving aspirin or salicylate-containing medications
 - Age 2–4 years with history of asthma or wheezing
 - Immunocompromised due to any cause (including medications and HIV infection)
 - Anatomic or functional asplenia
 - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
 - Pregnancy
 - Cochlear implant
 - Cerebrospinal fluid-opharyngeal 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

- **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 **Recombinax HB** only).
- Adolescents age 18 years or older may receive a 2-dose series of HepB (**HepSiv-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

- **Immuno-compromising 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

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/r6909a1.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
- Menveo 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/r6909a1.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)
 - 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

Notes

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 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.

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

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_cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
- Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
- Doses of OPV administered on or after April 1, 2016, should not be counted.
- For guidance to assess doses documented as “OPV,” see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Table 2.

Rotavirus vaccination
(minimum age: 6 weeks)

Routine vaccination

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

Catch-up vaccination

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

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

Routine vaccination

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

Catch-up vaccination

- **Adolescents age 13–18 years who have not received Tdap:** 1 dose Tdap, then Td or Tdap booster every 10 years
- **Persons age 7–18 years not fully vaccinated* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at 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 Tdap 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](http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) 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)

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).

Vaccines in the Adult Immunization Schedule*

Vaccines	Abbreviations	Trade names
<i>Haemophilus influenzae</i> type b vaccine	Hib	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	HepA	Havrix® Vaqta®
Hepatitis A and hepatitis B vaccine	HepA+HepB	Twintix®
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	Prenvair 13®
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax 23®
Tetanus and diphtheria toxoids	Td	Tenivac™ Tdavax™
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.

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

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Table 1 Recommended Adult Immunization Schedule by Age Group, United States, 2021

Vaccine	19–26 years	27–49 years	50–64 years	>65 years
Influenza inactivated (IIV) or influenza recombinant (RIV4) or Influenza live, attenuated (LAIV4)		1 dose annually or 1 dose annually		
Tetanus, diphtheria, pertussis (Tdap or Td)		1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management (see notes)		
Measles, mumps, rubella (MMR)		1 dose Tdap, then Td or Tdap booster every 10 years		
Varicella (VAR)		1 or 2 doses depending on indication (if born in 1957 or later)		
Zoster recombinant (RZV)		2 doses (if born in 1980 or later)	2 doses	
Human papillomavirus (HPV)			2 doses	
Pneumococcal conjugate (PCV13)		2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years	
Pneumococcal polysaccharide (PPSV23)			1 or 2 doses depending on indication	1 dose
Hepatitis A (HepA)			2 or 3 doses depending on vaccine	
Hepatitis B (HepB)			2 or 3 doses depending on vaccine	
Meningococcal A, C, W, Y (MenACWY)			1 or 2 doses depending on indication, see notes for booster recommendations	
Meningococcal B (MenB)			2 or 3 doses depending on vaccine and indication, see notes for booster recommendations	
Haemophilus influenzae type b (Hib)			19 through 23 years	1 or 3 doses depending on indication

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection
 Recommended vaccination for adults with an additional risk factor or another indication
 Recommended vaccination based on shared clinical decision-making
 No recommendation/Not applicable

Table 2 Recommended Adult Immunization Schedule by Medical Condition and Other Indications, United States, 2021

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 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
IIV or RIV4 or LAIV4		Not Recommended	<200 mm ³							1 dose annually
			≥200 mm ³							1 dose annually
Tdap or Td	1 dose Tdap each pregnancy									1 dose annually
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*									2 or 3 doses 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										<60 years ≥60 years
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 HSCIP recipients only								1 dose

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, 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/macc-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 (Havix 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 HepB or 3-dose series HepA-HepB) only applies when 2 doses of HepB 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 (HepB 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 (HepB 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 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**

Notes

Recommended Adult Immunization Schedule, United States, 2021

- **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 ccliv4, 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)
 - Anatomical 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/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 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
- **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/r6909a1.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 (Trumenb) 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/r6909a1.htm

Pneumococcal vaccination

Routine vaccination

- **Age 65 years or older** (immunocompetent—see www.cdc.gov/mmwr/volumes/68/wr/mm6846a5.htm?ts_cid=mm6846a5_wj); 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/mm³ with no evidence of immunity:** Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with 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:** Consider delaying RZV until after pregnancy if RZV is otherwise indicated.
- **Severe immunocompromising conditions (including HIV infection with CD4 count < 200 cells/mm³):** Recommended use of RZV under review

2/11/2021

Centers for Disease Control and Prevention | Recommended Adult Immunization Schedule, United States, 2021

APPENDIX C

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 | <ul style="list-style-type: none"> ▪ 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 | <ul style="list-style-type: none"> ▪ 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 | <ul style="list-style-type: none"> ▪ 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: | <ul style="list-style-type: none"> ▪ 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: | <ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ We can use your health information and share it with professionals who are treating you. 	<p>Example: A doctor sends us information about your diagnosis and treatment plan, so we can arrange additional services.</p>
Run our organization	<ul style="list-style-type: none"> ▪ 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. 	<p>Example: We use health information about you to develop better services for you.</p>
Pay for your health services	<ul style="list-style-type: none"> ▪ We can use and disclose your health information as we pay for your health services. 	<p>Example: We share information about you with your dental plan to coordinate payment for your dental work.</p>
Administer your plan	<ul style="list-style-type: none"> ▪ We may disclose your health information to your health plan sponsor for plan administration. 	<p>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.</p>
<p>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</p>		
Help with public health and safety issues	<ul style="list-style-type: none"> ▪ We can share health information about you for certain situations such as: <ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ We can use or share your information for health research. 	

OUR USES AND DISCLOSURES *CONTINUED*

Comply with the law	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ We can use or share health information about you: <ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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 D

COVERAGE RELATING TO COVID-19

“FAMILIES FIRST CORONAVIRUS RESPONSE ACT” (“FFFCRA”) AND THE “CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT” (“CARES ACT”)

This Appendix D 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): Copays, 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): Copays, 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): Copays, 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.

AMENDMENT 1
PRIME HEALTHCARE
SUMMARY PLAN DESCRIPTION OF THE
SHASTA REGIONAL MEDICAL CENTER CHEU & SHASTA
REGIONAL MEDICAL GROUP EPO 4
MEDICAL AND PRESCRIPTION DRUG BENEFITS

Effective January 1, 2023, the Prime Healthcare Summary Plan Description of the Shasta Regional Medical Center CHEU & Shasta Regional Medical Group EPO 4 Medical and Prescription Drug Benefits (the “Plan”), dated January 1, 2022, is hereby amended as follows:

Delete “**APPENDIX A – PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)**” and “**APPENDIX B – PREVENTIVE CARE SERVICES**” and replace them with new **APPENDIX A** and **APPENDIX B** attached hereto.

There are no other changes to the Plan.

APPENDIX A

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – MEDICAID

Website: <http://myalhipp.com>
Phone: (855) 692-5447

ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: (866) 251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
<https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – MEDICAID

Website: <http://myarhipp.com/>
Phone: (855) MyARHIPP ((855) 692-7447)

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program
Website: <http://dhcs.ca.gov/hipp>
Phone: (916) 445-8322
Fax: (916) 440-5676
Email: hipp@dhcs.ca.gov

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website:
<https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
(800) 221-3943 | State Relay 711
CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>
CHP+ Customer Service: (800) 359-1991 | State Relay 711
Health Insurance Buy-In Program (HIBI):
<https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>
HIBI Customer Service: (855) 692-6442

FLORIDA – MEDICAID

Website:
<http://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: (877) 357-3268

GEORGIA – MEDICAID

GA HIPP Website:
<https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: (678) 564-1162, Press 1
GA CHIPRA Website:
<https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: (678) 564-1162, Press 2

INDIANA – MEDICAID

Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov./fssa/hip/>
Phone: (877) 438-4479
All other Medicaid
Website: <https://www.in.gov/medicaid/>
Phone: (800) 457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website: <https://dhs.iowa.gov/ime/members>
Medicaid Phone: (800) 338-8366
Hawki Website: <http://dhs.iowa.gov/Hawki>
Hawki Phone: (800) 257-8563
HIPP Website:
<https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
HIPP Phone: (888) 346-9562

KANSAS – MEDICAID

Website: <https://www.kancare.ks.gov/>
Phone: (800) 792-4884

KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
Phone: (855) 459-6328
Email: KIHIPPPROGRAM@ky.gov
KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>
Phone: (877) 524-4718
Medicaid Website: <https://chfs.ky.gov>

LOUISIANA – MEDICAID

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: (888) 342-6207 (Medicaid hotline) or (855) 618-5488 (LaHIPP)

MAINE – MEDICAID

Enrollment Website:
<https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: (800) 442-6003 | State Relay 711
Private Health Insurance Premium Webpage:
<https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: (800) 977-6740 | State Relay 711

MASSACHUSETTS – MEDICAID AND CHIP

Website: <https://www.mass.gov/masshealth/pa>
Phone: (800) 862-4840
TTY: (617) 886-8102

MINNESOTA – MEDICAID

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
Phone: (800) 657-3739

MISSOURI – MEDICAID

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
 Phone: (573) 751-2005

MONTANA – MEDICAID

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
 Phone: (800) 694-3084
 Email: HSHIPPProgram@mt.gov

NEBRASKA – MEDICAID

Website: <http://www.ACCESSNebraska.ne.gov>
 Phone: (855) 632-7633
 Lincoln: (402) 473-7000
 Omaha: (402) 595-1178

NEVADA – MEDICAID

Medicaid Website: <http://dhcnp.nv.gov>
 Medicaid Phone: (800) 992-0900

NEW HAMPSHIRE – MEDICAID

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
 Phone: (603) 271-5218
 HIPP Program Toll-Free Phone: (800) 852-3345, ext. 5218

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
 Medicaid Phone: (609) 631-2392
 CHIP Website: <http://www.njfamilycare.org/index.html>
 CHIP Phone: (800) 701-0710

NEW YORK – MEDICAID

Website: https://www.health.ny.gov/health_care/medicaid/
 Phone: (800) 541-2831

NORTH CAROLINA – MEDICAID

Website: <https://medicaid.ncdhhs.gov/>
 Phone: (919) 855-4100

NORTH DAKOTA – MEDICAID

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
 Phone: (844) 854-4825

OKLAHOMA – MEDICAID AND CHIP

Website: <http://www.insureoklahoma.org>
 Phone: (888) 365-3742

OREGON – MEDICAID

Websites: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
 Phone: (800) 699-9075

PENNSYLVANIA – MEDICAID

Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>
 Phone: (800) 692-7462

RHODE ISLAND – MEDICAID AND CHIP

Website: <http://www.eohhs.ri.gov>
 Phone: (855) 697-4347 or (401) 462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID

Website: <https://www.scdhhs.gov>
 Phone: (888) 549-0820

SOUTH DAKOTA – MEDICAID

Website: <http://dss.sd.gov>
 Phone: (888) 828-0059

TEXAS – MEDICAID

Website: <http://gethipptexas.com/>
 Phone: (800) 440-0493

UTAH – MEDICAID AND CHIP

Medicaid Website: <https://medicaid.utah.gov/>
 CHIP Website: <http://health.utah.gov/chip>
 Phone: (877) 543-7669

VERMONT – MEDICAID

Website: <http://www.greenmountaincare.org/>
 Phone: (800) 250-8427

VIRGINIA – MEDICAID AND CHIP

Website: <https://www.coverva.org/en/famis-select>
<https://www.coverva.org/en/hipp/>
 Medicaid Phone: (800) 432-5924
 CHIP Phone: (800) 432-5924

WASHINGTON – MEDICAID

Website: <https://www.hca.wa.gov/>
 Phone: (800) 562-3022

WEST VIRGINIA – MEDICAID AND CHIP

Website: <https://dhhr.wv.gov/bms/>
<http://mywvhipp.com/>
 Medicaid Phone: (304) 558-1700
 CHIP Toll-Free Phone: (855) MyWVHIPP ((855) 699-8447)

WISCONSIN – MEDICAID AND CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
 Phone: (800) 362-3002

WYOMING – MEDICAID

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
 Phone: (800) 251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
 (866) 444-EBSA (3272)

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 (877) 267-2323, menu option 4, ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

APPENDIX B – 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 persons.
	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.
Hypothyroidism 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
<i>Haemophilus influenzae</i> 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)	IV4	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	Prenar 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 <i>Haemophilus influenzae</i> type b vaccine	DTap-IPV/Hib	Pentacel®
DTap and inactivated poliovirus vaccine	DTap-IPV	Kinrix® Quadacel®
DTap, inactivated poliovirus, <i>Haemophilus influenzae</i> 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 vaccine types, frequencies, 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

Scan QR code for access to online schedule



CS310020-A



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

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).

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)	1 st dose	← 2 nd dose →					← 3 rd dose →										
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)		1 st dose	2 nd dose	See Notes													
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)		1 st dose	2 nd dose	3 rd dose	3 rd dose		← 4 th dose →					5 th dose					
Haemophilus influenzae type b (Hib)		1 st dose	2 nd dose	2 nd dose	See Notes		← 3 rd or 4 th dose → See Notes										
Pneumococcal conjugate (PCV13)		1 st dose	2 nd dose	2 nd dose	3 rd dose		← 4 th dose →										
Inactivated poliovirus (IPV <18 yrs)		1 st dose	2 nd dose	2 nd dose	3 rd dose		← 3 rd dose →					4 th dose					
Influenza (IIV4) or Influenza (LAIV4)										Annual vaccination 1 or 2 doses			Annual vaccination 1 or 2 doses		Annual vaccination 1 dose only		
Measles, mumps, rubella (MMR)						See Notes	← 1 st dose →						2 nd dose				
Varicella (VAR)							← 1 st dose →						2 nd dose				
Hepatitis A (HepA)						See Notes											
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)																	1 dose
Human papillomavirus (HPV)																	See Notes
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos, MenACWY-TT ≥2 years)																	1 st dose
Meningococcal B (MenB-4C, MenB-FHbp)																	See Notes
Pneumococcal polysaccharide (PPSV23)																	See Notes
Dengue (DENACYD; 9-16 yrs)																	See Notes

Range of recommended ages for catch-up vaccination
 Range of recommended ages for certain high-risk groups
 Recommended vaccination can begin in this age group
 Recommended vaccination based on shared clinical decision-making
 No recommendation/not applicable
 Seropositive in endemic areas only (See Notes)

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.**

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
<i>Haemophilus influenzae</i> 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 1 st 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 PIP-T (ActHib [®] , Pentacel [®] , Hibberix [®] , 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 1 st birthday and second dose was administered at younger than 15 months; OR if both doses were PerwaxHIB [®] and were administered before the 1st birthday	6 months	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1 st 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 1 st birthday. 8 weeks (as final dose for healthy children) if first dose was administered at the 1 st 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
Meningococcal ACWY	Not applicable (N/A)	8 weeks			
Tetanus, diphtheria, tetanus toxoids, and acellular pertussis	7 years	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1 st birthday 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1 st birthday		6 months if first dose of DTaP/DT was administered before the 1 st 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 if 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 ages 12 through 15 months after 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			

Children and adolescents age 7 through 18 years

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.

VACCINE	INDICATION									
	Pregnancy	Immunocompromised status (excluding HIV infection)	HIV infection total CD4 cell count of <200/mm ³	HIV infection CD4+ count ¹ ≥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 deficiencies	Chronic liver disease	Diabetes
Hepatitis B										
Rotavirus		SCID ²								
Diphtheria, tetanus, and acellular pertussis (DTaP)										
<i>Haemophilus influenzae</i> type b										
Pneumococcal conjugate										
Inactivated poliovirus										
Influenza (IV4) or Influenza (LAIV4)										
Measles, mumps, rubella	*									
Varicella	*									
Hepatitis A										
Tetanus, diphtheria, and acellular pertussis (Tdap)										
Human papillomavirus	*									
Meningococcal ACWY										
Meningococcal B										
Pneumococcal polysaccharide										
Dengue										

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 or vaccine. See Notes.
 Precaution—vaccine 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 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/imz/adcp/ics/immunocompetence.html and Table 4-1 (footnote J) at www.cdc.gov/vaccines/imz/adcp/ics/general-ics/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

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 (eg, 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.

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

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?z=detail&tid=7006a1_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 Quadriacel®))

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[®], Hibberix[®], 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.

- **PedvaxiHB[®]**; 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 PedvaxiHB[®] 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 the 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

- 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

- 1 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)

- 2-dose series (minimum interval: 6 months) at age 12–23 months
- **Routine vaccination** (minimum interval: 6 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)

- **Birth dose (monovalent HepB vaccine only)**
 - 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 3 to dose 4: 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).
- **Recombivax HB**® (HepB+HBsAg) at least 4 weeks apart.
- Adolescents age 18 years or older may receive a 2-dose series of HepB 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 [IV], 2 years [LAIV], 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/r7005a1.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 16–18 years: 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)

Special situations

- **Anatomic or functional asplenia (including sickle cell disease), HIV infection; persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:**
 - 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/r6909a1.htm.

Meningococcal serogroup B vaccination

(minimum age: 10 years [MenB-4C, Bexsero[®]; MenB-HHbp, 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:
 - **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.

- **Bexsero**[®]; 2-dose series at least 1 month apart

- **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/r6909a1.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)

- No history of PPSV23; 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

Cerebrospinal fluid leak, cochlear implant:

- 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 the most recent dose of PCV13)

- 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; 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
 - 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 the most recent dose of PCV13)

- Age 6–18 years
 - No history of either PCV13 or PPSV23; 1 dose PCV13, 2 doses 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

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[®]

- **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[®]

- **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[®]

- **Travel in countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj** (www.cdc.gov/travel/):

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- **Menveo**[®] (age 2–23 months)
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 - 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)

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- **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)
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- 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)
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- 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[®]

- **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)

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/r15911.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_cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.

Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).

Doses of OPV administered on or after April 1, 2016, should not be counted.

For guidance to assess doses documented as “OPV,” see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.

- For other catch-up guidance, see Table 2.

Rotavirus vaccination (minimum age: 6 weeks)

Routine vaccination

- Rotarix**: 2-dose series at 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^a 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.
- 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.

^aFully 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 www.cdc.gov/mmwr/pdf/rr/r15604.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: Contraindications 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/immwrt/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)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIV, RIV, or LAIV of any valency) Severe allergic reaction (e.g., anaphylaxis) to any vaccine component³ (excluding egg) 	<ul style="list-style-type: none"> 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 [(ccIV4); Fluceivax [®] Quadrivalent]	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) to any ccIV of any valency, or to any component³ of ccIV4 	<ul style="list-style-type: none"> 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]	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component³ of RIV4 	<ul style="list-style-type: none"> 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, ccIV, 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]	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIV, RIV, or LAIV of any valency) Severe allergic reaction (e.g., anaphylaxis) to any vaccine component³ (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 	<ul style="list-style-type: none"> 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

- 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
- 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
- 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 (DENV4CVD)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 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) 	<ul style="list-style-type: none"> Pregnancy HIV infection without evidence of severe immunosuppression Moderate or severe acute illness with or without fever
Diphtheria, tetanus, pertussis (DTaP) Tetanus diphtheria (DT)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 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 	<ul style="list-style-type: none"> 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 tetanus-toxoid – containing vaccine (deter vaccination until at least 10 years have elapsed since the last dose) For DTaP only: Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy, dejer DTaP until neurologic status clarified and stabilized Moderate or severe acute illness with or without fever
<i>Haemophilus influenzae</i> type b (Hib)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ For Hibrix, A-Chib, and PedvaxHB only: History of severe allergic reaction to dry natural latex Less than age 6 weeks 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ including neomydn 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ including yeast For Hepbisav-B only: Pregnancy 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Hepatitis A, Hepatitis B vaccine (HepA-HepB, Twinrix [®])	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ including neomydn and yeast 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 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 	<ul style="list-style-type: none"> 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 [®])	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ For MenACWY and MenACWY-CRM only: severe allergic reaction to any diphtheria toxoid – or CRM1197 – containing vaccine For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine 	<ul style="list-style-type: none"> 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 (Biosero [®]) MenB-HPb (Trumenb [®])	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 	<ul style="list-style-type: none"> Pregnancy For MenB-4C only: Latex sensitivity Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV13)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid – containing vaccine or its component³ 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Poliovirus vaccine inactivated (IPV)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 	<ul style="list-style-type: none"> Pregnancy Moderate or severe acute illness with or without fever
Rotavirus (RV) (RV1 (Rotarix [®]), RV5 (RotaTeq [®]))	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ Severe combined immunodeficiency (SCID) History of intussusception 	<ul style="list-style-type: none"> Altered immunocompetence other than SCID Chronic gastrointestinal disease RV1 only: Spina bilida or bladder atrophy Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 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 	<ul style="list-style-type: none"> 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 tetanus-toxoid – containing vaccine (deter vaccination until at least 10 years have elapsed since the last dose) 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)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 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 	<ul style="list-style-type: none"> 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, Bahita L, Hunter P, ACP 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, Bahita L, Hunter P, ACP 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)
<i>Haemophilus influenzae</i> type b vaccine	Hib	Act-HIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	HepA	Havrix® Vaqta®
Hepatitis A and hepatitis B vaccine	HepA-HepB	Twintrix®
Hepatitis B vaccine	HepB	Engerix-B® Recombivax HB® HepIsav-B®
Human papillomavirus vaccine	HPV	Gardasil 9®
Influenza vaccine (inactivated)	IV4	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	Prenar 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



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

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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		
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)		
Measles, mumps, rubella (MMR)		1 dose Tdap, then Td or Tdap booster every 10 years		
Varicella (VAR)		1 or 2 doses depending on indication (if born in 1957 or later)		
Zoster recombinant (RZV)		2 doses (if born in 1980 or later)	2 doses	
Human papillomavirus (HPV)		2 doses for immunocompromising conditions (see notes)	2 doses	
Pneumococcal (PCV15, PCV20, PPSV23)		2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years	1 dose PCV15 followed by PPSV23 OR 1 dose PCV20 (see notes)
Hepatitis A (HepA)		1 dose PCV15 followed by PPSV23 OR 1 dose PCV20 (see notes)	2 or 3 doses depending on vaccine	1 dose PCV15 followed by PPSV23 OR 1 dose PCV20
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		
Haemophilus influenzae type b (Hib)		19 through 23 years	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
IIV4 or RIV4 or LAIV4			<15% or <200 mm ³	Contraindicated	1 dose annually	Precaution				1 dose annually
Tdap or Td	1 dose Tdap each pregnancy		≥15% and ≥200 mm ³							
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							
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 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

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**
- **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 HepB (Engerix-B* 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])
- 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: HepB 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 (HepBisav-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/immwrv/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 $\geq 15\%$ 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
- **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/immwrv/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/mmmwr/volumes/69/rr/r6909a1.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/mmmwr/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/mmmwr/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/mmmwr/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 \geq 15% and CD4 count \geq 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/mmmwr/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/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)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, cclIV, RIV, or LAIV of any valency) Severe allergic reaction (e.g., anaphylaxis) to any vaccine component³ (excluding egg) 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component³ of ccIIV4 	<ul style="list-style-type: none"> 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 ccIIV4, 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	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component³ of RIV4 	<ul style="list-style-type: none"> 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]	<ul style="list-style-type: none"> 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 component³ (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. 	<ul style="list-style-type: none"> 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/licenses-licensed-use-united-states.

Appendix

Recommended Adult Immunization Schedule, United States, 2022

Vaccine	Contraindications ¹	Precautions ²
<i>Haemophilus influenzae</i> type b (Hib)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ For Hibertix, Act-Hib, and Pedvax Hib only: History of severe allergic reaction to dry natural latex 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ including neomycin 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ including yeast For HepBisav-B only: Pregnancy 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Hepatitis A + Hepatitis B vaccine (HepA+HepB, (Ivlnrk [®]))	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ including neomycin and yeast 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 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 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 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 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Meningococcal B (MenB)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 	<ul style="list-style-type: none"> Pregnancy For MenB-4C only: Latex sensitivity Moderate or severe acute illness with or without fever
MenB-4C (Bexsero); MenB-FHbp (Tumbarba)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV15)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV20)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid-containing vaccine or to its vaccine component³ 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 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 	<ul style="list-style-type: none"> 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
Vaccinia (VAR)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 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 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ 	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever Current herpes zoster infection

- 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
- 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
- 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.

AMENDMENT 2
PRIME HEALTHCARE
PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION OF THE
SHASTA REGIONAL MEDICAL CENTER CHEU & NON-UNION EPO 4 MEDICAL
AND PRESCRIPTION DRUG BENEFITS

Effective May 1, 2023, the Prime Healthcare Plan Document/Summary Plan Description of the Shasta Regional Medical Center CHEU & Non-Union EPO 4 Medical and Prescription Drug Benefits (the “Plan”), dated January 1, 2022, is hereby amended as follows:

1. The Section entitled “**SCHEDULE OF MEDICAL AND PRESCRIPTION DRUG BENEFITS**” is hereby amended by removing the first paragraph under the subsection “**SCHEDULE OF PRESCRIPTION COPAYS**” and replacing it with the following:

“Prescription drug coverage is provided through separate agreement(s) between the Plan Sponsor and OptumRx.”

2. 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 B**.

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 B**.

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 B**.

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 B 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 B**, 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.

PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

**AMENDMENT 3
PRIME HEALTHCARE
PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION OF THE
SHASTA REGIONAL MEDICAL CENTER CHEU & NON-UNION
EPO 4 MEDICAL 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: 

AUTHORIZED REPRESENTATIVE OF PLAN SPONSOR

Date: 8/25/2023

THE ATTACHED EMPLOYEE BENEFIT DOCUMENT IS NOT INTENDED AS LEGAL ADVICE.

AMENDMENT 3
PRIME HEALTHCARE
PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION OF THE
SHASTA REGIONAL MEDICAL CENTER CHEU & NON-UNION EPO 4 MEDICAL
AND PRESCRIPTION DRUG BENEFITS

Effective May 11, 2023, the Prime Healthcare Plan Document/Summary Plan Description of the Shasta Regional Medical Center CHEU & Non-Union EPO 4 Medical 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 DRUGS**”:

“**COVID-19 Test Kits (OTC)** – Limited to four tests per Participant per month.”

2. Amend “**APPENDIX B – 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.
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3. Remove **APPENDIX D** 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
SHASTA REGIONAL MEDICAL CENTER NON-UNION &
SHASTA REGIONAL MEDICAL GROUP
EPO 4 MEDICAL 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: 01/09/2024
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
SHASTA REGIONAL MEDICAL CENTER NON-UNION EPO 4 MEDICAL AND
PRESCRIPTION DRUG BENEFITS

Effective January 1, 2024, the Prime Healthcare Plan Document/Summary Plan Description of the Shasta Regional Medical Center Non-Union & Shasta Regional Medical Group EPO 4 Medical and Prescription Drug Benefits (the “Plan”), dated January 1, 2022, is hereby amended as follows:

1. CHEU employees are no longer eligible for this Plan.
2. 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.”
3. The Section entitled “**ELIGIBLE MEDICAL EXPENSES**” is hereby amendment by adding the following note under the entry “**Ambulance**” at page 21:

“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.”
4. 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 58:

“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.”
5. The Section entitled “**EXTENSION OF COVERAGE FOR HANDICAPPED DEPENDENT CHILDREN**” at page 66 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 is 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.”

6. The Section entitled “**ASSIGNMENT TO PROVIDERS**” at page 71 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.”

7. The Section entitled “**ADMINISTRATIVE PROVISION**” is hereby amended by removing the subsection “**Anticipation, Alienation, Sale or Transfer**” at page 96 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.”

8. Delete “**APPENDIX A – PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)**” and “**APPENDIX B – PREVENTIVE CARE SERVICES**” and replace them with new **APPENDIX A** and **APPENDIX B** attached hereto.

There are no other changes to the Plan.

APPENDIX A
PREMIUM ASSISTANCE UNDER MEDICAID AND
THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you live in one of the following states, you may be eligible for assistance from Medicaid in paying for your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA | Medicaid
Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA | Medicaid
The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS | Medicaid
Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA | Medicaid
Website: Health Insurance Premium Payment (HIPP) Program
<http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO | Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA | Medicaid
Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA | Medicaid
GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: 678-564-1162, Press 2

INDIANA | Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/>
Phone: 1-877-438-4479
All other Medicaid
Website: <https://www.in.gov/medicaid/>
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki) Medicaid Website: <https://dhs.iowa.gov/ime/members>
Medicaid Phone: 1-800-338-8366
Hawki Website: <http://dhs.iowa.gov/Hawki>
Hawki Phone: 1-800-257-8563
HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
HIPP Phone: 1-888-346-9562

KANSAS | Medicaid
Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPAA Phone: 1-800-967-4660

KENTUCKY | Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
Phone: 1-855-459-6328
Email: KIHIP.PPROGRAM@ky.gov
KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA | Medicaid
Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE | Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS | Medicaid and CHIP
Website: <https://www.mass.gov/masshealth/pa>
Phone: 1-800-862-4840
TTY: 711
Email: masspreassistance@accenture.com

MINNESOTA | Medicaid
Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
Phone: 1-800-657-3739

MISSOURI | Medicaid
Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

MONTANA | Medicaid
Website:
<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084
Email: HSHIPPProgram@mt.gov

NEBRASKA | Medicaid
Website:
<http://www.ACCESSNebraska.net>
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA | Medicaid
Medicaid Website:
<https://dhcfp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE | Medicaid
Website:
<https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY | Medicaid and CHIP
Medicaid Website:
<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 609-631-2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1-800-701-0710

NEW YORK | Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA | Medicaid
Website:
<https://medicaid.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA | Medicaid
Website:
<https://www.hhs.nd.gov/healthcare>
Phone: 1-844-854-4825

OKLAHOMA | Medicaid and CHIP
Website:
<http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON | Medicaid
Website:
<http://healthcare.oregon.gov/Pages/index.aspx>
Phone: 1-800-699-9075

PENNSYLVANIA | Medicaid and CHIP
Website:
<https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>
Phone: 1-800-692-7462
CHIP Website:
<https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND | Medicaid and CHIP
Website: <http://www.eohhs.ri.gov/>
Phone: 855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA | Medicaid
Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA | Medicaid
Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS | Medicaid
Website:
<https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
Phone: 1-800-440-0493

UTAH | Medicaid and CHIP
Medicaid Website:
<https://medicaid.utah.gov/>
CHIP Website:
<http://health.utah.gov/chip>
Phone: 1-877-543-7669

VERMONT | Medicaid
Website:
<https://dvha.vermont.gov/members/medicaid/hipp-program>
Phone: 1-800-250-8427

VIRGINIA | Medicaid and CHIP
Website:
<https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON | Medicaid
Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

WEST VIRGINIA | Medicaid and CHIP
Website: <https://dhhr.wv.gov/bms/>
<http://mywvhipp.com/>
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN | Medicaid and CHIP
Website:
<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1-800-362-3002

WYOMING | Medicaid
Website:
<https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

APPENDIX B

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.

<i>NEW</i>	<i>REVISED</i>
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 persons.
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.
Hypothyroidism 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.

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