

COOK GROUP HEALTH PLAN MANUAL

Amended and Restated Effective January 1, 2026

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COOK GROUP HEALTH PLAN MANUAL

This document is the plan document for the Cook Group Health Plan (hereinafter referred to as “Plan” or “Manual”). There is a Summary Plan Description (also known as a “Benefit Booklet”) for the Clinic, Traditional, and High Deductible Health Plan Options. This document is amended and restated effective January 1, 2026, except as otherwise indicated.

ARTICLE I. ELIGIBILITY

Section 1.1. Employees. An *Employee* is a person who is classified as an employee by an Employer who has adopted the Plan. An Employee is eligible as set out in the Benefit Booklet and the Eligibility Policy of the Employer, which is attached as Addendum D. A person classified by the Employer as a leased employee or independent contractor is not eligible to participate. Any classification or re-classification of a person as an Employee of an Employer by a court or by action of a governmental agency shall be of no effect regarding the exclusion of the person from participation in the Plan, and the person shall not be treated as an Employee for purposes of the Plan because of the classification or re-classification, except to the extent that the person’s exclusion from the Plan triggers a penalty under Code Section 4980H(a).

An Employee is not eligible if the Employee is a member of a bargaining unit covered by a collective bargaining agreement between an Employer and Employee representative if welfare benefits were subject to good-faith bargaining.

An Employee who is the Spouse of an Employee or the Child of an Employee may not be covered as both an Employee and the Spouse or Child of an Employee. The person, may, however, transfer to coverage as a Spouse or Child, and the Waiting Period will not apply, providing there is no lapse in coverage.

Section 1.2. Spouses.

A. Definition. A Spouse is a person of the opposite sex or the same sex to whom the Employee is legally married if their marriage was validly entered into in a state or foreign country whose laws authorized the marriage, even if the couple lives in a state that does not recognize the validity of their marriage, and from whom the Employee is not legally separated.

B. Eligibility. A Spouse is eligible to participate in the Plan if the Employee is covered. A Spouse cannot be covered as an Employee and as the Spouse of an Employee. A Spouse, who is also an Employee, may, however, transfer to being covered as an Employee, and the Waiting Period will not apply, providing there is no lapse in coverage.

(i) Working Spouse Rule. A Spouse of an Employee who is otherwise eligible to participate in the Plan is not eligible to participate in the Plan if the Spouse is eligible to enroll in any major medical plan offered by the Spouse's current or former employer (including under COBRA) if the monthly premium cost to the Spouse for single coverage is less than \$250.

Section 1.3. Children.

A. General Rule. An Employee's biological child, or a child adopted or placed for adoption with an Employee, a step or Foster Child, and a child for whom the Employee has been appointed guardian by court order ("Child") is eligible until the end of the month in which the Child turns age 26, if the Employee is covered. The Children don't need to live with the Employee or be financially dependent on the Employee, be single or be in school. The Child's spouse and children are not eligible for coverage. A Child cannot be covered as the Child of more than one Employee. A Child, who is also an Employee, may not be covered as both a Child and an Employee, but may transfer to be covered as an Employee, and the Waiting Period will not apply, providing there is no lapse in coverage. The Employee must apply for coverage of a newborn biological Child within 30 days of their birth.

B. Adopted Children. A child placed for adoption with a Covered Employee shall be eligible for coverage just like biological children of Covered Employees, irrespective of whether the adoption has become final. A child is "placed for adoption" with a Covered Employee when the Employee has assumed a legal obligation for total or partial support of the child in anticipation of adopting the child. The child's "placement for adoption" terminates when this legal obligation terminates. The Employee must apply for coverage of the Child within 30 days of when the Child is placed with the Employee for adoption.

C. Foster Children. A child placed for care and maintenance in a foster home by a department of a state, county or city government, a placing agency or a court is a Foster Child. A Foster Home is any home that must be licensed under state law for the care and support of no more than four foster children, unless all of the children are siblings. The Employee is a Foster Parent and must apply for coverage of the Child within 30 days of when the Child becomes a Foster Child of the Employee.

D. Guardianship. A Child is eligible for coverage under the Plan on the date on which the Child is placed in the Employee's home under a court order appointing the Employee as the legal guardian for the Child. The Employee must, however, apply for coverage within 30 days of the date the Child is placed in the Employee's home under the court order, or enroll the Child during Annual Open Enrollment or under the Special Enrollment provisions of the Plan.

E. Paternity. Children born outside of marriage are eligible Children of the mother, and may become eligible Children of the father if the father applies for coverage within 30 days of:

- (i) a court order declaring paternity; or
- (ii) the date on which the father files an acknowledgement of paternity with the Department of Health and Human Services, or its equivalent state agency.

F. Disabled Child. A Child who loses coverage under the Plan as a result of coverage ending on the last day of the month in which the Child turns age 26 may continue coverage under the Plan if and so long as the Child meets all of the requirements specified below:

- (i) the Child has a mental or physical disability that makes the Child incapable of self-sustaining employment; and
- (ii) the Child is not married; and
- (iii) the Covered Employee who is the Child's parent, stepparent, Foster Parent or guardian provides at least 50% of the support and maintenance for the Child; and
- (iv) the Child meets all other eligibility requirements of the Plan; and
- (v) the covered Employee who is the Child's parent, stepparent, Foster Parent or guardian is covered by the Plan; and
- (vi) the Child is covered as a Child in the Plan on the day immediately prior to the date on which the Child would lose coverage as a result of coverage ending on the last day of the month in which the Child turns age 26.

The Child or the Child's parent, stepparent, Foster Parent or guardian shall provide satisfactory proof to the Cook Insurance Department that the conditions described above existed on the date the Child would otherwise have lost coverage as a result of coverage ending on the

last day of the month in which the Child turns age 26. Such proof will not be requested more than annually after the date the first proof is provided. If satisfactory proof is not submitted when due, the Child's coverage will terminate on the last day of the month in which the Child turns age 26.

G. QMSCO. The Plan shall provide benefits pursuant to a Qualified Medical Child Support Order, provided the order does not require the Plan to provide any type or form of benefit, or any option not otherwise provided by the Plan or required by law. Plan payments shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

An "*Alternate Recipient*" is any Child of an Employee who is recognized under a Qualified Medical Child Support Order as having a right to enroll under the Plan with respect to the Employee.

A copy of the Plan's Qualified Medical Child Support Order procedures may be obtained, without charge, from the Cook Insurance Department.

Section 1.4. Covered Persons or Covered Members. Eligible Employees, Spouses and Children who enroll in and are covered by the Plan are "Covered Persons," also known as "Covered Members."

ARTICLE II. ENTRY

Section 2.1. Waiting Period and Initial Enrollment. As set out in the Benefit Booklet and in the Eligibility Policy which is attached as Addendum D, new Employees, and their Spouses and Children who are eligible for coverage may become covered by the Plan following 30 days of continuous employment with an Employer. This 30-day period is called the Waiting Period. Absence due to a health factor shall be treated as continuous employment. Written application for coverage must be made no later than the end of the Waiting Period. The eligible Employee may elect any Plan Option for which they are eligible. The effective date of coverage will be the day which is 30 days after the Employee's first day of employment. If coverage is not elected within the Waiting Period, then in order to enroll in the Plan the Employee must be eligible for a Special Enrollment Right or a Change in Election under the Cook Cafeteria Plan, or enroll during Annual Open Enrollment.

Section 2.2. Hours of Work Requirement. The Hours of Work Requirement is set out in the Eligibility Policy, which is attached as Addendum D.

Section 2.3. Plan Options.

Except as set out in the Benefit Booklet, Employees participating in the Clinic Plan Option must receive their primary care and purchase their prescription drugs at the Cook Family Health Center, Inc. ("Clinic") in Bloomington, Indiana or receive their primary care from an approved primary care Physician located outside the Clinic (while still purchasing prescribed drugs at the Cook Family Health Center, Inc.).

All Employees living outside Monroe County, Indiana may enroll in the Traditional or the High Deductible Health Plan Option and may use the Clinic for their primary care and prescription drugs.

Eligible Children and Spouses generally must enroll in the same Plan Option as the Employee. However, if an eligible Child and/or Spouse is, therefore, enrolled in the Clinic Option, but lives outside of Monroe County, the Child and/or Spouse may see any Network Provider instead of going to the Clinic. Covered Charges for the Child and/or Spouse from Out-of-Network providers where they live will only be paid at the Network benefit level as set out in the Benefit Booklet and Section 8.2.

During Annual Open Enrollment, Employees may change Plan Options. The effective date of the change shall be January 1.

Unless a Covered Person moves into Monroe County, Indiana or out of Monroe County, Indiana and the Plan Administrator approves, or the Covered Person has a Special Enrollment Right under the Cook Cafeteria Plan, the Covered Person may not change Plan Options until the next Annual Open Enrollment. An Employee who is not a Covered Person but who becomes newly eligible to enroll in the Plan mid-year may elect any Plan Option for which the person is eligible. If a Covered Person terminates employment and then rehires within the same calendar year, the person must re-enroll in the same Plan Option they were in when they terminated employment unless they have moved into or out of Monroe County.

ARTICLE III. ENROLLMENT RIGHTS

Section 3.1. Initial Enrollment. See Section 2.1.

Section 3.2. Annual Open Enrollment.

A. General Rule. Annual Open Enrollment is the period each fall during which Employees may elect to be covered by the Plan, and may elect to cover or drop coverage for their Spouse and Children. Their elections will be effective on January 1 of the next year. Unless the Annual Open Enrollment materials provide otherwise, every eligible Employee who has met the Waiting Period must enroll for the Employee and the Employee's Spouse and Children during Annual Open Enrollment, or the Employee, Spouse and/or Children will not be covered by the Plan during the next calendar year. The Employer has discretion to conduct a "passive" annual enrollment in which if an eligible Employee does not make an election for the next Plan Year, their election for the current Plan Year will carry over. During Annual Open Enrollment, Employees may also change Plan Options. The change shall be effective on January 1.

B. Late Addition of Child. If on December 31 of a year an Employee and one or more of the Employee's Children are covered by the Plan, and during Annual Open Enrollment, the Employee mistakenly failed to elect coverage for one or more of the Employee's eligible Children, the Employee may elect coverage of the Children, effective on January 1, so long as the Employee certifies in writing that the Employee excluded the Children by mistake, and so long as the Employee elects coverage of the Children no later than February 15. Premiums for coverage that is elected between January 1 and February 15 under this provision shall be paid on an after-tax basis, and are not eligible for payment on a pre-tax basis through the Cook Cafeteria Plan.

Section 3.3. Mid-Year Enrollment Rights.

A. Reinstatement of Coverage on Return to Work. If an Employee who is classified as a full-time Employee terminates employment with all Cook companies and loses coverage under the Plan, and the Employee returns to active employment with a Cook company within three years from the date on which their employment terminated, then, unless waived, coverage will be reinstated on the first day of work if the Employee is classified as a full-time Employee and applies for coverage within 30 days of the Employee's return. If an Employee who is classified as a variable hour, part-time or seasonal employee terminates employment with all Cook companies and loses coverage under the Plan, and the Employee returns to active employment with a Cook company and is classified as a variable hour, part-time or seasonal Employee, the Employee's enrollment rights shall be determined under the Eligibility Policy. If the Employee rehires within the same calendar year and reenrolls, the Employee must be reinstated in the same Plan Option they were in when they terminated employment, and the Deductibles and Out-of-Pocket Maximums will apply to the extent they were not previously satisfied.

B. Special Enrollment Rights. An eligible Employee who does not enroll within 30 days after becoming eligible for coverage or during a subsequent Annual Open Enrollment may still enroll as a Special Enrollee if the Employee meets the following requirements:

(i) Loss of Coverage. An Employee, Spouse or Child who is eligible for coverage, may be enrolled mid-year if the Employee, Spouse or Child declined coverage in this Plan in writing when initially eligible because the Employee, Spouse or Child had other coverage, and then the other coverage is lost.

(a) If the other coverage was COBRA Coverage, the COBRA Coverage must be lost because the COBRA Coverage period (e.g., 18, 29, or 36 months) was exhausted.

(b) If the other coverage was not COBRA Coverage, then the coverage must be lost because the Employee, Spouse or Child lost eligibility for the other coverage (e.g., divorce, death, termination of employment), or the employer must stop making contributions toward the cost of the other coverage of the Employee, Spouse or Child.

(c) The Employee, Spouse or Child must, however, request coverage in this Plan in writing no later than 30 days following the loss of coverage, as defined above. The Employee, Spouse or Child must also, within a reasonable period of time, provide acceptable written evidence that they had the other coverage, and the date the other coverage was lost. The Waiting Period must be satisfied. Coverage will become effective no later than the first of the month after enrollment materials are submitted. The Employee, Spouse and Child may elect any Plan Option for which they are eligible.

(ii) Family Status Change – A New Spouse or Child. If an Employee acquires a new Spouse or Child by marriage, birth, adoption or placement for adoption, guardianship, determination of paternity or by becoming a Foster Parent, then the Employee, Spouse and newly acquired Child may enroll in the Plan. The Employee, Spouse and newly acquired Child must request enrollment within 30 days of the change in family status event. The Waiting Period must be satisfied before coverage will become effective. If a new Spouse or Child is acquired through marriage, guardianship, determination of paternity or by the Employee becoming a Foster Parent, coverage will become effective no later than the first of the month after the Waiting Period is satisfied and the enrollment materials are submitted. If a new Child is acquired through birth, adoption or placement for adoption, coverage will be effective retroactively to the birth, adoption or placement for adoption. The Employee, Spouse and Child may elect any Plan Option for which they are eligible.

(iii) Eligibility for State Premium Assistance Subsidy. If an Employee, Spouse or Child becomes eligible for assistance in paying Plan premiums through either a Medicaid plan or a state children's health insurance program (CHIP), then that Employee, Spouse or Child, if otherwise eligible for coverage, may enroll for coverage in this Plan for 60 days after it is determined that the person is eligible for premium

assistance. The Employee, Spouse and Child may elect any Plan Option for which they are eligible.

(iv) Medicaid or CHIP Special Enrollment. If an Employee, Spouse or Child declined coverage in the Plan because they had Medicaid or CHIP coverage and then requests coverage in this Plan within 60 days of losing eligibility for coverage under Medicaid or CHIP, that Employee, Spouse or Child may enroll in the Plan as a Special Enrollee. The Employee, Spouse and Child may elect any Plan Option for which they are eligible.

Section 3.4. Mid-Year Change in Election Rights. Covered Persons may change the Plan Option and the tier of coverage they elected as permitted under the rules set out in the Cook Cafeteria Plan. Unless otherwise indicated in this Manual or the Booklet or the Cafeteria Plan, the change shall become effective on the first of the month following the trigger event if a completed enrollment/change form is received by the Cook Insurance Department prior to the effective date.

ARTICLE IV. TERMINATION OF COVERAGE

Section 4.1. General Rule. Except as otherwise provided in the Plan, coverage of an Employee, Spouse or Child will terminate on the earliest of the following:

termination of the Employee's employment;

as set out in the Eligibility Policy or the Benefit Booklet;

the date the Employee, Spouse, or Child ceases to be eligible for coverage;

when the Plan is amended to terminate coverage for the Employee, Spouse, or Child;

termination of the Plan;

the last day of a calendar year, unless the Employee elects coverage (or is deemed to elect coverage) for the next year;

the end of the period for which premiums have been paid;

as stated in Section 4.2;

the date the Plan Administrator or Claims Administrator determines, in its sole discretion, that the Covered Person continually interferes with or continually behaves in a manner that prevents a Physician from providing care to the Covered Person or another Covered Person; or

the date a Covered Person willfully submits a fraudulent claim for benefits; provided, however, that if an Employee, Spouse or Child is Hospitalized when coverage would otherwise terminate, coverage for that person will continue until midnight on the day the person is discharged from the Hospital.

Section 4.2. Rescission of Coverage. The Plan has the right to rescind coverage if the Employee or Covered Person (or a person seeking coverage on behalf of the Employee or Covered Person) performs an act, practice, or omission that constitutes fraud, or if the individual makes an intentional misrepresentation of a material fact. To rescind means to cancel coverage retroactively. The Plan will provide at least 30 days advance written notice to each Covered Person who would be affected by a retroactive rescission before coverage will be retroactively rescinded. The Plan will refund all contributions paid for any coverage rescinded, reduced by claims paid for the period for which coverage is rescinded. In addition, the Plan reserves the right to recover from the Employee, Covered Person or provider of service the amount paid on claims incurred during the period for which coverage is rescinded.

ARTICLE V. CONTINUATION OF COVERAGE

In some situations, coverage will continue for some period of time even though the Employee, Spouse, or Child is no longer eligible for coverage.

Section 5.1. Leaves of Absence. If an Employee is on an approved paid or unpaid leave of absence, the Employee may continue coverage for the period of time described below:

A. Approved Non-FMLA Leave. If a covered Employee takes an approved leave of absence for their own medical condition which is not a leave under the Family Medical Leave Act ("FMLA"), coverage will continue during the leave of absence for a maximum of 12 weeks from when the leave began. Any Plan changes and enrollment rights that apply to other Employees will also apply to an Employee on non-FMLA leave. During the leave, the Employer will continue to pay the Employer's share of the Plan premiums. If the Employee is on a paid leave, the Employee shall continue to pay the Employee's share of the Plan premiums, either pre-tax through the Cook Cafeteria Plan or after-tax, whichever way the Employee paid premiums prior to the leave. If the Employee is on an unpaid leave, the Employer will pay the Employee's share of the Plan premiums during the leave. When the Employee returns to work, the Employee's share of the Plan premiums that were paid by the Employer during the leave will be withheld from the Employee's pay. If the Employee does not return to work at the end of the approved leave or within 12 weeks, whichever is earlier, (1) the Employee's coverage under the Plan will terminate and (2) the Employee's share of the Plan premiums that were paid by the Employer during the leave will be withheld from the Employee's final pay, vacation pay, PTO payout, or any applicable qualified bonus. The Employee, Spouse, and Children may be eligible for COBRA Coverage.

B. Approved Family and Medical Leave Act (FMLA) Leave. An Employee who is covered by the Plan when the Employee takes an approved FMLA leave will remain covered by the Plan during the approved FMLA leave, for up to 12 weeks. Any Plan changes and enrollment rights that apply to other Employees will also apply to an Employee on FMLA leave. During the leave, the Employer will continue to pay the Employer's share of the Plan premiums. If the Employee is on a paid FMLA leave, the Employee shall continue to pay the Employee's share of the Plan premiums, either pre-tax through the Cook Cafeteria Plan or after-tax, whichever way the Employee paid premiums prior to the leave. If the Employee is on an unpaid FMLA leave, the Employer will pay the Employee's share of the Plan premiums during the leave. When the

Employee returns to work, the Employee's share of the Plan premiums that was paid by the Employer during the leave will be withheld from the Employee's pay. Coverage will terminate, however, if the Employee does not return to work at the end of the approved FMLA leave, unless the Employee is eligible for Extended Major Medical leave. If coverage terminates the Employee's share of the Plan premiums that were paid by the Employer during the leave will be withheld from the Employee's final pay, vacation pay, PTO payout, or any applicable qualified bonus. If the Employee is not eligible for Extended Major Medical leave, the Employee, Spouse, and Children may be eligible for COBRA Coverage at the end of the FMLA leave.

C. Extended Major Medical Leave. If an Employee has been on an FMLA leave and the Employee, due to their own medical condition, cannot return to work at the end of the 12-week FMLA leave, the Employee's leave may, in the discretion of the Employer, be extended for up to 14 more weeks of Extended Major Medical leave. If an Extended Major Medical leave is approved, the Employer will continue to pay the Employer's share of the Plan premiums during the leave. If the Employee is on a paid Extended Major Medical leave, the Employee shall continue to pay the Employee's share of the Plan premiums, either pre-tax through the Cook Cafeteria Plan or after-tax, whichever way the Employee paid premiums prior to the leave. If the Employee is on an unpaid Extended Major Medical leave, the Employer will pay the Employee's share of the Plan premiums during the leave. When the Employee returns to work, the Employee's share of the Plan premiums that was paid by the Employer during the leave will be withheld from the Employee's pay. Coverage will terminate, however, if the Employee does not return to work at the end of the Extended Major Medical Leave. If coverage terminates the Employee's share of the Plan premiums that were paid by the Employer during the leave will be withheld from the Employee's final pay, vacation pay, PTO payout, or any applicable qualified bonus. The Employee, Spouse and Children may be eligible for COBRA Coverage.

D. Additional Medical Leave. If an Employee has exhausted the leaves under Sections 5.1(A), (B) and (C) above for which the Employee is eligible, but is still on an approved medical leave for their own medical condition, the Employee's coverage under the Plan will continue so long as the Employee timely pays the active employee premium for the coverage. If the Employee is not enrolled in the Plan when this medical leave begins, the Employee may enroll during an Annual Open Enrollment or if the Employee has Special Enrollment Rights while still on this leave. Coverage will terminate if the Employee does not timely pay the active employee premium. The Employee, Spouse and Children may be eligible for COBRA Coverage.

Section 5.2. Uniformed Services Employment and Reemployment Rights Act (USERRA) Leave. The Plan will comply with the requirements of USERRA. An Employee who is absent from work for eligible military service may continue coverage for the Employee, Spouse and Children for up to 24 months, as required by USERRA. If, however, the Employee fails to return to work or to apply for reemployment within the required time period at the end of the military service, USERRA continuation coverage will end when the time period for reporting back to work or applying for reemployment ends.

An Employee returning to work at the end of military service will be reinstated in the Plan without any Waiting Period when the employee has met the requirements for returning under USERRA. The Plan does not, however, provide coverage for any Illness or Injury caused

or aggravated by military service. In most cases USERRA continuation coverage will run concurrently with COBRA Coverage.

The premium for the first 30 days of USERRA continuation coverage will be no more than the premium charged to an active employee. After 30 days, the premium for USERRA continuation coverage may be up to 102% of the applicable premium as defined in COBRA for the remaining months of USERRA continuation coverage.

Section 5.3. COBRA Coverage. COBRA is a federal law that lets employees and their families stay in their employer's health plan if certain events occur that cause the employees or family members to lose their health coverage. This temporary extension of coverage is called "COBRA Coverage." All medical, dental, vision, and prescription drug benefits under this Plan are considered one plan for purposes of COBRA Coverage. Therefore, a Qualified Beneficiary cannot elect COBRA Coverage for just some of these benefits. The Qualified Beneficiary must elect COBRA Coverage for all of these benefits, or none of these benefits.

A. Eligibility for COBRA Coverage. In order to be eligible for COBRA Coverage, an individual must be a "Qualified Beneficiary" and experience a "Loss of Coverage" due to a "Qualifying Event".

(i) Qualified Beneficiary. An individual is a Qualified Beneficiary if the individual was covered under the Plan on the day before a Qualifying Event either as an Employee, Spouse or Child, or as an Alternate Recipient under a QMSCO, or is a Child born to or placed for adoption with an Employee while the Employee has COBRA Coverage.

(ii) Qualifying Events For Employees. If an Employee is covered by the Plan on the day before any of the following Qualifying Events, and the Qualifying Event causes the Employee to lose coverage in the Plan, COBRA Coverage may continue for the Employee for up to 18 months from the date of the Loss of Coverage:

(a) A reduction in the hours the Employee works.

(b) A voluntary termination of employment from all companies affiliated with Cook Group Incorporated, including, but not limited to, at the end of an approved leave.

(c) An involuntary termination of employment from all companies affiliated with Cook Group Incorporated, unless the Plan Administrator determines that the Employee was terminated because of the Employee's gross misconduct.

(iii) Qualifying Events For A Spouse or Child. If a Spouse or Child is covered by the Plan on the day before any of the following Qualifying Events, and the Qualifying Event causes the Spouse and/or Child to lose coverage in the Plan, COBRA Coverage may continue for the Spouse and/or Child for the time period indicated below from the date of the Loss of Coverage:

(a) The death of the Employee (COBRA Coverage for the Spouse and Children for up to 36 months from the Loss of Coverage).

(b) Divorce or legal separation of the Employee (COBRA Coverage for the Spouse and Children for up to 36 months from the Loss of Coverage) (Note: Physical separation, where spouses are merely living apart, is not a legal separation. A legal separation is a separation pursuant to a statute or court order.).

(c) Reduction in the number of hours the Employee works, voluntary termination of employment, or involuntary termination of employment, unless the Plan Administrator determines that the Employee was involuntarily terminated because of the Employee's gross misconduct (COBRA Coverage for the Spouse and Children for up to 18 months from the Loss of Coverage).

(d) A Child no longer meets the eligibility requirements of the Plan (COBRA Coverage for the Child for up to 36 months from the Loss of Coverage).

(e) The covered Employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act.

(iv) Loss of Coverage.

(a) An Employee, Spouse or Child has a Loss of Coverage if the individual is no longer covered under the Plan, or is no longer covered under the Plan on the same terms that were in effect immediately before the Qualifying Event. For example, if because of a Qualifying Event an employer charges a higher premium or reduces the benefits, the Employee, Spouse or Child has had a Loss of Coverage. The Loss of Coverage does not have to occur at the same time as the Qualifying Event. It just must occur before the end of the maximum period of COBRA Coverage that applies to the Qualifying Event (i.e., 18, 29, or 36 months).

(b) If coverage is dropped in anticipation of a Qualifying Event, that loss of coverage is disregarded in determining whether the later Qualifying Event causes a Loss of Coverage. For instance, if an Employee drops the coverage of the Employee's Spouse in anticipation of a divorce, the Spouse will still be eligible for COBRA Coverage later when the divorce occurs even though the Spouse is not covered by the Plan at the time of the divorce and does not lose coverage at the time of the divorce.

B. Election of COBRA Coverage.

(i) 60-day Election Period. When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator shall notify the Qualified Beneficiaries that they have the right for 60 days to sign up for COBRA Coverage. This 60-day election period starts when the Qualified Beneficiary loses or would lose coverage under the Plan, and it ends no sooner than 60 days after the later of: a) the date that notice is provided to the Qualified Beneficiary of their right to elect COBRA

Coverage, or b) the date the Qualified Beneficiary would lose coverage under the Plan because of the Qualifying Event. Qualified Beneficiaries must elect COBRA Coverage in compliance with the procedures and deadlines set out in COBRA materials provided by the COBRA administrator. If a Qualified Beneficiary does not properly elect COBRA Coverage on time, the Qualified Beneficiary will no longer be eligible for COBRA Coverage.

(ii) Independent Right – Family Enrollment. The Employee, Spouse and each Child who is a Qualified Beneficiary has an independent right to elect COBRA Coverage, whether or not anyone else elects COBRA Coverage. If either the Employee or the Spouse elects COBRA Coverage and does not specify whom the election is for, then the Employee, Spouse and all eligible Children will be enrolled in COBRA Coverage. Either a parent or a legal guardian may elect or decline COBRA Coverage for a minor Child. However, no Qualified Beneficiary can decline COBRA coverage for another adult Qualified Beneficiary.

(iii) Incapacitated Qualified Beneficiary. If a Qualified Beneficiary is totally incapacitated and not legally competent to elect COBRA Coverage, the 60-day election period is extended until the Qualified Beneficiary is able to make the election, or until a guardian or legal representative is appointed who is able to make the election for the Qualified Beneficiary, plus the balance of the 60 days.

(iv) Alternate Coverage. If COBRA Coverage is rejected in favor of alternate coverage (e.g., USERRA coverage), COBRA Coverage will not be offered at the end of the alternate coverage. If the COBRA 60-day Election Period has expired, the person will have forfeited their right to COBRA Coverage.

C. COBRA Coverage.

(i) COBRA Coverage Start Date. COBRA Coverage will begin on the date there is Loss of Coverage due to a Qualifying Event if COBRA Coverage is properly elected and the COBRA premiums are paid on time. If a Qualified Beneficiary initially elects not to take COBRA Coverage, the Qualified Beneficiary may change the election and elect COBRA Coverage anytime during the 60-day election period. In this situation, however, the COBRA Coverage will begin when the person elects COBRA Coverage, not on the day of the Loss of Coverage. This will result in a gap in the person's coverage under the Plan.

(ii) Options and Tiers. In general, a Qualified Beneficiary may only elect the same Plan Option (e.g., the Clinic Plan Option, Traditional Plan Option, or High Deductible Health Plan Option) that was in effect immediately before the Loss of Coverage. However, a Qualified Beneficiary may change Plan Options whenever an active Employee may change Plan Options. In addition, at Annual Open Enrollment and Special Enrollment, a Qualified Beneficiary may change tiers of coverage (e.g., from single coverage to family coverage), regardless of who initially elected COBRA Coverage.

(iii) Same Benefits. A Qualified Beneficiary who is eligible for COBRA Coverage is entitled to the same benefits as other similarly-situated non-COBRA Covered Persons. If coverage under the Plan is amended for non-COBRA participants, then COBRA Coverage will be amended in the same way at the same time for COBRA participants.

(iv) Not Eligible For COBRA Coverage. The Plan Administrator reserves the right to terminate a person's COBRA Coverage if it determines that the person is not eligible for COBRA Coverage. To the extent permitted by law, the termination will be retroactive, and the Plan may recover claims that were wrongfully paid.

D. Payment of COBRA Premiums.

(i) Calculation of COBRA Premiums. The Plan Administrator will determine the amount of the COBRA premiums owed by Qualified Beneficiaries. Once set, COBRA premiums will generally apply to all Qualified Beneficiaries for 12 months.

(a) General Rule. COBRA premiums will generally be up to 102% of the applicable premium.

(b) Disability COBRA Premiums. In the event COBRA Coverage is extended beyond 18 months due to a disability, then the COBRA premiums for those additional months may be up to 150% of the applicable premium; provided, however, that if only the non-disabled members of the family elect the disability extension, they will be charged up to 102% of the applicable premium.

(ii) Payment of Initial COBRA Premium. A Qualified Beneficiary has 45 days from the date on which the Qualified Beneficiary elects COBRA Coverage to pay the first COBRA Premium. Premiums must be paid in compliance with the procedures and deadlines set out in COBRA materials provided by the COBRA administrator. The initial COBRA premium payment must include the premiums due for all time periods prior to the payment. THERE IS NO GRACE PERIOD FOR PAYMENT OF THE INITIAL COBRA PREMIUM. IT MUST BE PAID WITHIN 45 DAYS OF ELECTING COBRA COVERAGE, OR COBRA COVERAGE WILL BE FORFEITED AND CANNOT BE REINSTATED.

(iii) Payment of Subsequent COBRA Premiums.

(a) Payment of Premiums. COBRA premiums should be paid to the COBRA administrator in compliance with the procedures and deadlines set out in COBRA materials provided by the COBRA administrator. After payment of the initial COBRA premium, COBRA premiums must be paid by the first day of each month. Qualified Beneficiaries have, however, a 30-day grace period from the first day of each month to make the payment. If payment is not "made" before the end of the grace period, COBRA Coverage will terminate, effective back to the last day for which COBRA premiums were paid, and further rights to COBRA coverage are forfeited.

(b) Insufficient Check. If a check is returned for insufficient funds, and the check is not properly funded before the end of the grace period, then COBRA Coverage will terminate and cannot be reinstated.

(c) Short Payment. If a COBRA premium payment is short by an insignificant amount, the Qualified Beneficiary will receive a notice of the deficiency and will have 30 days to pay the shortage. A payment is short by an insignificant amount if the shortage is no greater than \$50 or 10% of the required payment, whichever is less.

(d) Billing Statements May Be Sent. A bill or statement may be sent to Qualified Beneficiaries for COBRA premiums. However, even if no billing statement is sent or received, Qualified Beneficiaries must pay their COBRA premiums on time.

(e) If COBRA coverage is terminated because premiums are not timely paid, it cannot be reinstated.

(iv) No Coverage Before Election of COBRA Coverage and Payment of COBRA Premiums.

(a) Generally. If a Covered Person incurs medical expenses after Plan coverage ends and during the COBRA election period, but before the Covered Person has elected COBRA Coverage and paid the initial and/or monthly COBRA premiums, the Cook Insurance Department will not process the claims. The Covered Person must pay the claims and apply to the Cook Insurance Department for reimbursement, or the provider must submit the expenses for payment after the Covered Person has elected and paid for COBRA Coverage. If a health care provider calls the Cook Insurance Department to verify that a person has coverage under the Plan, the Cook Insurance Department will tell the provider that the person is not covered by the Plan, but is still eligible to elect COBRA Coverage and/or pay the COBRA premiums if the COBRA election and/or premium payments are made on time. The Covered Person must still obtain any referrals and Pre-authorizations required by the Plan, or the expenses will not be paid even after the Covered Person has elected and paid for COBRA Coverage. The Plan will only pay those expenses and provide those benefits that it would have paid and provided if the Covered Person had elected and paid for COBRA Coverage prior to incurring the expense.

(b) Use of Clinic. The Covered Person may use the Clinic during the COBRA election period before the Covered Person has elected and paid the initial and monthly premiums for COBRA Coverage. However, until the Covered Person has elected COBRA coverage and paid the initial premium, the Covered Person must pay the reasonable and customary charges for the Clinic's services at the time of the visit to the Clinic and submit the bills to the Cook Insurance Department for reimbursement after the Covered Person has elected and paid for COBRA Coverage. If the Covered Person obtains services outside the Clinic prior

to electing and paying the initial premium for COBRA Coverage, the Covered Person must still obtain Pre-authorizations that would otherwise be required. The Plan will only pay those expenses and benefits outside the Clinic that it would have paid had the Covered Person elected and paid for COBRA Coverage prior to incurring the expense.

E. COBRA Coverage Notice Requirements.

(i) Notice Requirements for Employees and Qualified Beneficiaries.

Employees and Qualified Beneficiaries must give the following notices:

(a) Notice of Certain Qualifying Events – Divorce, Legal Separation, Child Losing Eligibility. Each covered Employee or Qualified Beneficiary must notify the Cook Insurance Department of the occurrence of a divorce or legal separation of a covered Employee, and of a Child losing eligibility under the Plan. The divorce decree, decree of legal separation or the birth certificate of the Child, as applicable, must be given to the Cook Insurance Department within 60 days after the latest of: (i) the occurrence of the Qualifying Event, (ii) the day the person loses (or would lose) coverage under the Plan as a result of the Qualifying Event, or (iii) the date the Qualified Beneficiary is informed of the responsibility to give the notice and the Plan's procedures for giving notice.

(b) Notice of Second Qualifying Event – Death of Employee, Divorce, Legal Separation, Child Losing Eligibility. If a Qualified Beneficiary is eligible for a maximum COBRA Coverage period of 18 or 29 months, and a second Qualifying Event occurs during those 18 or 29 months, including the death of a covered Employee, divorce or legal separation from the covered Employee, or a Child losing eligibility under the Plan, then the Qualified Beneficiary or a representative must notify the Cook Insurance Department of the second Qualifying Event. The death certificate, divorce decree, decree of legal separation or the birth certificate of the Child, as applicable, must be given to the Cook Insurance Department within 60 days after the latest of: (i) the date on which the second Qualifying Event occurs, (ii) the date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the second Qualifying Event, and (iii) the date on which the Qualified Beneficiary is informed of the responsibility to give the notice and the Plan's procedures for giving notice.

(c) Notice of Disability Determination. If a Qualified Beneficiary who is eligible for a maximum COBRA Coverage period of 18 months is determined by Social Security to have become disabled at any time prior to or during the first 60 days of COBRA Coverage, the Qualified Beneficiary or a representative must notify the COBRA administrator of the disability determination. A copy of Social Security's determination must be given to the COBRA administrator within the first 18 months of COBRA Coverage and within 60 days of the latest of: (i) the date of the final disability determination by Social Security, (ii) the date the Qualifying Event occurs (termination of employment or reduction in hours), (iii) the date the Qualified Beneficiary loses (or would lose) coverage under the Plan

as a result of the Qualifying Event, and (iv) the date on which the Qualified Beneficiary is informed of both the responsibility to provide the notice of the disability determination and the Plan's procedures for providing the notice.

(d) Notice of Birth or Adoption of a Child During COBRA Coverage.

An Employee receiving COBRA Coverage must give notice of the birth or adoption of a Child to the Cook Insurance Department and the COBRA administrator within 30 days of the birth or adoption of a Child, or COBRA Coverage for the Child will not be retroactive to the day of the birth or adoption.

(e) Notice of Change in Disability Status. A Qualified Beneficiary approved for a disability extension of COBRA Coverage must notify the COBRA administrator if Social Security later determines that the Qualified Beneficiary is no longer disabled. A copy of Social Security's decision that the Qualified Beneficiary is no longer disabled must be given to the COBRA administrator within 30 days of the later of: (i) the date of Social Security's final determination that the Qualified Beneficiary is no longer disabled, and (ii) the date on which the Qualified Beneficiary is informed of both the responsibility to provide the notice and the Plan's procedures for providing the notice.

(f) Notice of Other Group Health Plan Coverage. A Qualified Beneficiary who has COBRA Coverage must promptly give notice to the COBRA administrator if the Qualified Beneficiary becomes covered under any other group health plan. The other coverage may terminate the Qualified Beneficiary's eligibility for COBRA Coverage. The Qualified Beneficiary must send evidence of the other coverage to the COBRA administrator, such as the insurance card or application for coverage.

(g) Notice of Medicare Enrollment After Electing COBRA Coverage. When a Qualified Beneficiary who has elected COBRA Coverage later becomes enrolled in Medicare Part A or B, or both, due to age, the Qualified Beneficiary must promptly give the Qualified Beneficiary's Medicare card to the COBRA administrator, showing the effective date of the Medicare enrollment. In this case, the Medicare coverage will terminate the Qualified Beneficiary's eligibility for COBRA Coverage.

(h) Address Changes. Qualified Beneficiaries must give the Cook Insurance Department and the COBRA administrator notice of any change in their address. Qualified Beneficiaries must also give the Cook Insurance Department and the COBRA administrator notice of a Qualified Beneficiary's address if the Qualified Beneficiary lives at a different address than the Employee.

(ii) Employee and Qualified Beneficiary Notice Procedures.

(a) The Employee or a Qualified Beneficiary or a representative acting on behalf of either has the responsibility to give the notices in Section (E)(i)

above. Notice by one Qualified Beneficiary shall satisfy the notice obligations of all persons who are Qualified Beneficiaries as to the same Qualifying Event.

(b) Notice is considered “given” by the Employee, Qualified Beneficiary or representative when it is given as set out in the COBRA materials provided by the COBRA administrator.

(c) Oral notice, including notice by telephone, is not acceptable.

(d) If an Employee, Qualified Beneficiary or representative gives an incomplete notice, the notice will still be considered timely if: (i) the notice is initially mailed or delivered to the Cook Insurance Department and/or the COBRA administrator on time, (ii) the Cook Insurance Department and/or COBRA administrator is able to determine that the notice relates to the Plan, the identity of the Employee and Qualified Beneficiaries, the Qualifying Event or the event that extends COBRA Coverage, and the date of that event, and (iii) the incomplete notice is supplemented in writing with the additional information within 15 days after a written or oral request from the Cook Insurance Department and/or the COBRA administrator for additional information. If these requirements are not met, then the incomplete notice will be rejected and COBRA Coverage will not be offered or extended.

(e) If proper notice is not given by the applicable deadline set out in the COBRA materials provided by the COBRA administrator, the Qualified Beneficiary will not be entitled to elect COBRA Coverage, or to an extension of COBRA Coverage, as applicable.

(f) The Plan Administrator has the discretion to terminate the COBRA Coverage retroactively to the effective date of the Social Security determination that a Qualified Beneficiary is no longer disabled, or the effective date of the other coverage, or the effective date of the Medicare enrollment, as applicable, regardless of whether or when notices are provided. The Plan may seek reimbursement of claims paid after the termination of COBRA Coverage if the termination is retroactive.

(iii) Employer Notice Requirements.

(a) COBRA Initial Notice. The Cook Insurance Department and/or the COBRA administrator will provide an Initial COBRA Notice to Employees and Spouses when Plan coverage first becomes effective.

(b) Notice of Death, Termination of Employment or Reduction in Hours. The Employer must notify the Cook Insurance Department of an Employee’s death, termination of employment or reduction in hours.

(c) COBRA Election Notice. The COBRA administrator will provide a COBRA Election Notice to a person when the person has a Loss of Coverage and

becomes a Qualified Beneficiary, informing the Qualified Beneficiary of the Qualified Beneficiary's rights and obligations under COBRA and the Plan.

(d) Annual Open Enrollment Materials. The Plan Administrator will provide the Annual Open Enrollment materials to Qualified Beneficiaries so they may change the Plan Option and/or tier of coverage that they have previously elected.

(e) Notice that COBRA Coverage is Not Available. If the Plan Administrator receives notice of a Qualifying Event, a notice of a second Qualifying Event, or a Notice of Disability and determines that the individual is not entitled to COBRA Coverage or to an extension of COBRA Coverage, the COBRA administrator will provide a notice to the individual that COBRA Coverage is not available or that it will not be extended.

(f) Termination Notice. When COBRA Coverage terminates before the end of the maximum COBRA Coverage period, the COBRA administrator will provide written notice of termination of the COBRA Coverage to each affected Qualified Beneficiary.

F. Extension of COBRA Coverage.

(i) Disability Extension. If the initial Qualifying Event for a Qualified Beneficiary was termination of employment or a reduction in the hours of employment, and any Qualified Beneficiary with the same Qualifying Event is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA Coverage, the COBRA Coverage will be extended for up to an additional 11 months for all Qualified Beneficiaries sharing the same Qualifying Event, for a total of 29 months of COBRA Coverage. However, in order to be eligible for this extension of COBRA Coverage, one of the Qualified Beneficiaries affected by the Qualifying Event must give a copy of the Social Security Administration disability determination to the COBRA administrator during the first 18 months of COBRA Coverage and within 60 days of the latest of: (a) the date of the final determination by Social Security; (b) the date the Qualifying Event occurs (termination of employment or reduction in hours); (c) the date the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; and (d) the date on which the Qualified Beneficiary is informed of both the responsibility to provide the notice of disability determination and the Plan's procedures for providing the notice.

(a) A Qualified Beneficiary is "determined to be disabled within the first 60 days of COBRA Coverage" if the individual has been determined under Title II or Title XVI of the Social Security Act to have been disabled before the first day of COBRA Coverage and has not been determined to be no longer disabled before the first day of COBRA Coverage, or is determined to be disabled sometime during the first 60 days after the Loss of Coverage.

(b) The “first 60 days of COBRA Coverage” for an extension of coverage due to a Disability is measured from the Loss of Coverage due to Qualifying Event; provided however, that in the case of a Qualified Beneficiary who is a Child born to or placed for adoption with a Covered Employee during COBRA Coverage, the “first 60 days of COBRA Coverage” are measured from the date of birth or placement for adoption of the Child.

(c) The Disability extension applies independently with respect to each Qualified Beneficiary entitled to COBRA Coverage because of the same Qualifying Event. If the disabled Qualified Beneficiary drops COBRA Coverage, the rest of the Qualified Beneficiaries with the same Qualifying Event continue to have the right to the extended COBRA Coverage.

(d) If there is a final determination that the Qualified Beneficiary is no longer disabled, all Qualified Beneficiaries receiving the extended COBRA Coverage have an obligation to give notice to the COBRA administrator within 30 days after the date of that determination. COBRA Coverage then will end for all Qualified Beneficiaries who have the extended coverage as of the later of: (i) the first of the month that is more than 30 days after the final determination by Social Security, and (ii) the end of the regular COBRA Coverage period.

(e) See “Payment of COBRA Premiums” for information about increased COBRA Premiums that are owed during the Disability extension period. See “Notice Requirements for Employees and Qualified Beneficiaries” for information about the notice requirements that apply to Disability extensions.

(ii) Second Qualifying Event.

(a) When the Qualifying Event is a termination of employment or a reduction in hours, and within the 18 months of COBRA Coverage (or 29 months if there has been a disability extension), a second Qualifying Event occurs that provides up to 36 months of COBRA Coverage (e.g., death of the Employee, divorce or legal separation, or a Child no longer meeting the eligibility rules), then the 18 months (or 29 months) of COBRA Coverage is extended to 36 months of COBRA Coverage for the Spouse and Children, but not for the Employee. The 36 months runs, however, from the start date of the 18 (or 29) months of coverage, not from the date of the second Qualifying Event. This extended coverage is not available to a Spouse or Child who is not a Qualified Beneficiary, e.g., a Spouse or Child added later during Annual Open Enrollment.

(b) Termination of employment following a reduction in hours can never be the second Qualifying Event. In that instance, the COBRA Coverage will still be 18 months, measured from the Loss of Coverage.

(c) This extension of COBRA Coverage applies only to the Spouse and Children who elected COBRA Coverage in connection with the first

Qualifying Event and are still receiving COBRA Coverage in connection with that first Qualifying Event at the time of the second Qualifying Event.

(d) The Spouse and Children are eligible for this extension even if the Employee does not elect or continue COBRA Coverage until the second Qualifying Event occurs.

(e) In order to be eligible for the extension of COBRA Coverage, the Qualified Beneficiaries must give notice to the Cook Insurance Department within 60 days after the second Qualifying Event. If they timely give this notice, their COBRA Coverage is automatically extended. They do not need to apply for the extension. If they do not timely give this notice, then they are not eligible for the extension. See “Notice Requirements for Employees and Qualified Beneficiaries” for information about the notice requirements that apply to Second Qualifying Events.

(iii) Medicare Entitlement.

(a) When the Qualifying Event is a termination of employment or reduction in hours, and the termination of employment or reduction in hours occurs within 18 months after the date the Employee became entitled to (i.e. eligible for and enrolled in) Medicare, then COBRA Coverage for the Spouse and Children of the Employee is extended to 36 months from the later of when the Employee became entitled to Medicare or the loss of coverage due to the termination of employment or reduction in hours. The Employee’s COBRA Coverage is, however, still 18 months from the Loss of Coverage.

(b) If during the first 18 months of COBRA Coverage, a second Qualifying Event occurs as set out above, then, subject to those rules, COBRA Coverage may be extended for up to 36 months from the Loss of Coverage, instead of 36 months from the Employee’s eligibility for Medicare.

G. Termination of COBRA Coverage.

(i) COBRA Coverage will terminate no earlier than at the end of the 18, 29 and 36-month time periods, except as provided below:

(a) Failure to Pay COBRA Premium on Time. If a Qualified Beneficiary does not pay the proper COBRA premium by the due date, or by the end of any applicable grace period, then COBRA Coverage will end as of the last day of the period for which the COBRA premiums were paid on time. During the COBRA premium payment grace period, COBRA Coverage is terminated, but will be retroactively reinstated if the COBRA premiums are paid before the end of the grace period. Claims incurred during the grace period will not be paid until the COBRA premiums are paid.

(b) Other Group Health Plan Coverage. If a Qualified Beneficiary becomes covered under another group health plan (as an employee or otherwise)

or covered by Medicare (either Part A or Part B, or both) due to age after the Qualified Beneficiary elects COBRA Coverage, the Qualified Beneficiary's COBRA Coverage will terminate, even if the other coverage is different than or less valuable than the COBRA Coverage.

(c) Termination of Health Plan. If the Employer and all Affiliated Employers stop providing group health insurance to all Employees, COBRA Coverage will terminate.

(d) Qualified Beneficiary No Longer Disabled. If the maximum coverage period has been extended to 29 months because of the Disability of a Qualified Beneficiary and then there is a final determination by Social Security that the Qualified Beneficiary is no longer Disabled, COBRA Coverage will be terminated for all Qualified Beneficiaries who are receiving the extended coverage due to the same Qualifying Event as of the later of: (i) the first day of the month that is more than 30 days after the final determination by Social Security, or (ii) the end of the COBRA Coverage period that applies without regard to the disability extension. All Qualified Beneficiaries receiving the extended coverage have an obligation to give notice to the COBRA administrator of Social Security's final determination within 30 days of the latest of: (i) the date of Social Security's final determination that the Qualified Beneficiary is no longer disabled and (ii) the date on which the Qualified Beneficiary is informed of the responsibility to give the notice and the Plan's procedures for giving notice.

(e) Qualified Beneficiary Entitled to Medicare. If the Qualified Beneficiary first becomes entitled to benefits under Medicare, after the COBRA election.

(f) For Cause. If a Qualified Beneficiary's coverage would have been terminated had the Qualified Beneficiary been covered as an active Employee or Spouse or Child of an active Employee (e.g., a failure to enroll during Annual Open Enrollment, fraud or misrepresentation of a material fact), then the Qualified Beneficiary's COBRA Coverage will be terminated.

(g) Not Eligible. If the Plan Administrator determines that a Qualified Beneficiary was not eligible for coverage under the Plan, or was not eligible for COBRA Coverage, the Plan Administrator shall terminate the COBRA Coverage to the full extent permitted by law, and may seek reimbursement for claims improperly paid.

ARTICLE VI.

NON-EMPLOYEE DIRECTOR AND GRANDFATHERED DIRECTOR EMERITUS COVERAGE

Section 6.1. Coverage for Non-Employee Directors and Director Emeritus.

A. Eligibility. A non-Employee director and the non-Employee director's eligible Spouse and Children may become covered immediately upon commencement of service as a

non-Employee director if the non-Employee director applies for coverage within 30 days after beginning service as a non-Employee director. If the non-Employee director does not apply for coverage within 30 days, then the right to non-Employee director coverage is forever forfeited. Notwithstanding any other provision of the Plan, if the non-Employee director timely applies for coverage, then the non-Employee director, and if applicable, the Spouse and Children of the non-Employee director, are “Covered Persons” (also known as “Covered Members”). In addition, if a director or non-Employee director becomes a director emeritus before January 1, and is a Covered Person when the individual becomes such director emeritus (“grandfathered director emeritus”), then the individual may continue their coverage in the Plan, and their eligible Spouse and Children who are Covered Persons at that time may also continue their coverage in the Plan. For purposes of clarification, no individual shall meet the definition of grandfathered director emeritus after January 1, 2025 and no Plan coverage is provided to any non-grandfathered director emeritus.

B. Contributions. The Employer on whose Board the non-Employee director or grandfathered director emeritus serves shall pay the same Employer contribution at the same time for the non-Employee director or grandfathered director emeritus as it pays for an active Employee. The Employer shall report this contribution amount as taxable income to the non-Employee director or grandfathered director emeritus. The non-Employee director or grandfathered director emeritus shall pay the active Employee contribution at the same time as active Employees. The contribution paid by the non-Employee director or grandfathered director emeritus shall not, however, be paid with pre-tax dollars.

C. Termination of Coverage.

(i) Non-Employee Director and Grandfathered Director Emeritus. The coverage for a non-Employee director or grandfathered director emeritus will terminate on the earliest of the following events: 1) the date on which the individual ceases to serve on the board as a director of a participating Employer; 2) the date on which the Plan is amended to terminate coverage of non-Employee directors or grandfathered directors emeritus; 3) the end of the period for which a contribution for coverage has been paid if the contribution for the next period is not paid when due; 4) the date of termination of the Plan; 5) the date the non-Employee director or grandfathered director emeritus willfully submits a fraudulent claim for benefits; or 6) the date on which the Plan Administrator determines, in its sole discretion, that the non-Employee director or grandfathered director emeritus continually interferes with the safe and efficient provision of care to the non-Employee director or grandfathered director emeritus or continually behaves in a manner which prevents a Physician from providing care to the non-Employee director, grandfathered director emeritus or another Covered Person.

(ii) Spouse or Child of Non-Employee Director. Spouse or Child of non-Employee director or grandfathered director emeritus. The coverage for a Spouse or Child of a non-Employee director or grandfathered director emeritus will terminate on the earliest of the following events: 1) the date on which the non-Employee director or grandfathered director emeritus ceases to be covered by the Plan or ceases to serve as a director of a participating Employer for any reason other than death; 2) the date on which the Spouse or Child otherwise no longer meets the eligibility rules for a Spouse or

Child; 3) the date on which the Plan is amended to terminate coverage of non-Employee directors, grandfathered directors emeritus, or the Spouse or Children of non-Employee directors or grandfathered directors emeritus; 4) the end of the period for which a contribution for coverage has been paid if the contribution for the next period is not paid when due; 5) the date of termination of the Plan; 6) the date the Spouse or Child willfully submits a fraudulent claim for benefits; or 7) the date on which the Plan Administrator determines, in its sole discretion, that the Spouse or Child continually interferes with the safe and efficient provision of care to the Spouse or Child, or continually behaves in a manner that prevents a Physician from providing care to the Spouse or Child or another Participant.

D. Coordination of Benefits. When a non-Employee director, grandfathered director emeritus or Spouse or Child of a non-Employee director or grandfathered director emeritus becomes eligible to enroll in either Part A or Part B of Medicare benefits under Title XVIII of the Social Security Act, then the benefits of the non-Employee director, grandfathered director emeritus, Spouse and Child under this Plan shall be administered under the section of the Plan entitled “Coordination of Benefits with Medicare.”

ARTICLE VII. PREAUTHORIZATION AND CASE MANAGEMENT

Section 7.1. General Provisions.

A. Preauthorization. Preauthorization is a determination whether care is Medically Necessary. Preauthorization is required for all Plan Options, as described in the Benefit Booklet. See the Benefit Booklet for information about who provides these services for each Plan Option.

(i) OBGYN Services. A Covered Person does not need Preauthorization from the Plan or from a primary care provider to obtain obstetrical or gynecological care from a health professional in the Network who is authorized by state law to provide obstetrical or gynecological care (“OBGYN”). The health care professional, however, must otherwise comply with the Plan’s procedures regarding referrals and Preauthorization. The care, items and services provided by the OBGYN shall be treated as if they were authorized by a primary care provider.

(ii) Children. Children in the Clinic Plan Option up to the age of 16 may see a Network pediatrician or family practitioner for primary care without a referral from the Clinic. The pediatrician or family practitioner, however, must otherwise comply with the Plan’s procedures regarding referrals and Preauthorization. The care, items and services provided by the pediatrician or family practitioner shall be treated as if they were authorized by a primary care provider.

(iii) Primary Care. Participants may see any primary care Physician or nurse practitioner who is providing services at the Cook Family Health Center or any approved primary care Physician who is providing services outside the Cook Family Health Center.

(iv) Maternity Admissions. Maternity stays for up to 48 hours following a vaginal delivery or up to 96 hours following a cesarean delivery do not need Preauthorization. Maternity stays for longer time periods need Preauthorization, and will be approved if Medically Necessary.

(v) Not a Guarantee. Preauthorization is not a determination that any specific charge will be a Covered Charge.

(vi) Penalty. Except as otherwise provided, if a Covered Person does not comply with the Preauthorization requirements, charges will not be Covered Charges and will not apply to the Out-of-Pocket Maximum.

B. Managed Care. Case Management focuses on acute or chronic conditions that result from serious or debilitating Illnesses or Injuries by coordinating the needs of the Covered Person, the family, the health care providers and the Plan. Case Management contact information is listed in the Benefit Booklet and on the Cook Group Health Plan ID cards.

ARTICLE VIII. GENERAL LIMITATIONS AND EXCLUSIONS

Section 8.1. Cost-Sharing.

A. Deductible. A Deductible is the amount of Covered Charges that a Covered Person must incur and pay each calendar year before the Plan begins paying Covered Charges. Unless otherwise provided in the Benefit Booklet: (a) there is a separate Deductible for Network charges and Out-of-Network charges; and (b) Network charges apply only towards the Network Deductible, and Out-of-Network charges apply only towards the Out-of-Network Deductible. Deductibles are described in the Benefit Booklet. Some charges, as outlined in the Benefit Booklet, do not count toward meeting the Deductible. If a Covered Person changes Plan Options during the year, amounts accrued toward a Deductible during the calendar year will apply to the new Plan Option.

B. Annual Out-of-Pocket Maximum. The annual Out-of-Pocket Maximum is the dollar amount of Copayments, Deductibles and Coinsurance that a Covered Person must pay during a calendar year before the Plan begins paying 100% of Network Covered Charges incurred during the calendar year, except as otherwise provided. The Out-of-Pocket Maximums are embedded. Therefore, when any individual in family coverage hits the Single Out-of-Pocket Maximum, the Covered Charges for that individual are generally paid at 100%. The Out-of-Pocket Maximums are described in the Benefit Booklet. Some charges, as outlined in the Benefit Booklet, do not count toward meeting the Out-of-Pocket Maximum. Unless otherwise provided in the Benefit Booklet, there is no Out-of-Pocket Maximum for Out-of-Network charges. If a Covered Person changes Plan Options during the year, amounts accrued toward an Out-of-Pocket Maximum during the calendar year will apply to the new Plan Option.

C. Benefit Maximum. Benefit Maximums are the total amount the Plan will pay for a service or supply. As set out in the Benefit Booklet, the Benefit Maximums may be based on the number of services provided while the person is covered by the Plan, or they may be determined on a periodic basis, such as a set period of time or per occurrence of an Illness or

Injury, the number of days or visits, or a dollar amount. If a Covered Person changes Plan Options during the year, amounts accrued toward a Benefit Maximum during the calendar year will apply to the new Plan Option.

D. Copayment. A Copayment is a fixed amount of money that a Covered Person must pay toward the cost of a service or the cost of a Network office visit that is covered by the Plan.

E. Coinsurance. Coinsurance is the percentage of a Covered Charge that a Covered Person must pay in addition to any Copayment, after meeting the Deductible.

(i) Network Coinsurance. See Benefit Booklet.

(ii) Out-of-Network Coinsurance. See Benefit Booklet.

Section 8.2. Networks.

A. Network Requirement. As set out in the Benefit Booklet, unless otherwise provided, the Plan generally pays higher benefits when a Network Provider is used, and pays fewer benefits, or in some cases no benefits, when an Out-of-Network Provider is used. The Networks that apply to the different Plan Options are listed in the Benefit Booklet.

B. Exceptions to the Clinic and Network Requirements. In some circumstances, as set out in this section and in the Benefit Booklet, the Plan pays benefits to non-Clinic providers and at the Network level to Out-of-Network providers.

(i) Eligible Children and Spouses generally must enroll in the same Plan Option as the Employee. However, if an Eligible Child and/or Spouse is, therefore, enrolled in the Clinic Option but lives outside of Monroe County, Indiana, the Child and/or Spouse may see any Network provider instead of going to the Clinic for primary care, and the charges will be paid at the Network level.

(ii) Charges incurred by an Eligible Child or Spouse at a university's medical clinic will be paid at the Network level.

C. Exceptions to the Network Requirements for Non-Emergent Services. If a Participant receives care in an approved Ambulatory Surgical Center or a Network Hospital and the facility utilizes the services of an Out-of-Network lab, radiologist, anesthesiologist, pathologist or emergency room physician, then any such Out-of-Network provider services at a Network facility would be covered at Network rates.

Section 8.3. Usual and Customary Fee. The Plan will pay the Usual and Customary fee for each Covered Charge. For Network Providers, the Usual and Customary Fee is the negotiated network discount rate. For Out-of-Network Providers, the Usual and Customary Fee is a percentage of the amount that is usually and customarily accepted as payment for the service, supply, equipment or medicine within the geographic area in which the provider practices, as determined by the Plan Administrator. Additional information may be requested regarding the amount of an Out-of-Network charge. If the information provided does not demonstrate to the

Plan Administrator that the charge is the Usual and Customary Fee, then the amount of the charge that exceeds the Usual and Customary Fee will be denied, and the Covered Person will be responsible to pay the amount that is in excess of the Usual and Customary Fee. The Covered Person shall have the review and appeal rights set out in the Claims Procedures.

Section 8.4. Medically Necessary Charges. The Plan covers only Medically Necessary treatments, services, supplies, equipment and medicines provided by a Hospital, Physician or other health care provider.

Medically Necessary treatments, services, supplies and equipment:

- (i) are required to identify or treat an Injury or Illness; and
- (ii) are appropriate and consistent with the symptoms, diagnosis or treatment of the Covered Person's condition, disease, Illness or Injury; and
- (iii) do not involve unnecessary or repeated tests; and
- (iv) are not of an Experimental or Investigative or educational nature; and
- (v) are furnished by a Provider with appropriate training and experience, acting within the scope of their license; and
- (vi) are the most appropriate that can be safely provided under the circumstances on a cost-effective basis; and
- (vii) meet the following definition of standard of care:
 - (a) *Standard of care* refers to an acceptable level of patient care provided by a medical practitioner. It considers how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances. Standard of care is sometimes referred to as "standard therapy" or "best practice" and is generally satisfied by any medicine or treatment that experts agree is consistent with generally accepted standards of medical practice, is appropriate, accepted, and widely used for a certain type of patient, Illness, or clinical circumstance. Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the view of medical practitioners practicing in relevant clinical areas and any other relevant factors.

The fact that a provider may prescribe, order, recommend or approve a treatment, service, supply, equipment or medicine does not, of itself, make that treatment, service, supply, equipment or medicine Medically Necessary. Care that is solely for the convenience of the Covered Person, Physician, Hospital or other health care provider is not Medically Necessary.

Section 8.5. Experimental or Investigative Charges.

Drugs, devices, treatment modalities, services and procedures are excluded from coverage if they are Experimental or Investigative. The Plan Administrator (and/or its designee) has the authority to determine whether a drug, device, treatment modality, service or procedure is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended or approved the drug, device, treatment modality, service or procedure does not, in itself, make it eligible for payment.

A drug, device, treatment modality, service or procedure for a specific diagnosis (collectively, "*Treatment or Procedure*") is Experimental or Investigative if:

(i) the Treatment or Procedure has failed to obtain final approval for a specific diagnosis from the appropriate governmental body at the time the Treatment or Procedure is furnished to the Covered Person; or

(ii) Reliable Evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of such Treatment or Procedure on health outcomes for a specific diagnosis; or

(iii) such Treatment or Procedure, or the patient-informed consent document utilized with the Treatment or Procedure was reviewed and approved by the treating facility "institutional review board" or other body serving a similar function, or if federal law requires such review or approval; or

(iv) Reliable Evidence shows that the Treatment or Procedure is: (1) the subject of ongoing phase I or phase II clinical trials; (2) the subject of on-going phase III clinical trials; or (3) otherwise under study to determine its:

(a) maximum tolerated dose;

(b) toxicity;

(c) safety;

(d) efficacy; or

(e) efficacy as compared with the standard means of treatment or diagnosis; or

(v) Reliable Evidence shows that the prevailing opinion among experts regarding such Treatment or Procedure is that further studies or clinical trials are needed to determine its:

(a) maximum tolerated dose;

(b) toxicity;

- (c) safety;
- (d) efficacy; or
- (e) efficacy as compared with the standard means of treatment or diagnosis.

“Reliable Evidence” means only:

- (i) published reports and articles in the authoritative medical and scientific literature; or
- (ii) the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same Treatment or Procedure; or
- (iii) the written informed consent used by the treating facility or by another facility studying substantially the same Treatment or Procedure.

Qualified Individuals shall not be denied the right to participate in an Approved Clinical Trial, and the Plan will not discriminate against an individual based on their participation in an Approved Clinical Trial. Routine Patient Costs for items and services furnished in connection with an Approved Clinical Trial, including Prescription Drugs, are not Experimental or Investigative items or services, but are Covered Charges. For purposes of this subsection D, a Qualified Individual is a Covered Person who is eligible, according to the clinical trial protocol, to participate in an Approved Clinical Trial for treatment of cancer or other life-threatening disease or condition (i.e., a disease or condition likely to result in death unless interrupted), if either: (i) the referring health care professional is in the Network and has concluded that the Covered Person’s participation in a clinical trial would be appropriate; or (ii) the Covered Person provides medical and scientific information establishing that the individual’s participation in the clinical trial would be appropriate. An Approved Clinical Trial is a Phase I, Phase II, Phase III or Phase IV clinical trial that: (i) is conducted in connection with the prevention, detection or treatment of cancer or other life-threatening disease or condition and is federally funded; or (ii) is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration; or (iii) is exempt from investigational new drug application requirements. Routine Patient Costs include items and services, including Prescription Drugs, typically provided under the Plan for a Covered Person who is not enrolled in a clinical trial, but they do not include: (i) the investigational item, device or service itself; or (ii) items and services not included in the direct clinical management of the patient, but instead provided in connection with the data collection and analysis; or (iii) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

Section 8.6. Examinations. The Plan shall have the right, at its expense, to have a Covered Person examined to evaluate and determine whether a Claim is a Covered Charge. If any charge is covered under two or more provisions, only one benefit will be provided per expense.

Section 8.7. Continuity of Care. If the Covered Person’s Provider or facility ceases to be a member of the Network, or the Provider’s contract with the Plan Administrator changes in way that affects Plan benefits while the Covered Person is a “continuing care patient,” the Plan

Administrator or its designee will notify the Covered Person of the change in the Provider's status, provide the Covered Person an opportunity to notify the Plan Administrator or its designee of their need for transitional care, and allow the Covered Person to elect to continue to have benefits provided under the Plan under the same terms and conditions as would have applied, had the Covered Person's Provider's Network status remained unchanged, for a period of up to ninety (90) days, or until the Covered Person is no longer a "continuing care patient," whichever occurs first.

A "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from the Provider or facility;
2. is undergoing a course of institutional or inpatient care from the Provider or facility;
3. is scheduled to undergo non-elective surgery from the Provider or facility, including receipt of postoperative care with respect to the surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility; or
5. is determined to be terminally ill (as defined under the Social Security Act) and is receiving treatment for the illness from the Provider or facility.

The term "serious and complex condition" means:

1. For an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
2. For a chronic illness or condition, a condition that:
 - (a) is life-threatening, degenerative, potentially disabling, or congenital; and
 - (b) requires specialized medical care over a prolonged period of time.

ARTICLE IX. MEDICAL BENEFITS

Section 9.1. Abortion. As allowed under Indiana state law, abortion procedures performed only at a Hospital or Ambulatory Outpatient Surgical Center owned by a Hospital for a covered Employee or covered Spouse are Covered under the following circumstances (i) a Physician determines that the abortion is Medically Necessary to present any serious health risk to the pregnant woman or to save the pregnant woman's life, (ii) the fetus is diagnosed with a lethal fatal anomaly, or (iii) the pregnancy is a result of rape and incest and the abortion is provided within the first 10 weeks of the pregnancy.

Section 9.2. Ambulance Services.

Eligible charges are Covered Charges as specified in the Benefit Booklet for local professional ambulance service which is Medically Necessary or in the event of an Emergency Medical Condition. Transportation to a Hospital must be to the nearest Hospital qualified to provide treatment for the Injury or Illness. If the Injury or Illness requires special treatment which is not available in a local Hospital, transportation is covered to the nearest Hospital equipped to provide treatment.

Air ambulance charges to the nearest facility that is qualified to treat an Emergency Medical Condition are Covered Charges if a Covered Person suffers an Emergency Medical Condition and no local medical facility is qualified to treat the Emergency Medical Condition, and the air ambulance is certified by the Case Manager as Medically Necessary. Transportation must be to the nearest Hospital qualified to provide treatment for the Injury or Illness. Travel expenses of family members or travel companions are not Covered Charges. If a Participant receives air ambulance services from an Out-of-Network Provider, services provided shall be at the same cost to the Participant as if such services were provided through the Network, including cost-sharing. In addition, payment of recognized amount (or denial) must be made within thirty (30) days of incurring the expense.

C. Emergency Medical Condition is defined in Section 9.7(C).

Illness is a pregnancy, or a disease or disturbance in the function or structure of the body which causes physical signs and/or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or systems of the body.

An *Injury* is a condition caused by accidental means and from an external force which results in damage to the Covered Person's body from the external force.

Hospital is defined in Section 9.12(E).

Section 9.3. Ambulatory Surgical Center.

A. Definition of Ambulatory Surgical Center. An *Ambulatory Surgical Center* is a licensed facility that provides general surgery and meets all of the following requirements:

- (i) is directed by a staff of Physicians, at least one of whom is on the premises when surgery is performed and during the recovery period;
- (ii) has at least one certified anesthesiologist at the site when surgery that requires general or spinal anesthesia is performed;
- (iii) extends surgical staff privileges to Physicians who practice surgery;
- (iv) has at least two operating rooms and one recovery room;
- (v) provides or coordinates with a medical facility in the area for diagnostic X-ray and laboratory services needed in connection with surgery;

(vi) provides in the operating and recovery rooms full-time skilled nursing services directed by a registered nurse, and

(vii) is equipped and has trained staff to handle medical emergencies, including a Physician trained in cardiopulmonary resuscitation, a defibrillator, a tracheotomy set, and a blood volume expander.

B. Covered Charges. If a Covered Person receives care in an approved Ambulatory Surgical Center, professional services and facility charges shall be paid as set out in the Benefit Booklet. Covered Charges for outpatient services include, for example, the following: surgery, treatment of an accidental Injury, treatment of a condition requiring medical care, radiation, X-ray, chemotherapy, and pre-admission testing.

Section 9.4. Anesthesia. Charges for anesthesia and its administration by a licensed provider are Covered Charges.

Section 9.5. Bariatric Surgery. The Plan covers bariatric surgery when all criteria of the Plan's Policy for Bariatric Surgery (as set forth in Addendum F) are met, as they are amended from time to time. Notwithstanding any other provision of the Plan, nutritional counseling, dietary counseling and weight loss services are Covered Charges for Covered Persons for whom bariatric surgery is a Covered Charge.

Section 9.6. Durable Medical Equipment. Eligible charges for Durable Medical Equipment prescribed by a Physician are covered as set out in the Benefit Booklet, and include rental (not to exceed the purchase price) or purchase of Durable Medical Equipment, such as wheelchairs, hospital-type beds, iron lungs and oxygen equipment (including the oxygen).

Durable Medical Equipment is equipment that:

- (i) can withstand repeated use;
- (ii) is primarily and customarily used to serve a medical purpose; and
- (iii) generally, is not useful to a Covered Person in the absence of an Illness or Injury.

Eligible charges are limited to the least expensive item that is adequate for the Covered Person's needs. Repairs are covered when needed to restore proper function. If the charges are more than \$200, they will be considered incurred monthly, based upon the estimated length of time the equipment will be used, up to a maximum of 12 months.

Section 9.7. Emergency Room Services.

A Covered Person may, without Preauthorization, receive Emergency Services for an Emergency Medical Condition in an emergency department of a Network or Out-of-Network Hospital. The Plan will in either event pay the Network benefit, and the Covered Person must pay the Network Copayment, Deductible and Coinsurance for Emergency Services.

For this purpose, “Emergency Services” include:

- (i) a medical screening examination within the capability of the emergency department of the Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
- (ii) further medical staff services and Hospital facilities as necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from the facility.

For this purpose, an “Emergency Medical Condition” is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

- (i) a condition that places the health of the individual (and/or unborn child) in serious jeopardy;
- (ii) serious impairment to bodily functions; or
- (iii) serious dysfunction of any bodily organ or part.

To the extent the Out-of-Network charge exceeds the Network charge, a Covered Person may be required to pay the balance after the Plan pays the greater of: (1) the Network amount for the Emergency Services, less the Network Copayment, Network Deductible and Network Coinsurance; and (2) the amount that would be paid by Medicare for the Emergency Services, excluding the Network Copayment and Network Coinsurance.

Section 9.8. Family Planning Services.

A. Eligible Charges. Covered Charges for Family Planning Services are as specified in the Benefit Booklet, and include the following charges:

- (i) diagnosis and treatment of Infertility, including, but not limited to:
 - (a) artificial insemination, sperm washings, sperm banking and/or storage;
 - (b) cryopreservation of semen;
 - (c) embryo implants;
 - (d) gamete intrafallopian transfer (“GIFT”);
 - (e) in vitro fertilization (“IVF”);
 - (f) medications for infertility and ultrasounds associated with infertility medication therapy;

- (g) zygote intrafallopian transfer (“ZIFT”);
- (h) hamster egg penetration tests;
- (ii) treatment of Sexual Dysfunction, including, but not limited to:
 - (a) surgical procedures;
 - (b) FDA-approved prescription drugs;
 - (c) Prescribed devices and appliances;
 - (d) Psychotherapy and counseling.
- (iii) voluntary sterilization, including, but not limited to:
 - (a) vasectomy.

B. Excluded Charges. The following charges are excluded:

- (i) egg or sperm donor costs;
- (ii) implantation;
- (iii) treatment of or support of a surrogate mother;
- (iv) reversal of elective or Medically Necessary sterilization;
- (v) any treatments for infertility after voluntary sterilization, except in cases of ectopic pregnancy;
- (vi) treatment of Children, other than Preventive Care services for a pregnant Child; and
- (vii) in vitro procedures for pre-implantation genetic diagnoses.

All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, including Children, are covered as Preventive Care Services, instead of as Family Planning Services.

“*Infertility*” means the inability to conceive after twelve consecutive months of unprotected sexual intercourse.

“*Sexual Dysfunction*” means sexual dysfunction which is a result of: (a) a specific physically traumatic event; (b) organic disease (such as prostate cancer, diabetes mellitus, arterio sclerosis); or (c) the effects of surgery, radiation therapy or drug therapy.

Prescribed drugs are covered under the Prescription Drug benefits. Prescribed drugs, psychotherapy and counseling for Sexual Dysfunction do not count toward the Family Planning maximum benefit.

Section 9.9. Foot Orthotics. Foot orthotics and other supportive devices for the feet are not Covered Charges, except the following are Covered Charges:

A shoe, if it is an integral part of a leg brace and its expense is included in the cost of the brace.

Therapeutic shoes (depth or custom molded) along with inserts that are Medically Necessary and are not Experimental or Investigative for persons with diabetes mellitus and the following complications involving the foot:

- (i) peripheral neuropathy with evidence of callus formation;
- (ii) history of pre-ulcerative calluses;
- (iii) history of previous ulceration;
- (iv) foot deformity;
- (v) previous amputation of the foot or part of the foot; or
- (vi) poor circulation.

Section 9.10. Home Health Care.

Home Health Care includes services or supplies rendered to, and in the home of, a Covered Person or in the home of a family member by a Home Health Care Agency as part of a Home Health Care Plan as an alternative to services and supplies provided as part of an inpatient confinement in a Hospital or Skilled Nursing Facility.

A Home Health Care Agency is an agency that: (i) is certified by the Covered Person's Physician as an appropriate provider of Home Health Care services, (ii) has a full-time administrator, (iii) maintains daily clinical records of services provided to the Covered Person, (iv) includes on its staff at least one registered nurse to supervise nursing care, and (v) is coordinated by a state-licensed Medicare-certified home health care agency or certified rehabilitation agency.

Covered Charges for Home Health Care are those charged by a Home Health Care Agency for:

- (i) evaluation of the need for, and development of, a Home Health Care Plan by a registered nurse or medical social worker when approved or requested by the attending Physician;

(ii) part-time or intermittent home nursing care provided by, or under the supervision of, a registered nurse;

(iii) part-time or intermittent services of qualified Home Health Aides, other than registered nurses, that are:

(a) Medically Necessary as part of the Home Health Care Plan,

(b) under the supervision of a registered nurse or medical social worker, and

(c) solely for the care of the Covered Person;

(iv) physical, respiratory, occupational and speech therapy;

(v) medical supplies, drugs and medicines prescribed by the attending Physician, if necessary under the Home Health Care Plan, but only to the extent such items would have been covered by the Plan had the Covered Person been Hospitalized; and

(vi) nutritional counseling provided by, or under the supervision of, a registered dietitian when the services are Medically Necessary as part of the Home Health Care Plan.

A *Home Health Care Plan* is a plan that is established and approved in writing by the Covered Person's attending Physician for the care and treatment of a Covered Person for an Injury or Illness. The Physician must also certify that the treatment for the Injury or Illness would otherwise require confinement in a Hospital or a Skilled Nursing Facility. The Home Health Care Plan must be reviewed at least every two months.

A *Home Health Aide* is a person, other than a registered nurse, who is qualified to provide services that are Medically Necessary for the care and treatment of a Covered Person.

Covered Home Health Care services do not include:

(i) services or supplies not included in the Home Health Care Plan;

(ii) services by a family member;

(iii) Custodial Care;

(iv) food;

(v) housing;

(vi) homemaker services;

(vii) home-delivered meals; or

- (viii) transportation services.

Custodial Care is care that is primarily for the purpose of assisting a Covered Person in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an Illness or Injury. Custodial Care is care that is not expected to substantially improve a medical condition and has minimal therapeutic value. Care may be Custodial Care even if it is recommended by a professional, and regardless of whether it is performed in a facility, such as a Hospital or Skilled Nursing Facility or at home. Custodial Care includes, but is not limited to:

- (i) Assistance with walking, bathing or dressing;
- (ii) Transfer or positioning in bed;
- (iii) Administration of normally self-administered medicine;
- (iv) Meal preparation;
- (v) Feeding by utensil, tube or gastrostomy;
- (vi) Oral hygiene;
- (vii) Ordinary skin and nail care;
- (viii) Catheter care;
- (ix) Suctioning;
- (x) Using the toilet;
- (xi) Enemas;
- (xii) Preparation of special diets; and
- (xiii) Supervision over medical equipment or exercises or over self-administration of oral medications not requiring the constant attention of trained medical personnel.

Section 9.11. Hospice. If a Physician certifies that a Covered Person is terminally ill, eligible charges for Medicare-certified hospice care are Covered Charges. Hospice care emphasizes the management of pain and other symptoms associated with terminal Illness.

Section 9.12. Hospital Inpatient and Outpatient Services.

A. Hospital Room and Board. Covered Charges are those incurred for Hospital semi-private rooms, wards, an Intensive Care Unit or a Coronary Care Unit. Covered Charges for a private room are limited to the average semi-private room rate for the facility. When the facility has only private rooms, or a private room is Medically Necessary, the private room rate will be considered.

B. Hospital-Based Services and Supplies. Covered Charges include, but are not limited to, lab tests, and other charges for Medically Necessary services and supplies that are provided while a Covered Person is Hospital-confined. Personal items that are not Medically Necessary are not Covered Charges.

C. Physician Services. Visits by a Physician while confined in a Hospital or Skilled Nursing Facility are Covered Charges.

D. Diagnostic Procedures. Diagnostic procedures are Covered Charges as set out in the Benefit Booklet.

Hospital means an institution which is duly licensed as a hospital (to the extent such licensing is required by state or federal law) and which is engaged primarily in providing medical care and treatment of ill and injured persons on an inpatient basis and which meets all of the following requirements:

(i) is an institution accredited by the Joint Commission on Accreditation of Hospitals or is a hospital that is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare;

(ii) provides organized facilities for laboratory services, diagnostic services, medical treatment and surgery;

(iii) provides 24-hour nursing care by licensed registered nurses;

(iv) has a staff of one or more licensed Physicians available at all times; and

(v) is not an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an extended care facility or a home for the aged.

To the extent that Covered Charges are provided to a Covered Person, a facility approved under the laws of the state of its jurisdiction for the treatment of Mental Health and Substance Abuse will be considered a Hospital under this Plan, with respect to Covered Charges for such treatment.

Intensive Care and Coronary Care Units are a section, ward or wing within a Hospital which is operated solely for critically ill patients. These Units provide special supplies, equipment and constant observation and care by registered nurses or other Hospital personnel.

Section 9.13. Maternity and Newborn Services.

A. Maternity Charges. Medical care in connection with pregnancy, childbirth or a related medical condition of a covered Employee or Spouse are Covered Charges. Charges for Child maternity, except for preventive care during pregnancy and prescribed contraceptives, are not Covered Charges. Covered Charges include charges for services provided in a birthing center if a Physician in charge is acting within the scope of the Physician's license and the birthing center meets all legal requirements. Covered Charges also include the services of a

midwife performing the delivery if the midwife and the facility are properly licensed at the time the delivery is performed.

B. Newborn Charges. Covered Charges for inpatient care of a newborn infant of a covered Employee or Spouse include, for example:

- (i) Hospital nursery room, board and care;
- (ii) x-rays;
- (iii) laboratory services;
- (iv) Physician's visits;
- (v) charges for circumcision;
- (vi) treatment for premature birth; and
- (vii) surgery to repair or restore a body part to achieve normal function.

Section 9.14. Mental Health and Substance Abuse Services.

A. General Rule. Eligible charges for inpatient, outpatient and transitional treatment of Mental Health and Substance Abuse are covered as set out in the Benefit Booklet and are subject to all limitations and exclusions of the Plan. Treatment must be provided in a facility approved or licensed to provide the services in the state in which it is located.

B. Outpatient Services. Outpatient services include partial Hospitalization and collateral interviews with the family of the Covered Person receiving treatment. Treatment must be related to the diagnosed condition.

C. Transitional Treatment Programs. A Transitional Treatment Program is a non-residential program that provides Case Management, counseling, medical care and psychotherapy on a regular basis for a scheduled part of a day and a scheduled number of days per week. In a Transitional Treatment Program, services are rendered in a less restrictive manner than inpatient services, but in a more intensive manner than outpatient services.

D. ADD/ADHD. Covered Charges for the treatment of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) are covered as Mental Health benefits. They include outpatient charges for evaluation, testing and treatment for ADD and ADHD, and charges for monitoring medication for ADD and ADHD.

E. Mental Health. Mental Health means a mental, nervous or emotional disease or disorder of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders, including, but not limited to, transgender therapy and treatments. This is true regardless of the original cause of the disorder. (Note: Substance Abuse shall not be deemed a Mental Health condition for purposes of this Plan.)

F. Substance Abuse. Substance Abuse means the use of a psychoactive substance, including alcohol, in a manner detrimental to society or the Covered Person and which meets, or with continued use may meet, criteria for substance abuse or drug dependency.

Section 9.15. Physician Office Visits.

A. Physician Office Services – Clinic Plan Option.

- (i) Primary care services will be provided at the Clinic or outside the Clinic by an approved primary care Physician, except as set out in the Benefit Booklet.
- (ii) Lab work will be provided at the Clinic as set out in the Benefit Booklet.
- (iii) Specialist office visits, including Mental Health and Substance Abuse counseling sessions, will be paid as set out in the Benefit Booklet.
- (iv) Specialist office surgery, x-rays and lab tests will be paid as set out in the Benefit Booklet.

B. Physician Office Services – Traditional Plan Option and High Deductible Health Plan Option.

- (i) Physician office visits for primary care and specialty care, including Mental Health and Substance Abuse counseling sessions, will be paid as set out in the Benefit Booklet.
- (ii) Lab Work will be paid by the Plan as set out in the Benefit Booklet.
- (iii) Specialist office visits, surgery, x-rays and lab tests will be paid as set out in the Benefit Booklet.
- (iv) Persons enrolled in the Traditional Plan Option or High Deductible Health Plan Option may use the Clinic for their primary care, subject to any applicable Deductible.

C. Physician. A *Physician* is a person who is validly licensed to perform services for which benefits are provided under the Plan and who is acting within the scope of that license. For purposes of Mental Health and Substance Abuse charges, Physician shall also include any person approved or licensed by the state in which services are rendered for the treatment of Mental Health or Substance Abuse conditions.

Section 9.16. Preventive Care.

A. Covered Preventive Care Services - Generally.

- (i) The following Preventive Care Services are Covered Charges at 100% when they are provided by a Network Provider.

(a) Items or services with a rating of A or B in the recommendations of the United States Preventive Services Task Force for the Covered Person, per the attached Addendum A, Section 1, as amended from time to time;

(b) Immunizations for routine use in children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for the Covered Person, per the attached Addendum A, Section 2, as amended from time to time;

(c) If applicable, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, per the attached Addendum A, as amended from time to time, for:

I covered infants, children, and adolescents, per the attached Addendum A, Sections 3 and, as amended from time to time; and

II covered women, per the attached Addendum A, Section 5, as amended from time to time.

(ii) Items and services that are added to the recommendations of the United States Preventive Services Task Force under (a) above, immunizations newly recommended by the Advisory Committee under (b) above, and preventive care and screenings added to the guidelines supported by the Health Resources and Services Administration under (c) above shall become covered Preventive Care Services effective on January 1 of the next year, unless otherwise provided in a Plan amendment.

(iii) Where these recommendations and guidelines for Preventive Care Services do not specify the frequency, method, treatment or setting for the provision of a service, the Plan will use reasonable medical management techniques and existing relevant evidence to limit or exclude benefits under the Plan based on Medical Necessity or medical appropriateness and to determine the frequency, method, treatment or setting for Covered Preventive Care Services.

B. Specific Covered Preventative Care Services. The Plan will also cover specific Preventive Care Services, as set out in the Benefit Booklet, including, but not limited to, Digital Breast Tomosynthesis or 3D screening mammography.

C. Billing for Preventive Care Services. The Plan will pay benefits based on how services are coded by the provider. If an office visit is coded as Preventive Care Services, then the Plan will not impose a Deductible, Copayment and/or Coinsurance on the office visit charge.

All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, including Children, will be covered as Preventive Care Services, instead of as Family Planning Services.

Section 9.17. Second and Third Surgical Opinion. Eligible charges for a second surgical opinion are Covered Charges, and include Physician charges and laboratory and diagnostic services if: (i) the services are performed by a Board-Certified surgeon or specialist, (ii) the services are prior to surgery, (iii) the surgeon/specialist giving the second opinion is not in the same office or medical practice with the first Physician, and (iv) the surgeon/specialist giving the second opinion does not assist in any way with the surgery, including providing anesthesia services. If the first two Physicians disagree about whether the surgery is advisable, eligible charges for a third surgical opinion are Covered Charges, including Physician charges and laboratory and diagnostic services if the third surgeon/specialist meets all of the criteria set out above.

Section 9.18. Nursing Home Services.

Eligible charges for care provided in a licensed Skilled Nursing Facility are Covered Charges as set out in this Section. The attending Physician must certify every seven days that the care is Medically Necessary. The charges must not be for Custodial Care, as defined in Section 9.10(G). The daily rate will not exceed the Usual and Customary Fee as established by the Plan.

Skilled Nursing Facility means a facility which meets the following:

- (i) is regularly engaged in providing skilled nursing care for Ill and Injured persons;
- (ii) requires that the patient be regularly attended by a Physician;
- (iii) maintains a daily record of each patient;
- (iv) provides 24-hour nursing care which is supervised by a registered nurse;
- (v) is not, except incidentally, a home for the aged, a hotel, resort or the like;
- (vi) is not, except incidentally, a place for the treatment of Mental Health and Substance Abuse; and
- (vii) is licensed as a skilled nursing facility, if such licensing is required.

Services provided in an assisted living facility or independent living facility are not Covered Charges.

Section 9.19. Support Hose. Charges for support hose are Covered Charges as set out in the Benefit Booklet.

Section 9.20. Surgical Services. Other Than Oral Surgery.

Charges for surgery when performed in a Hospital or outpatient department of a Hospital, Ambulatory Surgical Center or clinic are Covered Charges. Covered Charges include Hospital pre-operative and post-operative care. Covered Charges for surgical services include, for example, the following:

(i) Cosmetic Surgery that is: a) required as a result of an Injury, if treatment is rendered within two years of the Injury; or b) for functional repair or restoration of any body part when necessary to achieve normal body function; or c) for a congenital deformity or anomaly;

(ii) charges for an assistant surgeon; and

(iii) charges for an elective sterilization for a covered Employee or covered Spouse.

B. Oral Surgery. Eligible charges for the following oral surgical procedures are Covered Charges under the medical benefits of this Plan:

(i) surgical exposure of impacted teeth;

(ii) excision of exostosis of the jaw and hard palate;

(iii) excision of a tumor or cyst or incision to drain a cyst;

(iv) treatment of Injuries to natural teeth and surrounding tissue, including replacement of natural teeth;

(v) apicoectomy – excision of apex of tooth root;

(vi) external incision and drainage of cellulitis;

(vii) incision of accessory sinuses, salivary glands or ducts;

(viii) gingivectomy – excision of loose gum tissue to eliminate infection;

(ix) alveolectomy – the leveling of structures supporting teeth for the purpose of fitting dentures;

(x) frenectomy;

(xi) osseous surgery;

(xii) orthognathic surgery, and

(xiii) Cosmetic Surgery that is: a) required as a result of an Injury, provided the treatment is rendered within two years of the Injury; or b) for functional repair or restoration of any body part when necessary to achieve normal body function; or c) to correct a congenital deformity or anomaly.

Section 9.21. Temporomandibular Joint Dysfunction. Eligible charges for treatment of temporomandibular joint dysfunction (TMJ) are Covered Charges as specified in the Benefit Booklet.

Section 9.22. Therapies.

A. Chiropractic Services. Eligible charges for chiropractic care, including x-rays, manipulations and Supportive Care, are Covered Charges as specified in the Benefit Booklet. Supportive Care means treatment which is Medically Necessary to prevent the Covered Person's condition from significantly deteriorating.

B. Physical, Occupational and Speech Therapy. Physical, occupational and speech therapy are Covered Charges only when the therapy is Medically Necessary. Materials used in occupational therapy are not Covered Charges.

C. Chemotherapy and Radiation Therapy. Chemotherapy and radiation therapy are Covered Charges. Transplant of Human Organs and Tissue.

A. Coverage of Donor and Recipient. Covered Charges are as set out in the Benefit Booklet, and as follows:

(i) When only the recipient is a Covered Person, eligible charges related to the recipient are Covered Charges. Only charges of the donor for services to donate the human organ or tissue are Covered Charges; provided, however, that these charges of the donor will be Covered Charges only if the charges are not covered for the donor from any other source, including, for example, any other insurance coverage, employee benefit plan or government program. Eligible donor charges that are Covered Charges, other than the donor's transportation and lodging expenses, will accumulate toward any maximum applicable to the recipient who is a Covered Person.

(ii) When only the donor is a Covered Person, eligible charges of the donor are Covered Charges; provided, however, that any other source of coverage available to the donor will be considered the primary payer of benefits, and this Plan will be the secondary payer of benefits. No charges of a transplant recipient who is not a Covered Person are Covered Charges.

B. Covered Transplants.

(i) Heart Transplant

(a) Network – 100% of Covered Charges after the Deductible;

(b) Out-of-Network – 100% of Covered Charges after the Deductible, up to an overall Transplant Benefit Period maximum of \$110,000, and a Physician maximum of \$20,000

(ii) Lung Transplant

(a) Network - 100% of Covered Charges after the Deductible;

(b) Out-of-Network – 100% of Covered Charges after the Deductible, up to overall Transplant Benefit Period maximum of \$155,000, and a Physician maximum of \$20,000.

(iii) Bone Marrow Transplant

(a) Network - 100% of Covered Charges after the Deductible;

(b) Out-of-Network – 100% of Covered Charges after the Deductible up to overall Transplant Benefit Period maximum of \$130,000, and a Physician maximum of \$20,000.

(iv) Liver Transplant

(a) Network - 100% of Covered Charges after the Deductible;

(b) Out-of-Network – 100% of Covered Charges after the Deductible up to overall Transplant Benefit Period maximum of \$130,000, and a Physician maximum of \$20,000.

(v) Heart/Lung Transplant

(a) Network - 100% of Covered Charges after the Deductible;

(b) Out-of-Network – 100% of Covered Charges after the Deductible up to overall Transplant Benefit Period maximum of \$150,000, and a Physician maximum of \$20,000.

(vi) Pancreas Transplant

(a) Network - 100% of Covered Charges after the Deductible;

(b) Out-of-Network – 100% of Covered Charges after the Deductible up to overall Transplant Benefit Period maximum of \$70,000, and a Physician maximum of \$20,000.

(vii) Kidney Transplant

(a) Network - 100% of Covered Charges after the Deductible;

(b) Out-of-Network – 100% of Covered Charges after the Deductible up to overall Transplant Benefit Period maximum of \$55,000, and a Physician maximum of \$20,000.

C. Preauthorization Requirement for Organ Transplant.

(i) Expenses incurred in connection with any organ or tissue transplant listed in this Section will be Covered Charges, subject to referral to and Preauthorization by the Case Manager. (Cornea transplants are not subject to this Preauthorization provision, but will be considered on the same basis as any other medical expense covered under the Plan.) Transplant coverage is offered under this Plan through a Network of specialized professionals and facilities. Coverage is also provided for Transplant services obtained Out-of-Network, but at a reduced benefit level.

(ii) As soon as the Covered Person's attending Physician has indicated that the Covered Person is a potential candidate for a transplant or is a potential donor, the Covered Person or the Covered Person's Physician should contact the Case Manager to begin pre-authorization for the initial Evaluation and Listing of the transplant.

(iii) A comprehensive treatment plan must be developed for the Plan by the Case Manager. It must include such information as the diagnosis, the nature of the transplant, the setting of the procedure (i.e., name and address of the Hospital), any secondary medical complications, a five-year prognosis, two qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. (One or both confirming second opinions may be waived by the Case Manager.) Additional attending Physician's statements may also be required. The Covered Person may provide a comprehensive treatment plan independent of the Network, but this will be subject to medical appropriateness review and may result in Out-of-Network benefit coverage.

(iv) Failure to Preauthorize a transplant procedure will result in the application of a \$5,000 Deductible to all Covered Charges incurred as a result of the transplant. This Deductible is in addition to any other Deductible and Copayment requirements that would normally be applicable to the transplant procedure.

D. Organ Transplant Network. As a result of the Preauthorization review, the Covered Person will be asked to consider obtaining transplant services from a participating Center of Excellence or Blue Distinction Centers for Transplant facility arranged by the Plan Administrator. The purpose of designating Centers of Excellence or Blue Distinction Centers for Transplant facilities is to perform necessary transplants in the most appropriate setting for the procedure, to improve the quality and probability of a successful outcome, and to reduce the average cost of the procedure.

There is no obligation for the Covered Person to use a Center of Excellence or Blue Distinction Centers for Transplant facility. However, benefits for the transplant and its related expenses may vary depending on whether services are provided in or out of a Center of Excellence or Blue Distinction Centers for Transplants facility.

If a transplant is performed in a facility that is not a Center of Excellence or Blue Distinction Centers for Transplant facility, but the Covered Person has received approval from the Plan's Case Manager for the services, then Center of Excellence or Blue Distinction Centers for Transplant benefits will apply to the transplant and its related expenses. If services are provided at a facility that is not a Center of Excellence or Blue Distinction Centers for Transplant facility without the approval of the Case Manager, then Out-of-Network benefits will apply.

If a Network contract is terminated and an Organ Transplant treatment plan has begun and before benefits are exhausted, then Plan benefits will be paid for the same Organ Transplant expenses as though Network coverage had not ended.

E. Transplant Benefit Period. Covered transplant expenses will accumulate during a Transplant Benefit Period, and will be charged toward the Transplant Benefit Period maximums, if any. The term “Transplant Benefit Period” means the period beginning on the date of the initial evaluation for a transplant and ending on the date twelve consecutive months following the date of the transplant. If the transplant is a bone marrow transplant, the date the marrow is re-infused is considered the date of the transplant.

F. Covered Transplant Expenses. Covered Charges with respect to a human organ or tissue transplant include the Usual and Customary Fees for services and supplies that are covered under this Plan (or that are specifically identified as covered under this transplant Section) that are Medically Necessary and are not Experimental or Investigative.

(i) Covered Charges include:

(a) Charges incurred in the evaluation, screening, and candidacy determination process;

(b) Charges incurred for organ transplantation;

(c) Charges for organ procurement, including donor expenses not covered under any other source;

I Covered Charges for organ procurement from a non-living donor include the costs involved in removing, preserving and transporting the organ.

II Covered Charges for organ procurement from a living donor include the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow-up care.

III If the transplant procedure is a bone marrow transplant, Covered Charges include the cost involved in the removal of the patient’s bone marrow (autologous) or the donor’s marrow (allogeneic). Covered Charges also include search charges to identify an unrelated match, and treatment and storage cost of the bone marrow, up to the time of reinfusion. The harvesting of the bone marrow need not be performed within the Transplant Benefit Period.

(d) Charges incurred for follow-up care, including immuno-suppressant therapy;

(e) Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two other individuals.

(f) All reasonable and necessary lodging and meal expenses incurred during the Transplant Benefit Period will be covered, up to the maximum of \$10,000 per Transplant Benefit Period;

(g) Hospitalizations, supplies and medications which are dispensed while either an inpatient or outpatient in a medical facility;

(ii) Expenses incurred during any Transplant Benefit Period for the recipient and for the donor will accumulate towards the recipient's benefit if the recipient is a Covered Person, even if the donor is also a Covered Person.

(iii) Benefits will not be duplicated if they are available from another plan or organization or Medicare.

G. Re-Transplantation. Eligible charges for re-transplantation will be Covered Charges for up to two re-transplants, for a total of three transplants per person, per lifetime. Each transplant will be subject to the Preauthorization Requirement for organ transplants. Each transplant and re-transplant will have a new Transplant Benefit Period and a new maximum benefit.

H. Extended Benefits in the Event of Loss of Coverage. In the event of termination of the Plan, or of a recipient's loss of eligibility, if a transplant treatment program had commenced while coverage was in force and benefits had not been exhausted, then benefits will be paid for expenses related to the same organ transplant as though coverage had not ended, if the expenses are incurred during the lesser of:

(i) the remainder of the Transplant Benefit Period, or

(ii) one month after termination of the Plan or loss of eligibility.

Section 9.24. Urgent Care Centers.

Services provided in an Urgent Care Center are Covered Charges as described in the Benefit Booklet.

An Urgent Care Center is a facility that accepts walk-in patients of all ages during all hours of operation, treats a broad-spectrum of illnesses and injuries, has the ability to perform minor procedures, and has on-site diagnostic services.

Section 9.25. Wigs. Charges for wigs are Covered Charges as set out in the Benefit Booklet.

Section 9.26. Other Covered Services and Supplies. The following are Covered Charges:

Examinations for the diagnosis or treatment of an Illness or Injury;

Diagnostic x-ray, laboratory, and related radiology and pathology services when rendered for the diagnosis or treatment of an Illness or Injury;

Blood or blood plasma, other than the Covered Person's or that which has been donated specifically for the Covered Person (when administered on an outpatient basis, these benefits are under the Prescription Drug benefits of the Plan);

Initial purchase and fitting of prosthetic devices and supplies, including, but not limited to, artificial limbs or eyes which replace an absent or malfunctioning body part or organ; replacements are Covered Charges if approved by the Case Manager; repairs are Covered Charges when needed to restore proper function;

Casts, splints, trusses, orthopedic braces and crutches;

Non-surgical treatment to sound natural teeth due to an accidental Injury; provided, however, that treatment for Injury caused by chewing food or similar substances is not a Covered Charge under the Medical Benefits of the Plan;

Special supplies when prescribed by the attending Physician such as:

- (i) catheters;
- (ii) colostomy bags, rings and belts; and
- (iii) flotation pads.

Services and supplies which are Cosmetic if they:

- (i) Are required as the result of an Injury, provided the treatment was rendered within two years of the Injury, or
- (ii) are for functional repair or restoration of any body part when necessary to achieve normal body function, or
- (iii) are to correct a congenital deformity or anomaly;

I. Injections of medication related to a covered Illness or Injury;

Hospital, surgical and other necessary medical charges, including rental of kidney dialysis equipment for kidney dialysis treatment;

Charges or taxes legally imposed by a governmental entity, including those calculated based on the amount of Covered Charges paid for a Covered Person under the Plan;

Charges for and related to a mastectomy, including:

- (i) reconstruction of the breast on which the mastectomy has been performed;
- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance when performed in connection with a mastectomy, and

(iii) prostheses and physical complications of all stages of a mastectomy, including lymphedemas;

Charges which are not Covered Charges, but which are recommended by a large claim management company in lieu of Covered Charges;

Charges for covered services performed outside of the United States, provided the Covered Person did not travel there for the primary purpose of obtaining medical services, drugs, supplies or treatment not customarily rendered within the boundaries of the United States;

Charges for medical care provided by a Veteran's Administration Hospital for a non-service related Illness or Injury, and for medical care for a non-service related Illness or Injury that is provided on an inpatient basis by the United States to military retirees who are covered by the Plan.

Section 9.27. TeleHealth Services.

The Plan will provide coverage for on-line and/or telehealth services offered by a medical provider in the same manner as coverage would have been provided for an in-person office visit. For example, such on-line and/or telehealth services include, but are not limited to, patients use of smartphones, iPads, computers and similar devices to carry on live video chat with Providers about any coronavirus symptoms and other medical concerns. Any Copayments, Coinsurance and Deductibles will apply.

Section 9.28. Excluded Medical Charges. The following charges are not Covered Charges under the medical or prescription drug benefits of the Plan. Exclusions under the vision and dental benefits are set out in the separate Addendums for those benefits. No medical or prescription drug benefits will be paid with respect to the following, except as specified:

Charges incurred due to an Illness or Injury which results from riot, revolt, war, declared or undeclared, and/or armed aggression or resistance by the military forces of any country or combination of countries or international organization or any act incident to war;

Charges arising out of, or in the course of, any occupation or employment for wage or profit, or charges for which the Covered Person is entitled to benefits under any worker's compensation, occupational disease or similar law;

Charges or expenses for which the Covered Person (or the Covered Person's parent or guardian in the instance of a minor Child) is not, in the absence of this Plan, legally obligated to pay or for which a charge would not ordinarily be made in the absence of this Plan, or which are paid for, or reimbursable by or through the government of a nation, state, province, county, municipality or other political subdivision, or instrumentality or agency of such government; provided, however that this limitation will not apply where specifically prohibited by law;

Charges for medical care provided by a Veteran's Administration Hospital for a service-related Illness or Injury or a Hospital operated by one of the Uniformed Services, except for prescription drug charges;

Charges made by a person, Hospital, or entity normally making no charge for medical care if the patient has no insurance for medical care, regardless of the patient's financial ability; provided, however that this limitation will not apply where specifically prohibited by law;

Charges made for routine eye care, eyeglasses, contact lenses, routine hearing checks, hearing aids or charges for the fitting of eyeglasses, contact lenses or hearing aids, other than as provided in the Vision and Hearing Benefits section;

Charges made for personal hygiene items, convenience items, and charges for personal comfort items, including but not limited to, television and telephone charges;

Charges for routine examinations, routine immunizations, routine X-ray, routine laboratory services and well-baby care, except as otherwise specified by the Plan;

Charges for dental services, except as otherwise specified by the Plan;

Charges in excess of the "Usual and Customary Fee" as specified in the Plan;

Charges for surgery, devices, procedures, treatments, services, supplies, human organ and tissue transplants, prescription drugs or medications that are not Medically Necessary for the diagnosis or treatment of an Illness or Injury;

Charges for surgery, devices, procedures, treatments, services, supplies, human organ and tissue transplants, prescription drugs or medications that are Experimental or Investigative;

Charges for Custodial Care, convalescent care and rest cures, whether or not recommended or performed by a professional;

Charges for Injuries incurred during the commission or attempted commission by the Covered Person of any criminal act, as defined by the state that:

- (i) involves the use of alcohol or illegal drugs, including but not limited to, driving while under the influence of alcohol or an illegal substance, as defined by the state in which the offense took place; or

- (ii) involves violence or the threat of violence to another person; or

- (iii) involves use by the Covered Person of a firearm, explosive or other weapon likely to cause physical harm or death; unless the Injury results from an act of domestic violence or a medical condition (which includes both a physical condition and/or a Mental Health condition); provided, however that this exclusion shall not apply if the Covered Person is subsequently acquitted of any criminal conduct in connection with the acts involved;

Charges in connection with Cosmetic Surgery or treatment, except as otherwise specified by the Plan;

Charges incurred before the effective date of coverage or after the termination date of coverage, except as otherwise specified by the Plan;

Charges for (i) failure to keep a scheduled visit, (ii) completion of claim forms or return to work or school forms, or (iii) phone consultations except as otherwise provided in Section 9.29;

Charges for services rendered by a family member, including the mother, father, sister, brother, spouse, child or grandparent of:

- (i) the Covered Person,
- (ii) the Covered Person's Spouse,
- (iii) the Covered Person's Child, or
- (iv) the Child's Spouse;

Charges for purchase or rental of exercise equipment, whirlpools, saunas, spas, swimming pools, electric beds, water beds, lift chairs, home elevator, air conditioners, purifiers, filters, commodes, grab bars, shower seating, cervical pillows, massagers or heel lifts;

Charges for smoking cessation deterrents and products, except as otherwise specified by the Plan;

Except as otherwise provided under Sections 9.28 and 9.29 below, additional charges because a service was delivered "after hours" or on a weekend or a holiday;

Expenses incurred for Friday and Saturday Hospital admissions, unless due to an Emergency, and expenses connected with a Saturday or Sunday discharge, unless it was Medically Necessary to extend the confinement beyond Friday;

Any charges for treatment if the Covered Person either checks out of an inpatient facility without authorization of the treating Physician or has not cooperated with recommended treatment; provided, however, the Plan Administrator, in its sole discretion, may make care management services available and will communicate the terms of any such services to Plan Participants periodically;

Charges for autologous donation of blood and its storage;

Charges for treatment of Temporomandibular Joint Dysfunction (TMJ), except as otherwise specified by the Plan;

Charges for a grandchild of the Employee unless the grandchild meets the definition of a Child specified in the Plan;

Charges in excess of any maximum benefit amount specified in the Benefits Booklet;

Charges for services received from a dental or medical department, maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group, except for charges for services received at the Clinic;

Charges for room, board and general nursing care for Hospital admissions which are mainly for physical therapy or for diagnostic studies;

Charges for treatment to induce weight loss or to purchase exercise equipment, except as otherwise specified by the Plan;

Charges for an abortion, except as otherwise specified by the Plan;

Charges for massage therapy;

Charges incurred by a Child for pregnancy or complications of a pregnancy, except as otherwise specified by the Plan;

Charges which are reimbursable through medical coverage provided by or available through any applicable "No-Fault" automobile law or coverage, or any other automobile, homeowners, aircraft, boat owners, or similar policy of insurance;

Charges for vitamins and other non-prescription drugs, except as otherwise specified by the Plan; prescription cosmetic drugs such as Rogaine; and prescription cosmetic drugs such as Retin-A, unless Medically Necessary;

Charges for vocational training, including work-hardening programs;

Charges for orthodontia services or any other care, repair, removal, replacement or treatment of the teeth or surrounding tissues, except as otherwise specified by the Plan;

Charges for removal of corns, calluses, or trimming of toenails or similar procedures;

Charges for biofeedback, hypnosis, acupuncture or use of anorectics (including amphetamines for weight control);

Charges for environmental change;

Radial keratotomy, PRK, or LASIK procedures;

Charges by a provider or facility for Preauthorization or Concurrent Stay Review;

Charges greater than the Usual and Customary Fees for medical records, as determined by the Plan Administrator;

Charges for third party examinations and treatments, such as those requested for employment or the purchase of insurance, except as otherwise specified by the Plan;

Charges for examinations and all related services which are performed solely pursuant to court order, administrative order, state statute or regulation, unless the Injury or Illness results from an act of domestic violence or a physical condition and a Mental Health Condition;

Charges incurred for private duty nursing services, other than those performed under a Home Health Care Plan;

Charges which are not a Covered Charge under the Plan;

Charges for services that are provided by a person not validly licensed to perform the services or not acting within the scope of the person's license;

Charges for premarital tests;

Prosthetic devices and Durable Medical Equipment that are not Medically Necessary; and

Charges for medications related to vacation travel.

Prescription Drugs that are listed on the Major Medical Excluded Formulary (J Code drugs) and are provided either outpatient or as part of Home Health Care are excluded from the medical benefits of the Plan, and are covered only under the Prescription Drug Benefits of the Plan, unless the drugs are administered as part of emergency services or urgent care, or during an outpatient surgical procedure, or as part of an oncology infusion. The PBM shall administer this exclusion and may recommend that a drug that would otherwise be excluded from medical benefits under this subsection be covered under the medical benefits, or that a drug otherwise covered by the medical benefits be covered only under the Prescription Drug Benefits. The Major Medical Excluded Formulary is administered by the Pharmacy Benefit Manager, and it may be viewed at www.TrueScripts.com/Members.

ARTICLE X. PRESCRIPTION DRUG BENEFITS

Section 10.1. Prescription Drug Benefits.

A. Prescription Drugs. Prescription drugs are Covered Charges as specified in this Section of the Manual and in the Benefit Booklet.

SCHEDULE OF BENEFITS PER PERSON

	1-30 Day Supply Coinsurance	31-60 Day Supply Coinsurance	61-90 Day Supply Coinsurance
Clinic Plan Participant Generic Tier Brand Name Tier	20%* up to a \$100 Maximum; after Deductible met	20%* up to a \$200 Maximum; after Deductible met	20%* up to a \$300 Maximum; after Deductible met

	1-30 Day Supply Coinsurance	31-60 Day Supply Coinsurance	61-90 Day Supply Coinsurance
Traditional Plan Participant Generic Tier Brand Name Tier	20% up to a \$100 Maximum; after Deductible met	20% up to a \$200 Maximum; after Deductible met	20% up to a \$300 Maximum; after Deductible met
High Deductible Health Plan Participant Generic Tier Brand Name Tier	Deductible and Coinsurance Amounts Apply	Deductible and Coinsurance Amounts Apply	Deductible and Coinsurance Amounts Apply
Specialty Drug Tiers – Traditional and Clinic Plan Participants	Coinsurance: Tier 1: 20% to a \$100 Maximum Tier 2: 20% to a \$550 Maximum Tier 3: 20%; no Maximum Tier 4: 50%; no Maximum Tier 5 – Not Covered	Not Covered	Not Covered
Specialty Drug Tiers – High Deductible Health Plan Participants	Deductible and Coinsurance Amounts Apply	Not Covered	Not Covered
Prescription Drug Deductible – Traditional and Clinic Plan Participants	\$300 per family per calendar year		
Prescription Drug Deductible – High Deductible Health Plan Participants	Subject to Deductible and Coinsurance as set forth in the Medical Schedule of Benefits		
Prescription & Medical Out-of-Pocket Maximum** - Traditional and Clinic Plan Participants	\$2,000 Single / \$4,000 Family per calendar year		
Prescription & Medical Out-of-Pocket Maximum** - High Deductible Health Plan Participants	Subject to Out-of-Pocket Maximum as set forth in the Medical Schedule of Benefits		

*If a Clinic Plan Participant purchases a Prescription Drug at a Non-Clinic Network Pharmacy, the Coinsurance is **50%** after Deductible, instead of 20%, unless the Clinic Pharmacy is closed, the Covered Person lives outside Monroe County or is on vacation outside of Monroe County, the drug is not available at the Clinic Pharmacy, or the purchase is approved by the *Pharmacy Benefit Manager* (“PBM”).

****The family Prescription & Medical Out-of-Pocket Maximum is embedded. Therefore, when any individual in family coverage hits the Single Out-of-Pocket Maximum, the Covered Charges for that individual are paid at 100%. Rebates, discounts and/or reimbursements of all or a portion of a drug cost that are provided by a drug manufacturer, third-party assistance program or a discount program do not apply toward the Out-of-Pocket Maximum.**

Section 10.2. Clinic Pharmacy.

Covered Persons in the Clinic Plan Option must purchase their Prescription Drugs at the Clinic Pharmacy, or pay a higher Coinsurance unless the Clinic Pharmacy is closed, the Covered Person lives outside Monroe County or is on vacation outside of Monroe County, the drug is not available at the Clinic Pharmacy, or the purchase is approved by the PBM.

Covered Persons in the Traditional Plan Option or the High Deduction Plan Option may purchase their Prescription Drugs at the Clinic Pharmacy or at a Non-Clinic Network Pharmacy.

Covered Person in the High Deductible Health Plan must satisfy the Deductible amount prior to the pricing schedule under Section 10.2D applying.

The price schedule at the Clinic Pharmacy is follows:

1-30 day supply	If Clinic's cost is:	Coinsurance Before Satisfy Deductible (for Traditional Option only):	Coinsurance After Satisfy Deductible:
	\$0 to \$9.99	\$5	\$1
	\$10 to \$14.99	\$10	\$2
	\$15 to \$19.99	\$15	\$3
	\$20 to \$24.99	\$20	\$4
	\$25 to \$29.99	\$25	\$5
	\$30 to \$34.99	\$30	\$6
	\$35 to \$39.99	\$35	\$7
	\$40 to \$44.99	\$40	\$8
	\$45 to \$49.99	\$45	\$9
	\$50 to \$54.99	\$50	\$10
	\$55 to \$59.99	\$55	\$11
	\$60 to \$299.99	\$60	\$12
	\$300 +	20% of cost	20% of cost to max \$100

31-60 day supply	If Clinic's cost is:	Coinsurance Before Satisfy Deductible (for	Coinsurance After Satisfy Deductible:
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		Traditional Option only): :	
	\$0 to \$19.99	\$10	\$2
	\$20 to \$29.99	\$20	\$4
	\$30 to \$39.99	\$30	\$6
	\$40 to \$49.99	\$40	\$8
	\$50 to \$59.99	\$50	\$10
	\$60 - \$69.99	\$60	\$12
	\$70 - \$79.99	\$70	\$14
	\$80 - \$89.99	\$80	\$16
	\$90 - \$99.99	\$90	\$18
	\$100 - \$109.99	\$100	\$20
	\$110 - \$119.99	\$110	\$22
	\$120 - \$599.99	\$120	\$24
	\$600 +	20% of cost	20% of cost to max \$200

61-90 day supply	If Clinic's cost is:	Coinsurance Before Satisfy Deductible(for Traditional Option only): :	Coinsurance After Satisfy Deductible:
	\$0 to \$29.99	\$15	\$3
	\$30 to \$44.99	\$30	\$6
	\$45 to \$59.99	\$45	\$9
	\$60 to \$74.99	\$60	\$12
	\$75 to \$89.99	\$75	\$15
	\$90 to \$104.99	\$90	\$18
	\$105 to \$119.99	\$105	\$21
	\$120 to \$134.99	\$120	\$24
	\$135 to \$149.99	\$135	\$27
	\$150 to \$164.99	\$150	\$30
	\$165 to \$179.99	\$165	\$33
	\$180 to \$899.99	\$180	\$36
	\$900 +	20% of cost	20% of cost to max \$300

Section 10.3. Non-Clinic Network Pharmacy. For Prescription Drugs that are not purchased at the Clinic Pharmacy, the Plan has a network of participating retail pharmacies that have contracted with the PBM to charge Covered Members reduced fees for covered Prescription Drugs. The local retail Non-Clinic Network Pharmacies can be found in the Pharmacy Locator section of the PBM's website or by calling the PBM.

A. Traditional Plan Participants. If a Prescription Drug is purchased by a Traditional Plan Participant from a Non-Clinic Network Pharmacy, the Covered Person must pay the entire cost of the Prescription Drug until they have met their Prescription Drug Deductible. After they

have met their Prescription Drug Deductible, the Covered Person must pay the Coinsurance amount, as set out in the Schedule of Benefits. However, if the Covered Person's ID card is not used, the Covered Person must pay the entire cost of the Prescription Drug, and then submit the receipt to the PBM for direct reimbursement of all except the Deductible and Coinsurance amount.

B. High Deductible Health Plan Participants. If a Prescription Drug is purchased by a High Deductible Health Plan Participant from a Non-Clinic Network Pharmacy, the Covered Person must pay the entire cost of the Prescription Drug until they have met their Deductible. After they have met their Deductible, the Covered Person must pay the Coinsurance amount, as set out in the Schedule of Benefits. However, if the Covered Person's ID card is not used, the Covered Person must pay the entire cost of the Prescription Drug, and then submit the receipt to the PBM for direct reimbursement of all except the Deductible and Coinsurance amount.

C. Clinic Plan Participants. If a Prescription Drug is purchased by a Clinic Plan Participant from a Non-Clinic Network Pharmacy, the Covered Person must pay the entire cost of the Prescription Drug until they have met their Prescription Drug Deductible. After they have met their Prescription Drug Deductible, the Covered Person must pay 50% of the cost of the Prescription Drug; provided, however, that if the Clinic Pharmacy was closed, the Covered Person lives outside Monroe County or was on vacation outside of Monroe County, the drug was not available at the Clinic Pharmacy, or the purchase is approved by the PBM, the Covered Person may submit a claim form to the PBM for direct reimbursement in order to reduce their Coinsurance to 20%.

D. Direct Reimbursement. In order to file for direct reimbursement as set out above, the Covered Person must complete a Prescription Drug claim form available from the Cook Insurance Department or at the website of the PBM. Attach the receipt to the claim form and submit it to the PBM at the PBM's address, attention: Claims Department.

Section 10.4. Out-of-Network Pharmacy. If a Prescription Drug is purchased from an Out-of-Network Pharmacy, it is not a Covered Charge.

Section 10.5. Covered Charges.

Prescription Drugs are Covered Charges under the Prescription Drug benefits only if they are out-patient prescriptions that are supplied by the Clinic Pharmacy or by a Non-Clinic Network Pharmacy. For Excluded Charges, Covered Persons are responsible for paying 100% of the cost, and that cost will not apply toward the Prescription Drug Deductible or the Out-of-Pocket Maximum. Amounts in excess of the Plan's Specialty Drug per prescription maximum are Excluded Charges. The PBM will assist members seeking reimbursement from third party resources, but it does not guarantee any result.

Reimbursement by the Plan is determined per prescription. Amounts above the per prescription limit are not Covered Charges under the Plan.

The following Prescription Drugs are Covered Charges if they are prescribed and filled while the individual is a Covered Person, as outlined in the Schedule of Benefits, as set out in the Plan Manual and Benefit Booklet:

(i) Those necessary for the care and treatment of an Illness or Injury, that are prescribed by a duly licensed medical professional, that can be obtained only by prescription, and that are dispensed in a container labeled “Rx only (“Prescription Drugs”);

(ii) Diabetic supplies that are specifically stated as covered under the Prescription Drug Benefits in the Schedule of Benefits in the Plan Manual or the Booklet;

(iii) The following non-prescription products if prescribed by a duly-licensed medical professional, in an amount not to exceed the days’ supply outlined in the Plan Manual and Benefit Booklet:

(a) Compound medications of which at least one ingredient is a Prescription Drug;

(b) Medications or vitamins as required by The Affordable Care Act (e.g., for preventive care);

(c) Covered over-the-counter drugs that are dispensed with a written prescription by a duly-licensed medical professional; and

(iv) Specialty Drug fees and expenses.

D. Supply Limits. Some prescription drugs are subject to supply limits that restrict the amount dispensed per prescription order or refill. The Covered Charge for any one Prescription Drug will be limited to:

(i) A 90-day supply for retail Prescription Drugs that are not Specialty Drugs;

(ii) Refills only up to the number of times specified by a prescriber;

(iii) Refills up to one year from the date of order by a prescriber; and

(iv) Refills only within a category frequency of time.

Additionally, a maximum unit of measure quantity limit per person per Plan Year may apply to Specialty Drugs. Whether or not a Prescription Drug has a supply limit or maximum unit of measure quantity limit per person per Plan Year or is subject to a specific frequency limit, is subject to the PBM’s periodic review and modification.

E. Limitation on Pharmacy. If the PBM determines that a Covered Person is using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, the Covered Person’s selection of the Clinic or Non-Clinic Network Pharmacies may be limited. If this happens, the Covered Person may be required to use the Clinic Pharmacy or to select a single Non-Clinic Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Covered Person uses the designated single pharmacy.

F. Major Medical Excluded Formulary. Prescription Drugs that are listed on the Major Medical Excluded Formulary that are provided either outpatient or as part of Home Health Care are covered only under this Prescription Drug Benefit, and not under the medical benefits, unless they are administered as part of emergency services or urgent care, or during an outpatient surgical procedure, or as part of an oncology infusion. The PBM shall administer this provision and may recommend that a drug that would otherwise be excluded from medical benefits be covered under the medical benefits, or that a drug otherwise covered by the medical benefits be covered only under the Prescription Drug Benefits. The Major Medical Excluded Formulary is administered by the Pharmacy Benefit Manager, and it may be viewed at www.TrueScripts.com/Members.

Section 10.6. Preventive Care Schedule of Benefits. The Plan also covers Prescription Drugs that are used for Preventive Care, as follows:

A. Contraceptive Preventive Care. The Plan's Prescription Drug benefits cover all FDA-approved prescribed contraceptive methods for women with reproductive capacity, including Children, without cost sharing. Coverage without cost sharing means women can receive the prescriptions or devices without having to pay a Deductible or Coinsurance. The drug or device must be prescribed, must be generic (or brand name if no generic equivalent is available), and must be obtained from the Clinic Pharmacy or a Non-Clinic Network Pharmacy. The Plan also covers brand name drugs and devices with no cost sharing where a generic is available if the brand name drug or device is Preauthorized by the PBM.

B. Additional Preventive Care. Additional Preventive Care Prescription Drugs that are Covered Charges under the Affordable Care Act, without Deductible or Coinsurance, include the following if they are:

- (i) Prescribed;
- (ii) Generic, or brand-name if there is no generic equivalent; and
- (iii) Obtained from the Clinic Pharmacy or a Non-Clinic Network Pharmacy.

ASPIRIN		
Aspirin to prevent cardiovascular disease and colorectal cancer	Age limit ≥ 45 (men and women) Quantity Limit: 1/day	Aspirin products up to 325mg
BOWEL PREPARATION MEDICATIONS – No restrictions		
DIABETES PREVENTION MEDICATION		
Preventing or delaying diabetes for adults who have overweight or obesity.	Age limit 40 to 70	Generic diabetes prevention product (Rx): Metformin 850 mg
FLUORIDE		
Chemoprevention of dental cavities	Age limit ≤ 5 years	Sodium fluoride products only, not in combination

		• Sodium fluoride tab 0.5mg • Sodium fluoride chew tab 0.25mg – 0.5mg • Sodium fluoride solution
FOLIC ACID SUPPLEMENTS		
Supplementation with folic acid	Women Age limit ≤ 55 years of age Quantity limit: 1/day	Folic acid products only, not in combination • Folic Acid tab 0.4mg and 0.8mg
IRON SUPPLEMENT		
Iron supplementation in children	Age limit 0-1 year	• Iron Suspension • Ferrous sulfate elixir, syrup and solution
VITAMIN D		
Vitamin D for fall prevention	Age limit ≥ 65 years of age	Vitamin D
HIV PREVENTION DRUGS		
Recommended for persons who are at high risk of HIV acquisition. Coverage is restricted to medications denoted as ACA Eligible on the formulary. Coverage does not include treatment of HIV.		
TOBACCO CESSATION PRODUCTS		
Up to an 84-day supply of prescribed tobacco cessation drugs within 365 calendar days. The prescriber must prescribe all smoking cessation products for use within a 12-week treatment time frame.		
IMMUNIZATIONS		
Any CDC-recommended routine prescribed immunization administered at a Non-Clinic Network Pharmacy is covered at 100%. (Note: CDC-recommended routine immunizations not administered at a pharmacy (e.g., in a physician's office) are covered at 100% under the Medical Benefits of the Plan.)		
BREAST CANCER		
Prescribed chemoprevention medications for women at increased risk of breast cancer.		
ANTIRETROVIRAL THERAPY		
For preexposure prevention of human immunodeficiency virus (HIV) infection in people who are at an increased risk.		
STATINS (GENERIC) - Age limit 40-75 years		

Section 10.7. Reimbursement Levels. The Plan pays benefits at different levels for Prescription Drugs based upon Prescription Drug tiers. All Prescription Drugs covered by the Plan are categorized into these tiers. The tier status of a Prescription Drug can change periodically, as frequently as monthly, based on the PBM's periodic tier decisions.

A. Tiers. Each tier is assigned a reimbursement level which is the amount the Plan pays. Covered Persons pay the Prescription Drug Deductible and Coinsurance when a Prescription Drug is picked up at the Pharmacy. The Generic Tier is generally the lowest out-of-pocket expense. The Brand Name Tier is generally a higher out-of-pocket expense. Specialty Drugs are also assigned to tiers. See Specialty Drugs Section below.

B. Cost-Sharing. Covered Persons are responsible for the Prescription Drug Deductible, for amounts that are excluded by the Plan, and for the lower of:

- (i) The applicable Coinsurance;
- (ii) The Non-Clinic Network Pharmacy's Usual and Customary Fee for the Prescription Drug; and
- (iii) The Prescription Drug charge that the PBM agrees to pay a Non-Clinic Network Pharmacy.

C. "Dispensed As Written" Rule. The Plan requires that the Clinic Pharmacy and Non-Clinic Network Pharmacies dispense generic drugs and devices when available unless the prescriber specifically prescribes a brand name drug or device and marks the prescription "dispense as written."

- (i) "Dispense as written" prescriptions require Preauthorization by the PBM.
- (ii) Should a Covered Person choose a brand name drug or device, rather than the generic equivalent when the prescriber allows a generic drug or device to be dispensed, the Covered Person will be responsible for the applicable brand name drug or device Coinsurance, plus the cost difference between the brand name and generic drug or device.
- (iii) Only the applicable generic drug or device Coinsurance amount that the Covered Person would have paid will apply toward the Covered Person's Prescription Drug Deductible and Out-of-Pocket Maximum.

D. Step Therapy Program. The Plan includes a Step Therapy Program which promotes the utilization of certain preferred drugs in specific drug categories such as cholesterol lowering statins and proton pump inhibitors (gastro-intestinal agents). Certain drugs have been identified which will not be Covered Charges if the Step Therapy Program has not been followed and Preauthorization obtained. The program requires documentation from a prescriber that the Covered Person has tried a minimum number of alternative drug treatments that did not successfully treat the condition. If a medication the Covered Person is taking is identified as a Step Therapy drug, the Covered Person is not required to change medications, but the Prescription Drug will not be a Covered Charge unless approved by the PBM.

E. Deductible and Out-of-Pocket Maximum. The following amounts do not count toward the Plan's Prescription Drug Deductible or the annual Out-of-Pocket Maximum:

- (i) Charges that are excluded under the Plan's Prescription Drug Program;

- (ii) Charges in excess of the Usual and Customary Fees;
- (iii) Charges in excess of any maximum benefit in the Plan's Prescription Drug Program;
- (iv) Penalties;
- (v) Charges reimbursed or covered through assistance programs or discount programs; and
- (vi) Charges for Brand Name drugs above the applicable generic Coinsurance the Covered Person would have paid as outlined in the "Dispensed As Written" section.

Section 10.8. Specialty Drugs.

Specialty Drugs are drugs that are used to treat serious and chronic health conditions. Preauthorization is required for all Specialty Drugs, even those dispensed at the Clinic Pharmacy. Preauthorization is also required for some Compound Prescription Drugs. Additionally, a maximum unit of measure quantity limit per person per Plan Year may apply to some Specialty Drugs. If a Covered Person requires certain Specialty Drugs, the PBM may direct the Covered Person to a designated pharmacy with which it has an arrangement to provide those Specialty Drugs.

The first time a Specialty Drug is dispensed, the Drug will be limited to a 14-day supply, unless the Drug is prepackaged for a larger quantity. Additionally, a maximum unit of measure quantity limit per person per Plan Year applies to Specialty Drugs. Covered prescription injectable(s) and certain other Specialty Drugs such as chemotherapies may only be available through the designated Specialty Drug pharmacy. Specialty Drugs are categorized into Coinsurance Tiers 1-5 as set out in the Schedule of Benefits as determined by the PBM.

For Specialty Drug maximum unit of measure quantity limits per person per Plan Year and Specialty Drugs available only through the designated specialty pharmacy, contact the PBM.

The tier status of a Specialty Drug can change periodically, as frequently as monthly, based on the PBM's periodic tier decisions. The PBM has the most current information.

Section 10.9. Preauthorization.

The PBM has been retained by the Plan Administrator to provide Preauthorization services for the Prescription Drug program, as set out in this Article. The Plan has approved a predetermined set of criteria for Preauthorization. In order for a Prescription Drug which is subject to Preauthorization to be a Covered Charge, the pharmacist, Covered Person, or prescriber must call the PBM to obtain Preauthorization before the Prescription Drug is purchased. The PBM will fax the prescriber the necessary forms to obtain the information necessary to determine whether or not the Prescription Drug will be a Covered Charge. Within 72 hours after receiving the information from the prescriber, the PBM will notify the pharmacy, Covered Person and/or prescriber who submitted the request for Preauthorization that the drug is

or is not a Covered Charge. The request for Preauthorization is considered to be a Pre-Service claim under Article XIII, Claims Procedures.

Section 10.10. Exclusions.

A. Excluded Charges. In addition to other exclusions in the Plan Manual and Benefit Booklet, the following charges are not Covered Charges under the Prescription Drug benefits of the Plan, and they do not apply towards the Prescription Drug Deductible or the Out-of-Pocket Maximum:

- (i) Charges for over-the-counter medications that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan has designated the over-the-counter medication as a Covered Charge if it is obtained with a prescription order or refill from a prescriber;
- (ii) Charges for compound drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and that requires a prescription order or refill;
- (iii) Charges for compound drugs that are a commercially available Prescription Drug;
- (iv) Charges for drugs that are dispensed outside of the United States, except for an Emergency Medical Condition;
- (v) Charges for Durable Medical Equipment (prescribed and non-prescribed outpatient supplies) are covered under the Medical Benefits, not the Prescription Drug Benefits of the Plan, other than diabetic supplies that are specifically stated as covered under the Prescription Drug Benefits in the Schedule of Benefits in the Plan Manual or the Booklet;
- (vi) Charges for the amount dispensed (days' supply, quantity limit, or frequency limit) that exceeds the maximum supply limit, per prescription limit, or frequency limit;
- (vii) Charges for the amount dispensed (days' supply or quantity limit) that is less than the minimum supply limit;
- (viii) Charges for certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PBM;
- (ix) Charges for items that are prescribed, dispensed or intended for use during an inpatient stay;
- (x) Charges for Prescription Drugs, including new Prescription Drugs or new dosage forms, that do not meet the definition of a Covered Charge;

(xi) Charges for drugs that are used for conditions and/or at dosages determined to be Experimental and Investigative, unless the PBM and the Plan have agreed to cover an Experimental and Investigative treatment;

(xii) Medications related to vacation travel;

(xiii) Amounts in excess of the Plan's Specialty Drug per prescription maximum;

(xiv) Prescription Drugs listed on the Major Medical Excluded Pharmacy as provided in Section 10.5(F);

(xv) Drugs for which Preauthorization is required if Preauthorization is not obtained; and

(xvi) Rebates, discounts and/or reimbursement of all or a portion of the drug cost provided by a drug manufacturer, third-party assistance program or discount program.

Section 10.11. Miscellaneous Provisions.

A. Emergency Supply. For covered medications and in instances in which Preauthorization cannot be immediately obtained, Covered Persons may receive and be reimbursed for up to a 72-hour supply of a covered Prescription Drug as an "emergency supply." The emergency supply must be obtained in accordance with the Plan's Prescription Drug Benefits, and it must be obtained as an outpatient.

B. Prescription Drugs Lost. Covered Persons will be given the opportunity to prove to the PBM that drugs that were Covered Charges under this Article were lost. Acceptable proof could include, but is not limited to, proof of filed claims of loss for a natural disaster (e.g., homeowner's property insurance, etc.). If replacement is approved, the replacement drugs will be Covered Charges even if they exceed a limit.

ARTICLE XI. VISION AND HEARING BENEFITS

Section 11.1. General. Covered Charges include routine eye exams, prescription eyeglasses, prescription contact lenses and hearing aid products, services and supplies, as described in the Benefit Booklet and in Addendum C.

Section 11.2. Networks. As set out in the Benefit Booklet the Plan pays higher benefits when a Network Provider is used, and pays fewer benefits, or in some cases no benefits, when an Out-of-Network Provider is used. The Networks that apply to the Vision and Hearing Benefits are described in the Benefit Booklet and in Addendum C.

ARTICLE XII. DENTAL BENEFITS

Section 12.1. General Provisions. The dental benefits, coordination of benefits, claims processing and appeal procedures, termination of coverage, continuation of coverage and general conditions for dental benefits are described in the Benefit Booklet and in Addendum B.

Section 12.2. Covered Charges. Covered Charges are set out in the Benefit Booklet and in Addendum B.

Section 12.3. Orthodontia Services. Orthodontia services are covered as set out in the Benefit Booklet and in Addendum B.

Section 12.4. Dental Exclusions. Exclusions and limitations on dental benefits are set out in the Benefit Booklet and in Addendum B.

ARTICLE XIII. CLAIMS PROCEDURES

Section 13.1. Procedures for Filing Claims and Preauthorization of Claims.

This Article and these Claims procedures apply to all Claims, except vision and dental Claims. See Addendum B for the procedures that apply to dental Claims and Addendum C for the procedures that apply to vision Claims.

A. Submitting a Claim.

(i) Network Providers should submit Claims directly to the address listed on Cook Health Plan ID card, or the Covered Person (“Claimant”) may submit an itemized Claim for Out-of-Network services (not a canceled check or receipt) to:

Cook Group Health Plan
P.O. Box 1029
Bloomington, IN 47402-1029
CookInsuranceGroup@cookmedical.com

(ii) The itemized Claim should show:

- (a) Employee’s name, address and Cook Group Health Plan ID number;
- (b) Covered Person’s name and relationship to Employee;
- (c) Employer’s name;
- (d) Name and address of the provider;
- (e) Diagnosis;

(f) Itemization of charges; and

(g) Date Claim was Incurred.

(iii) A Claim is a request that benefits of this Plan be paid. A Claim is “Incurred” on the date the services or supplies are provided.

(iv) If benefits are subject to coordination with another health plan, a copy of the other plan’s Explanation of Benefits (EOB) must also be sent to the Cook Group Health Plan along with the Claim.

(v) Non-alienation of Benefits.

(a) Benefits will be paid directly to the provider unless the Claimant submits proof of payment. Then benefits will be paid to the Claimant.

(b) Except as otherwise provided in the Plan or under applicable law, no benefit, right, or interest of any Covered Person under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities, or other obligations of the Covered Person. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute, or levy upon, or otherwise dispose of any rights, benefits, or causes of action under the Plan shall be void and unenforceable. This prohibition applies to all rights and interests under the Plan, including rights to benefits, rights to documents, claims for fiduciary breach, claims for statutory penalties, and any other rights that may be asserted by a Covered Person under the Plan. Nothing in this provision prevents a Claims Administrator, in its sole discretion, from paying (either directly or on behalf of the Plan) medical benefits directly to a health care provider that provides services to a Covered Person, but a Covered Person has no authority or right to obligate the Claims Administrator to make direct payment to a medical provider and any attempt to obligate a Claims Administrator to make direct payment to a health care provider is void and unenforceable.

B. Time Limits on Submitting Claims.

(i) A Claim should be submitted to the Cook Group Health Plan within 90 days after it is Incurred.

(ii) No Claim will be eligible for payment if it is submitted more than 365 days after the Claim was Incurred.

(iii) Charges for Home Medical Equipment in excess of \$200 are Incurred monthly based on the estimated time of use, up to a maximum of 12 months.

C. Urgent Care Claims.

(i) An Urgent Care Claim is a request for the Preauthorization of medical care or treatment where using the standard time frames for the Preauthorization process could seriously jeopardize the Claimant's life or health or ability to regain maximum function, or would, in the opinion of a Physician with knowledge of the Claimant's medical condition, subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

(ii) Urgent Care Claims are always Pre-Service Claims or Concurrent Care Claims to extend a previously approved course of treatment that must be Preauthorized by the Plan. Post-Service Claims are never Urgent Care Claims because the service has already been provided. Whether a Claim is an Urgent Care Claim is decided at the time the Preauthorization request is being processed. If requested services are provided before the Claim for Preauthorization is processed, or while it is being processed, the Claim is no longer considered an Urgent Care Claim.

(iii) Urgent Care Claims should be submitted to the Case Manager. If the Claimant submits an Urgent Care Claim that identifies the Claimant, the medical condition and the service involved to someone who is customarily responsible for handling benefit matters, but who is the wrong person to receive an Urgent Care Claim request, the Plan will advise the Claimant of the proper procedures as soon as possible, but no later than two hours after receiving the Claim.

(iv) The Plan Administrator (or its designee) will notify the Claimant of its decision on an Urgent Care Claim as soon as possible (whether adverse or not), taking into account the medical exigencies, but no later than 72 hours after the Plan's receipt of the Claim, unless the Claim is incomplete.

(v) If a request for Preauthorization is made to extend the course of treatment for Urgent Care beyond the time period or number of treatments originally approved, then the Plan Administrator (or its designee) will respond to the Claim as soon as possible, but no later than 24 hours after the Claim for Preauthorization is received, if the Claim is filed at least 24 hours before expiration of the originally approved course of treatment.

(vi) If an Urgent Care Claim is incomplete, the Plan Administrator (or its designee) will notify the Claimant of the information necessary to complete the Claim as soon as possible, but no later than 24 hours after the Plan receives the Claim. The Claimant has a reasonable period of time (but not less than 48 hours) to provide the additional information. As soon as possible, but no more than 48 hours after the Plan receives the additional information, or after the Claimant's deadline for providing the additional information, if earlier, the Plan Administrator (or its designee) will notify the Claimant of its decision on the Claim. The Plan's decision may be provided orally, with a written or electronic notification furnished within three days.

(vii) If the Plan Administrator (or its designee) partially or completely denies the Claim for Urgent Care, the Claimant may orally or in writing request an expedited appeal of the decision, and the Plan Administrator (or its designee) will notify the

Claimant of its decision on the appeal by telephone, facsimile or electronically as soon as possible, but not later than 72 hours after the appeal is filed.

(viii) Appeals of Urgent Care claims should be sent to:

Cook Group Health Plan Administrator
Cook Group Incorporated
P.O. Box 1608
Bloomington, IN 47402-1608
812-331-1025

D. Concurrent Care Claims. If the Plan has approved an ongoing course of treatment that will be provided over a period of time or will include a certain number of treatments, and the Plan Administrator (or its designee) decides to reduce or terminate the period of time or number of treatments, it will give notice to the Claimant sufficiently in advance to allow the Claimant to appeal the decision before the benefits are reduced or terminated.

E. Pre-Service Claims.

(i) A Pre-Service Claim is a request for a determination whether medical services are Medically Necessary in advance of the services where the Claim or benefit level will be denied if Preauthorization is not obtained.

(ii) For a Pre-Service Claim, the Plan Administrator (or its designee) will notify the Claimant of its decision (whether adverse or not) within a reasonable time period, but no later than 15 days after the Plan receives the Claim.

(iii) This 15-day period may be extended for another 15 days if the Plan Administrator (or its designee) determines that the extension is necessary due to matters beyond its control and it notifies the Claimant during the initial 15-day period of the extension, the reason for the extension and the date by which the Plan expects to make a decision. If the extension is necessary because the Claimant failed to submit necessary information, the Plan Administrator (or its designee) will also describe the additional information needed. The Claimant will have at least 45 days from receipt of this notice to provide the requested information.

(iv) If the Claimant submits a Pre-Service Claim that identifies the Claimant, the medical condition and the service involved to someone who is customarily responsible for handling benefit matters, but is the wrong person to receive a Pre-Service Claim, the Plan Administrator (or its designee) will advise the Claimant of the proper procedures as soon as possible, but no later than five days after receiving the Claim.

(v) If the Plan Administrator (or its designee) partially or completely denies a Pre-Service Claim, the Claimant may appeal the decision within 180 days of receiving the adverse decision, and the Plan Administrator (or its designee) will notify the Claimant of its decision on the appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the appeal is filed.

- (vi) Appeals of Pre-Service Claims should be sent to:

Cook Group Health Plan Administrator
Cook Group Incorporated
P.O. Box 1608
Bloomington, IN 47402-1608
812-331-1025.

F. Post-Service Claims.

(i) A Post-Service Claim is any Claim that is not an Urgent Care Claim, Concurrent Care Claim or Pre-Service Claim. The Claimant is requesting reimbursement for or payment of care that has already been received.

(ii) The Plan Administrator (or its designee) will notify a Claimant of its decision on a Post-Service Claim within a reasonable time period, but no later than 30 days after the Claim is received.

(iii) This 30-day period may be extended for another 15 days if the Plan Administrator (or its designee) determines that the extension is necessary due to matters beyond its control, and the Plan Administrator (or its designee) notifies the Claimant during the initial 30-day period of the extension, the reason for the extension and the date by which the Plan expects to make a decision. If the extension is necessary because the Claim is incomplete, the Plan Administrator (or its designee) will also describe the additional information necessary to complete the Claim. The Claimant will have at least 45 days from receipt of this notice to provide the requested information.

(iv) If the Plan Administrator (or its designee) partially or completely denies a Post-Service Claim, the Claimant may appeal the decision within 180 days of receiving the adverse decision, and the Plan Administrator (or its designee) will notify the Claimant of its decision on the appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 60 days after the appeal is filed.

- (v) Appeals of Post-Service Claims should be sent to:

Cook Group Health Plan Administrator
Cook Group Incorporated
P.O. Box 1608
Bloomington, IN 47402-1608
812-331-1025.

Section 13.2. Internal Appeals Procedures.

A. Full and Fair Review On Internal Appeal. During a Claim Appeal, the Plan Administrator (or its designee):

(i) will allow the Claimant to review the Claim file, to submit written information, and to present evidence and testimony as part of the Appeal process;

(ii) will provide to a Claimant (without charge and without request) any new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim Appeal as soon as possible, and sufficiently in advance of the decision date to give the Claimant a reasonable opportunity to respond to the new information prior to the decision;

(iii) will provide the Claimant (upon request, but without charge), reasonable access to, and copies of, all documents, records and other information “relevant” to the claim;

(iv) will take into account all comments, documents, records and other information submitted by the Claimant, including new information that was not submitted or considered in the initial Claim decision;

(v) will identify any medical or vocational experts whose advice was obtained by the Plan in connection with the Claim, whether or not the advice was relied upon;

(vi) if an adverse benefit determination on Appeal will be based on a new or additional rationale, will provide the rationale (free of charge) as soon as possible and sufficiently in advance of the date on which the notice of internal adverse benefit determination is required to be provided, to give the Claimant a reasonable opportunity to respond to the new rationale;

(vii) will not give deference to the initial Claim decision;

(viii) will have the Appeal reviewed by a named fiduciary of the Plan who is not the individual who made the initial decision, nor subordinate to that individual;

(ix) will consult with health care professionals not consulted with for the initial decision, and not subordinate to those people;

(x) if a Claim involves a medical judgment (e.g., if the Plan determines that a treatment or drug or other item is Experimental or Investigative, or not Medically Necessary), will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

B. Definition of Relevant. Information is “relevant” to a claim for purposes of § 13.2(A)(iii) if:

(i) it was relied on to decide the Claim;

(ii) it was submitted, considered or generated while deciding the Claim, whether or not it was relied upon;

(iii) it demonstrates compliance with the administrative processes used to verify that Claim decisions are made in accordance with the Plan documents and that Plan provisions have been applied consistently to similarly situated individuals; or

(iv) it is a statement of policy or guidance regarding the treatment denied for the Claimant's diagnosis, whether or not it was relied on.

C. Rescission of Coverage. If the Plan Administrator (or its designee) rescinds a Claimant's health plan coverage retroactively, the Claimant may appeal that decision under these Appeal procedures and the external review procedures below, even if the rescission does not have a negative adverse effect on any particular benefit at the time of the rescission.

Section 13.3. General Rules Applicable to Internal Claims and Internal Appeals.

A. Sole Discretion. The Plan Administrator (or its designee) will have the sole discretion to make the determination of all internal Claims and Appeals. Benefits will be paid only if the Plan Administrator (or its designee) decides in its full and absolute discretion that the Claimant is entitled to benefits. The decision of the Plan Administrator (or its designee) shall be final and conclusive, and may include, without limitation, a determination of eligibility or whether the services, treatment or supplies are Covered Charges.

B. Calculation of Time Periods. The time period for making an initial or Appeal Claim decision shall begin on the date a Claim or Appeal is filed in accordance with the Plan's claims procedures, whether or not all the information necessary to make a decision has been filed. If a decision time period is extended because the Claimant must submit more information, the decision time period is tolled from the date the Claimant is notified that more information is needed until the Claimant provides the additional information; provided, however, that if the Claimant does not provide any additional information within 45 days from receipt of the notice that additional information is necessary, the Plan Administrator may make an initial or Appeal Claim decision.

C. Conflicts of Interest. Decisions regarding the hiring, compensation, termination, promotion, or other similar matters regarding persons who are involved in making Claims and Appeals decisions (e.g., claims adjudicators and medical experts) will not be based upon the likelihood that the individual will support the denial of benefits.

D. Claim Denial. If the Plan Administrator (or its designee) denies a Claimant's initial Claim for benefits or Appeal, the written or electronic denial will include in a culturally and linguistically appropriate manner:

(i) The date of service, the health care provider, the Claim amount (if applicable) and the specific reasons for the adverse decision or denial;

(ii) Reference to the specific Plan provision on which the decision is based;

(iii) A description of any information necessary to complete the Claim, and an explanation of why the information is needed;

(iv) Any specific internal rule, guideline, protocol, standard or criterion relied on in making the decision, or a statement that a criterion was relied on and will be provided free of charge upon request;

(v) For any decision based on the requirement that services be Medically Necessary or the exclusion of Experimental or Investigative services, an explanation of the scientific or clinical judgment for the decision, applying the Plan terms to the Claimant's medical circumstances, or a statement that the explanation will be provided free of charge upon request;

(vi) For an initial denial of a Claim, a description of the Plan's internal review procedures and external review processes, including information regarding how to initiate an Appeal, the time limits for an Appeal, and a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA only following exhaustion or deemed exhaustion of the internal Claim and Appeal procedures;

(vii) For a denial on Appeal, a discussion of the decision, a statement of the Claimant's right to external review and to bring an action under Section 502(a) of ERISA only following exhaustion or deemed exhaustion of the internal Claim and Appeal procedures;

E. Notices to Claimants. The notice of adverse benefit decision on the internal Claim and Appeal will include, upon request:

(i) the diagnosis code and its meaning, and the treatment code and its meaning;

(ii) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

F. Deemed Exhaustion of Internal Claims and Appeals Processes.

(i) If the Plan Administrator (or its designee) fails to adhere to the regulatory requirements for claims processing:

(a) the Claimant is deemed to have exhausted the internal Claims and Appeals processes of the Plan, unless the Plan Administrator's failure is de minimis and it does not cause and is not likely to cause prejudice or harm to the Claimant, so long as the Plan Administrator (or its designee) demonstrates that the failure was for good cause or due to matters beyond the control of the Plan, and the failure occurred in the context of an ongoing, good faith exchange of information between the Plan Administrator (or its designee) and the Claimant, and the failure was not part of a pattern or practice of violations by the Plan Administrator (or its designee);

(b) the Claimant is entitled to pursue any available remedies under ERISA, including, where applicable an external review; and

(c) the Claim or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(ii) The Claimant may request from the Plan Administrator (or its designee) a written explanation of the violation of the regulatory requirements for claims processing, and the Plan Administrator (or its designee) will provide it within ten days, including the Plan Administrator's (or its designee's) basis for asserting that the violation should not cause the internal Claims and Appeals process to be deemed exhausted.

(iii) If an external reviewer or court rejects the Claimant's request for immediate review because the Plan Administrator's (or its designee's) failure was de minimis, the Claimant may resubmit the Claim and pursue the internal Appeal of the Claim. Within ten days of the decision of the external reviewer or court to reject the Claim for immediate review, the Plan will notify the Claimant of the Claimant's right to resubmit the Claim for internal Appeal. The time period for re-filing the Claim begins to run upon Claimant's receipt of the notice.

Section 13.4. External Review Procedures.

A. Request for External Review. A Claimant may file a request for External Review with the Plan if the request is filed within four (4) months after receipt of a notice of an adverse benefit determination on the Claimant's internal Appeal, if the adverse benefit determination involves a rescission of coverage or a medical judgment, including, but not limited to, Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or a determination that a treatment is Experimental or Investigative.

(i) If there is no corresponding date four months after the date the denial is received, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(ii) A denial, reduction, termination or failure to pay a benefit based on a determination that a participant does not meet the eligibility requirements of the Plan is not eligible for External Review.

(iii) The Covered Person's request will be eligible for an External Review if the claim decision involves an unfavorable or adverse determination involving non-network emergency services, non-network air ambulance, or services provided by a non-network practitioner at a network facility.

B. Preliminary Review of Request for External Review. Within five business days following receipt of the External Review request, the Plan Administrator (or its designee) must complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or provided;

(ii) The Claim denial is eligible for External Review;

(iii) The Claimant has exhausted the Plan's internal Claims and Appeal process (or, the Claimant is deemed to have exhausted the internal Claims and Appeal process); and

(iv) The Claimant has provided all the information and forms required to process an External Review.

C. Notification of Preliminary Review Findings. Within one business day after completing the preliminary review, the Plan Administrator (or its designee) must notify the Claimant of its findings in writing. 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 Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification must describe the information or materials needed to make the request complete, and the Plan must allow the Claimant to perfect the request for External Review within the four-month filing period or within the 48-hour period following the Claimant's receipt of the notification, whichever is later.

D. Referral to Independent Review Organization. The Plan Administrator (or its designee) will assign an independent review organization ("IRO") that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. The Plan Administrator, or its designee, will rotate claims assignments among its IRO's (or incorporate other independent, unbiased methods for selection of IRO's, such as random selection). The IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

E. Independent Review Organization Procedures.

(i) The assigned IRO will timely notify the Claimant in writing that the Claimant's request is eligible for External Review and that it has been accepted for External Review. This notice will include a statement that the Claimant may submit additional information in writing to the assigned IRO within ten business days following receipt of the notice, and that the IRO will consider the information when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(ii) Within five business days after the IRO is assigned to the Claim, the Plan Administrator (or its designee) will provide to the assigned IRO the documents and information considered in making the benefit determination. If the Plan Administrator (or its designee) fails to timely provide the documents and information, the assigned IRO may terminate the External Review and reverse the adverse benefit determination. Within one business day after making this decision, the IRO will notify the Claimant and the Plan Administrator (or its designee).

(iii) If the IRO receives any information from the Claimant, the IRO must within one business day forward the information to the Plan Administrator (or its designee). Upon receipt of the information, the Plan Administrator (or its designee) may

reconsider its adverse benefit determination that is the subject of the External Review. The External Review will be terminated as a result of the Plan's reconsideration only if the Plan decides to reverse its adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan Administrator (or its designee) must provide written notice of its decision to the Claimant and the assigned IRO. The assigned IRO will terminate the External Review upon receipt of the notice from the Plan Administrator (or its designee).

(iv) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the Claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal Claim or Appeal process.

(v) In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- (a) The Claimant's medical records;
- (b) The attending health care professional's recommendation;
- (c) Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating provider;
- (d) The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- (e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, or national or professional medical societies, boards, and associations;
- (f) Any applicable clinical review criteria developed and used by the Plan Administrator (or its designee), unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- (g) The opinion of the IRO's clinical reviewer or reviewers after considering the information and documents available, to the extent the clinical reviewer or reviewers consider appropriate.

F. Decision of Independent Review Organization. The assigned IRO will provide written notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO will deliver the notice of final External Review decision to the Claimant and the Plan.

- (i) The assigned IRO's decision will contain:

(a) A general description of the reason for the request for External Review, including information sufficient to identify the Claim, including the date or dates of service, the health care provider, the Claim amount (if applicable), and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the Claimant;

(f) A statement that judicial review may be available to the Claimant; and

(g) Current contact information, including the phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793.

G. Record Retention. After a final External Review decision, the IRO will maintain records of all Claims and notices associated with the External Review process for six years. The IRO will make these records available for examination by the Claimant, the Plan, or a State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

H. Reversal of the Plan's Decision. Upon receiving a final External Review decision reversing an adverse benefit determination, the Plan will immediately provide coverage or immediately pay the Claim.

I. Request for Expedited External Review of Urgent Care Claim.

(i) A Claimant may request an expedited External Review if the Claimant receives:

(a) An initial Claim denial for a medical condition of the Claimant for which the timeframe for completion of an expedited internal Appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, and the Claimant has filed a request for an expedited internal appeal; or

(b) A denial on Appeal if the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final Appeal denial concerns 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.

(ii) Preliminary Expedited Review. Immediately upon receipt of the request for expedited External Review, the Plan Administrator (or its designee) will determine whether the request meets the reviewability requirements for External Review. The Plan will immediately send to the Claimant a notice of its decision that meets the requirements set forth in Section 13.4(B) and (C) above for standard External Review.

(iii) Expedited Referral to Independent Review Organization. Upon a determination that a request is eligible for External Review, the Plan will assign an IRO pursuant to the requirements set forth in Section 13.4(D) above for standard review. The Plan Administrator (or its designee) will provide to the assigned IRO all necessary documents and information considered in making the adverse benefit determination, by telephone or facsimile or electronically or by any other available expeditious method. The assigned IRO will consider the information or documents described above under the procedures for standard review.

(iv) Expedited Notice of Final External Review Decision. The IRO will provide notice of the final external review decision, in accordance with the requirements set forth in Section 13.4(F) above, 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 is not provided in writing, then within 48 hours after the date of providing the notice, the IRO will provide written confirmation of the decision to the Claimant and the Plan Administrator (or its designee).

Section 13.5. Claims Litigation. After a Claimant has exhausted the Plan's Internal and External Claims and Appeal process, if a Claim has been partially or completely denied, the Claimant may bring an action under ERISA Section 502(a). However, no such legal action with respect to a denied Claim may be brought more than 3 years following the date of the first decision on the Claim.

ARTICLE XIV. PLAN ADMINISTRATION

Section 14.1. Plan Sponsor and Plan Administrator.

Cook Group Incorporated is the Plan Sponsor. Cook Group Incorporated, by its Board of Directors, has appointed an Advisory Committee to serve as the Plan Administrator and Named Fiduciary, and has delegated all of its powers and responsibilities as to administration of the Plan to the Advisory Committee, except for the authority to terminate the Plan. The Advisory

Committee may appoint a Claims Administrator to process claims, and perform other tasks assigned to it by Cook Group Incorporated.

Section 14.2. Plan Adoption by Affiliated Employers.

Employers that are considered a single employer with Cook Group Incorporated under Code Sections 414(b), 414(c) 414(m) or 414(o) and that are incorporated in the United States shall automatically participate in the Plan from their inception unless they are excluded from participation initially or subsequently by Cook Group Incorporated. Participating Employers that, as the result of a transaction, are no longer considered a single employer with Cook Group Incorporated under the Code shall automatically cease participating in the Plan upon the closing of the transaction, unless otherwise agreed by Cook Group Incorporated.

Participating Employers are bound by the premiums, policies and provisions of the Plan and the Cook Group Health Plan Trust ("Trust") and interpretations of the Plan and Trust by the Plan Administrator (or its designee), the Claims Administrator and the Trustees.

Each participating Employer accepts the Trustees and designates Cook Group Incorporated as its agent with respect to administration of the Plan and Trust and communication with the Trustees.

Cook Group Incorporated, in its sole discretion, may set the premiums required for participation in the Plan and allocate the claims and administrative expenses of the Plan among participating Employers. Its decisions are binding on all Employers.

Cook Group Incorporated may terminate the participation of any or all Employers in its sole discretion.

Section 14.3. Plan Interpretation.

The Plan Administrator (or its designee) and the Claims Administrator shall have all powers necessary to administer the Plan. They shall interpret the eligibility rules and benefits of the Plan and issue rules for administration in their sole discretion. Their decisions shall be conclusive on Employers and Covered Persons and providers, and shall not be set aside by a reviewing tribunal unless they acted in an arbitrary and capricious manner. Benefits will be paid only if the Plan Administrator and/or Claims Administrator, in their sole discretion, determine that benefits are owed.

This Plan shall be interpreted to comply with applicable law. To the extent not preempted by Federal law, this Plan shall be interpreted under the laws of the State of Indiana.

The calendar year is the Plan Year and will be used to measure Deductibles and Out-of-Pocket Maximums.

Section 14.4. Plan Amendment. Cook Group Incorporated, in its sole discretion, may at any time amend the Plan by action of its Board of Directors, or by action of an officer or committee authorized by the Board of Directors. The amendment shall be binding on all Employers, Employees and Covered Persons.

Section 14.5. Plan Termination.

Cook Group Incorporated, in its sole discretion, may at any time terminate the Plan or any benefit provided by the Plan by action of its Board of Directors, or by action of an officer or committee authorized by the Board of Directors. The termination shall be binding on all Employers, Employees and Covered Persons. In the event of termination of the Plan, Covered Charges incurred prior to termination will be paid if they are submitted within 75 days of the termination date. Plan assets will be used for the exclusive benefit of Covered Persons.

Employers may terminate their participation in the Plan, with the consent of Cook Group Incorporated.

Section 14.6. Not a Contract of Employment. The Plan shall not be deemed to be a contract of employment between an Employer and Employee, or to be consideration for, or a condition of employment. The Plan does not give any Employee the right to remain employed, or affect the ability of an Employer to discharge an Employee at any time and with or without cause.

Section 14.7. Compliance with HIPAA. The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires that the Plan establish the permitted and required uses and disclosures of protected health information, particularly in relation to the Plan Sponsor’s use of such information.

A. Definitions For This Section 14.7.

(i) “Protected health information” (“PHI”) means both demographic information collected from an individual and genetic information, whether oral or recorded, that:

(a) is maintained or transmitted in any form or medium, including electronic media;

(b) is created or received by the Plan;

(c) relates to the past, present or future physical or mental health condition of an individual, the provision of health care to the individual, or the past, present or future payment for health care; and

(d) identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(ii) “Plan” means this Cook Group Health Plan;

(iii) “HIPAA” refers to the Health Insurance Portability and Accountability Act’s (HIPAA) Privacy of Individually Identifiable Health Information standards (45 CFR Parts 160 and 164), as those regulations exist and as they may be amended from time to time; and

(iv) “Plan Sponsor” is Cook Group Incorporated.

B. Plan Certification. The Plan will disclose PHI to the Plan Sponsor and its designees only upon receipt of a certification by the Plan Sponsor that the Plan documents have been amended in accordance with (i), (ii) and (iii) below. When using or disclosing PHI or when requesting PHI from another party, the Plan will make reasonable efforts to limit PHI to: (1) the minimum necessary: (a) to accomplish the intended purpose of the use and disclosure and (b) to satisfy the purposes of the request; or (2) a limited data set for purposes of health care operations.

(i) Assurances of Plan Sponsor. With respect to PHI about Plan participants, the Plan Sponsor agrees to:

(a) use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA, including but not limited to, purposes related to health care treatment, payment for health care, and health care operations of the Plan;

(b) not use or further disclose PHI from claims or enrollment data other than as permitted or required by the Plan documents or as permitted or required by law;

(c) ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(d) not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

(e) report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the permitted uses or disclosures;

(f) make available PHI in accordance with HIPAA's access requirements;

(g) make PHI available for amendment and incorporate any amendments in accordance with HIPAA;

(h) make available the information required under HIPAA to provide an accounting of disclosures of PHI;

(i) make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of HHS for purposes of determining compliance by the Plan with HIPAA;

(j) if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, then limit further uses and

disclosures to those purposes that make the return or destruction of the information infeasible; and

(k) ensure that adequate separation between the Plan and the Plan Sponsor is established, as described below.

(l) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI.

(m) (1) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan; (2) ensure that adequate separation is supported by reasonable and appropriate security measures; (3) ensure that any agent, to whom it provides electronic PHI agrees to implement reasonable and appropriate safeguards to protect the PHI; and (4) report to the Plan any security incident of which Plan Sponsor becomes aware.

(ii) Separation Between Group Health Plan and Plan Sponsor. The Plan Sponsor agrees that the confidentiality of PHI will be protected by adoption of the following measures:

(a) The following employees, or classes of employees or other persons under the control of the Plan Sponsor will be given access to and use of PHI to the extent necessary to perform the Plan administration functions that Employers perform for the Plan: (1) the Cook Insurance Department; (2) the Advisory Committee for the Plan; (3) the Benefits Coordinator; (4) the Cook IT Department; (5) the payroll staff of Employers; (6) the Privacy Officer for the Plan, and (7) the assistants of each of the above. In the event that any of these employees does not comply with the provisions of this Section, that employee will be subject to disciplinary action by the Employer for non-compliance, pursuant to the Employer's employee discipline and termination procedures. All Employers will ensure that this sub-section is supported by reasonable and appropriate security measures to the extent that the employees have access to electronic PHI.

(b) Access to and use of PHI from the Plan by these employees and agents is limited to Plan administration functions;

(c) In the event that the persons described above do not comply with the limitations on uses and disclosures of PHI as described in the Plan, they shall be subject to disciplinary sanctions up to and including termination of employment and/or removal from Plan administration functions.

Questions or concerns about use or disclosure of PHI should be directed to the Plan's Privacy Officer.

(iii) Security of Electronic PHI (“EPHI”). The Plan Sponsor shall:

(a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of EPHI which it creates, receives, maintains or transmits on behalf of the Plan;

(b) ensure that the separation between the Plan and the Plan Sponsor set out in Paragraph (ii) above is supported by reasonable and appropriate security measures;

(c) ensure that any agent, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect the information; and

(d) report to the Plan any attempted or successful unauthorized access, use, disclosure, modification or destruction of EPHI or interference with information systems containing EPHI of which it becomes aware.

C. Breach of PHI. Upon discovery of any breach of unsecured PHI, the Plan will evaluate whether the breach requires notice and will make appropriate notifications as provided under HIPAA, including, when applicable, notice to each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired or disclosed as a result of a breach and notice to the Secretary of Health and Human Services if required by HIPAA.

ARTICLE XV. REQUIRED NOTICES

Section 15.1. Newborn’s and Mother’s Health Protection Act. Group health plans generally may not restrict benefits for a 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 section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours). In any case, plans may not require that a provider obtain Preauthorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable). Maternity stays exceeding either the 48-hour or 96-hour period, require Preauthorization by the designated contact listed in the Benefit Booklet or the ID card, or benefits may not be paid for the remainder of the Hospital stay.

Section 15.2. Women’s Health and Cancer Rights Act Notice. If you have had or will have a mastectomy, you may be entitled to benefits under the Women’s Health and Cancer Rights Act of 1998. For a person receiving care due to a mastectomy, coverage will be provided for:

Reconstruction of the breast on which the mastectomy was performed;

Surgery and reconstruction of the other breast to produce a symmetrical appearance;

Prostheses; and

Treatment of the physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under the Plan.

Section 15.3. Medicare Part D Notice, Children's Health Insurance Program (CHIP) Notice and HIPAA Notice of Privacy Practices. See the annual Employee Benefits Open Enrollment packet and/or the Benefit Booklet for these notices.

ARTICLE XVI. MISCELLANEOUS INFORMATION

Section 16.1. Funding. This Plan is self-insured. All premiums and contributions are paid by Covered Persons and participating Employers. Cook Group Incorporated shall determine the premiums owed by Employers and Covered Persons. The premiums and contributions are deposited into the Cook Group Health Plan Trust. Claims and administrative expenses are paid by Employers and from the Trust. Although an insurance company may process claims payments, no insurance company is responsible for paying claims from its own assets.

Section 16.2. Right to Recover Payments. If payments are made that are greater than the amount owed by the Plan or are made for an ineligible person, Covered Persons and ineligible persons agree to reimburse the Plan for the excess payments. Alternatively, the Plan may recover the excess payments from any person to whom or for whom the payments were made, or from any other plan or insurance carrier that provides benefits for the same expense. In the discretion of the Plan Administrator or Claims Administrator, the Plan may recover the excess payments by reducing the future benefits of the ineligible person, Employee or their Spouse or Children.

Section 16.3. Coordination of Benefits. This Coordination of Benefits section is intended to determine which medical plan provides benefits when there are two or more medical plans providing coverage to an individual.

A. Definitions. For purposes of this Coordination of Benefits section:

(i) "plan" means any plan providing medical or dental benefits or services by: (a) group, blanket, individual or franchise coverage; (b) group practice and other group prepayment coverage; (c) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; (d) any coverage under governmental programs such as, but not limited to, Medicare, and any coverage required or provided by any statute; (e) individual automobile "no-fault" and traditional auto insurance; (f) individual or family insurance; (g) subscriber contracts; (h) individual or family coverage through Health Maintenance Organizations (HMO); (i) limited service organizations or any other prepayment program; (j) student accident insurance provided through or by an educational institution; (k) a group practice or individual practice plan; and (l) This Plan;

The term "plan" is construed separately with respect to each plan, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such plan, contract, or other arrangement which reserves the right to take the benefits

or services of other plans into consideration in determining its benefits and that portion which does not;

(ii) “Allowable Expense” means any Usual and Customary Fee, at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered as both an Allowable Expense and a benefit paid;

(iii) “Claim Determination Period” means the calendar year, except that if in any calendar year the person is not covered under a plan for the full calendar year, the Claim Determination Period for that year will be that portion of the year during which the person was covered under the plan;

(iv) “Claim” means a request that benefits of a plan be provided or paid;

(v) “Primary Plan” means a plan whose benefits are determined without regard to any other plan;

(vi) “Secondary Plan” means a plan which is not a Primary Plan according to the Order of Benefit Determination rules, and whose benefits are determined after those of another plan and may be reduced because of the other plan’s benefits; and

(vii) For purposes of this Coordination of Benefits section, “This Plan” means the Cook Group Health Plan, including the medical, prescription drug, dental, vision and hearing benefits of the Cook Group Health Plan.

B. Effect on Benefits. When a Claim is made, the Primary Plan pays its benefits without regard to any other plan. The Secondary Plan adjusts its benefits so that the total benefits available do not exceed the Allowable Expense. No plan pays more than it would without this coordinating provision. This Plan will not administer the Coordination of Benefits with a reserve amount.

C. Order of Benefits Determination. The rules establishing the Order of Benefits Determination are:

(i) If the other plan does not have a Coordination of Benefits provision, that plan pays first;

(ii) The benefits of a plan which covers the person as an employee, member or subscriber (other than as a Child) are determined before the benefits of a plan which covers the person as a child;

(iii) Birthday Rule and Children with Divorced Parents:

(a) The benefits of a plan which covers the person as a child are determined according to which parent’s birthday occurs first in a calendar year (day and month). If the birth dates of both parents are the same, the plan which

has covered the person for the longer period of time will determine benefits first. If the other plan does not contain the birthday rule, but has a rule which coordinates benefits based on gender and the plans do not agree on the Order of Benefits, the rule in the other plan will determine the Order of Benefits.

(b) If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

I When parents are separated or divorced and the parent with physical custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be the Primary Plan.

II When parents are divorced and the parent with physical custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody are determined before the benefits of the plan which covers that child as a dependent of the stepparent. In addition, the benefits of a plan which covers that child as a dependent of the stepparent are determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

III Notwithstanding the provisions of the above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses with respect to a child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility are determined before the benefits of any other plan which covers the child as a child.

(iv) When rules (i), (ii) and (iii) above do not establish an Order of Benefits Determination, the benefits of a plan which covers the person as a laid-off or retired employee, or as a child of such person, are determined after the benefits of a plan which covers such person through his or her own present employment or through the present employment of another person; and

(v) When rules (i), (ii), (iii) and (iv) above do not establish an Order of Benefits Determination, the benefits of a plan which has covered the person for the longer period of time are determined before the benefits of a plan which has covered such person for the shorter period of time.

D. Right to Necessary Information. This Plan may need to receive or disclose certain information in order to apply and coordinate these provisions with other plans. To secure the needed information, This Plan, without the Covered Person's consent, will, to the extent permitted by law, release to, or obtain from, any insurance company, organization or person information needed to implement these provisions. The Covered Person, by accepting benefits under This Plan, agrees to furnish any information required to apply these provisions.

E. Coordination of Benefits With Medicare. In all cases, Coordination of Benefits with Medicare will conform to Federal statutes and regulations. This Plan will pay secondary to

Medicare to the full extent permitted by law. Generally, when a Covered Person is eligible for this Plan based on employment and eligible for Medicare based on the Covered Person's age or disability, this Plan will be the Primary Plan, and Medicare will be the Secondary Plan. However, if the Employee is eligible for Medicare because of end-stage-renal disease (ESRD), then Medicare will be the Primary Plan after the first 30 months of Medicare eligibility or entitlement. If the Covered Person is eligible for Medicare benefits, but is not enrolled, the benefits under This Plan will be coordinated to the extent benefits would have been payable under Medicare, as allowed by Federal statutes and regulations, as if the Covered Person had enrolled. The Covered Person must notify the Cook Insurance Department within 30 days from the time of Medicare eligibility that the Covered Person or dependent is eligible for Medicare.

F. Facility of Payment.

(i) Payment made under any other plan which, according to these provisions, should have been made by This Plan will be adjusted. This Plan may pay to the organization which made a payment the amount which is determined to be warranted. Any amount paid is deemed to be a benefit paid under This Plan.

(ii) Payment made by This Plan which, according to these provisions, should have been made by any other plan, will be adjusted. This Plan may collect from the other plan or from the Covered Person (by direct collection or by set off from future benefits) or from the provider a payment in the amount which is determined to be warranted.

Section 16.4. Plan's Rights to Subrogation and Reimbursement.

If a Covered Person incurs medical, dental or prescription drug expenses for an Illness or Injury because of the fault, in whole or in part, of another person, that other person may be legally responsible for those medical, dental, vision or prescription drug expenses. Furthermore, a Covered Person or the Covered Person's guardian or estate may be entitled to receive money from an insurance contract for medical, dental, vision or prescription drug expenses resulting from an Injury or Illness. The Plan will be subrogated to all rights of recovery the Covered Person or the Covered Person's guardian or estate may have against such other person(s) and such insurance contract(s) for medical, dental, vision or prescription drug expenses that the Plan has paid or that it is legally obligated to pay to or on behalf of the Covered Person or the Covered Person's guardian or estate.

The Plan shall have the right to receive payment or repayment of those expenses referred to above from the person(s) that caused the Illness or Injury, any person who has legal responsibility for that person, that person's liability insurer, or any other insurer providing coverage for that person. The Plan shall also have the right to recover expenses it has paid or is obligated to pay from amounts paid for those expenses by the Covered Person's or his or her guardian's or estate's auto insurance, including but not limited to, uninsured or underinsured motorist coverage and medical expense payments.

The Plan shall have “dollar one” recovery entitlement from any amounts paid and not simply from amounts received, regardless of whether the Covered Person or his or her guardian or estate is “made whole.”

The Plan is automatically assigned the Covered Person’s or the Covered Person’s guardian’s or estate’s right of recovery against third parties (including their insurers) who are responsible in whole or in part for causing the Injury or Illness, to the extent of amounts the Plan has paid or is legally obligated to pay for the medical, dental, vision or prescription drug expenses of the Covered Person. The Plan will be entitled, but not obligated, to proceed in the name of the Covered Person or the Covered Person’s guardian or estate against the person or persons responsible to repay the Plan for expenses the Plan has incurred for the Covered Person as identified above, if the Covered Person or the Covered Person’s guardian or estate fails to take the necessary action to recover such expenses.

The amount of the Plan’s subrogation claim must be included in any litigation filed or any claim made or asserted by or for the Covered Person or the Covered Person’s guardian or estate in connection with the Injury or Illness giving rise to the expenses referred to above, including claims made against the Covered Person’s own insurance. When the claim is settled or any amount is paid to the Covered Person, his or her legal representative, or guardian, or estate, then the person receiving such funds must reimburse the Plan or cause the Plan to be reimbursed from the settlement or payment received for medical, dental, vision or prescription drug expenses that the Plan has paid or that it is legally obligated to pay to or on behalf of the Covered Person.

The Covered Person or the Covered Person’s guardian or estate shall not prejudice the Plan’s rights of subrogation and reimbursement and shall sign and deliver documents to evidence or to secure those rights to the Plan. The Plan has the right to receive from the Covered Person or the Covered Person’s guardian or estate, prior to the Plan’s payment of Claims or at any time subsequent thereto, a completed subrogation questionnaire, a reimbursement agreement and an acknowledgment of the Plan’s subrogation and recovery rights signed by the Covered Person or the Covered Person’s guardian or estate, or his or her authorized legal representative, on forms provided by the Plan.

The Covered Person, or the Covered Person’s guardian or estate is not authorized to obtain legal representation to act on behalf of the Plan for recovery of any amounts paid by the Plan. Any contingent fee or retainer agreement entered into by the Covered Person or the Covered Person’s guardian or estate will have no effect on the Plan’s entitlement to the full amount of its subrogation claim on a “dollar one, first priority basis,” regardless of any asserted offset for attorney fees or costs or other reduction, unless specifically agreed to in writing by the Plan. This also applies to any other similar federal or state statute or common law which would cause the Plan to receive less than the full amount of its claim. The concept of the “common fund doctrine” that governs the allocation of attorney’s fees does not apply to this Plan or its rights to subrogation and recovery. The Plan may, at its discretion, enter into an agreement with the Covered Person, or his or her legal representative, guardian, or estate to represent its subrogation interest.

The Plan’s rights as provided in this Section are created and preserved regardless of whether the Covered Person or the Covered Person’s guardian or estate is “made whole,” signs a

reimbursement agreement or signs an acknowledgment of the Plan's subrogation and recovery rights. The Covered Person, the Covered Person's guardian, estate, or legal representative shall make no distributions, nor authorize any distributions, from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien or the expenses for medical, dental or prescription drug expenses that the Plan has paid or that it is legally obligated to pay to or on behalf of the Covered Person without the written approval of the Plan, and shall not release any party or their insurer without the prior written approval of the Plan. In addition, the Covered Person, and his or her guardian, estate, or legal representative will not withhold or intercept any amounts due the Plan from any party. Additionally, the Covered Person, his or her guardian, estate, or legal representative shall not instruct any party to forward amounts that are owed to the Plan, to any entity other than the Plan, in the absence of a prior written agreement with the Plan.

The subrogation rights of the Plan shall be superior to and the Plan shall have "first priority" over any competing claims of the Covered Person, his or her guardian, estate, or legal representative, or any competing claims of a parent, spouse or child of a Covered Person, to any designated or undesignated proceeds of a judgment, award, or insurance payment or settlement of the claims of the Covered Person, or of any other person where such settlement, judgment, payment or award relates to or arises from the circumstances giving rise to the medical, dental or prescription drug expenses of the Covered Person that the Plan has paid or that the Plan is legally obligated to pay to or on behalf of the Covered Person.

A Covered Person includes the Employee and any Spouse or Child of the Covered Person where applicable.

ARTICLE XVII. GLOSSARY

- A. "Allowable Expense" - Section 16.3(A)(ii)
- B. "Alternate Recipient" - Section 1.3(G)
- C. "Ambulatory Surgical Center" - Section 9.3(A)
- D. "Annual Open Enrollment" - Section 3.2(A)
- E. "Approved Clinical Trial" – Section 8.5(D)
- F. "Benefit Maximum" - Section 8.1(C)
- G. "Case Management" – Section 7.1(B)
- H. "Child" – Section 1.3(A)
- I. "CHIP" - Section 3.3(B)(iii)
- J. "Claim" – Sections 13.1(A)(iii) and 16.3(A)(iv)

- K. “Claim Determination Period” – Section 16.3(A)(iii)
- L. “Claimant” – Section 13.1(A)(i)
- M. “Claims Administrator” – Section 14.1
- N. “Clinic” – Section 2.3(A)
- O. “COBRA” – Section 5.3
- P. “COBRA Coverage” - Section 5.3
- Q. “Coinsurance” - Section 8.1(E)
- R. “Concurrent Care Claim” – Section 13.1(D)
- S. “Coordination of Benefits” – Section 16.3
- T. “Copayment” - Section 8.1(D)
- U. “Coronary Care Unit” – Section 9.12(G)
- V. “Covered Members” – Sections 1.4 and 6.1(A)
- W. “Covered Persons” - Sections 1.4 and 6.1(A)
- X. “Custodial Care” – Section 9.12(G)
- Y. “Deductible” - Section 8.1(A)
- Z. “Durable Medical Equipment” - Section 9.8(A)
- AA. “Electronic PHI (EPHI)” - Section 14.7(B)(iii)
- BB. “Eligibility Policy” – Section 1.1
- CC. “Emergency Medical Condition” – Section 9.7(C)
- DD. “Emergency Services” - Section 9.7(B)
- EE. “Employee” - Section 1.1.
- FF. “Experimental and Investigative” – Section 8.5(B)
- GG. “Extended Major Medical Leave” - Section 5.1(C)
- HH. “External Review” – Section 13.4(A)
- II. “Family Planning Services” – Section 9.10(A)

- JJ. “FMLA” – Section 5.1(A)
- KK. “Foster Child” - Section 1.3(C)
- LL. “Foster Home” - Section 1.3(C)
- MM. “Foster Parent” - Section 1.3(C)
- NN. “Generally accepted standards” – Section 8.4(A)(vii)(a)
- OO. “Health Insurance Portability and Accountability Act (HIPAA)” - Section 14.7(A)(iii)
- PP. “Home Health Aide” – Section 9.10(E)
- QQ. “Home Health Care” - Section 9.12(A)
- RR. “Home Health Care Agency” - Section 9.12(B)
- SS. “Home Health Care Plan” - Section 9.12(D)
- TT. “Hospital” – Section 9.14(E)
- UU. “Illness” – Section 9.2(D)
- VV. “Incurred” – Section 13.1(A)(iii)
- WW. “Independent Review Organization (IRO)” – Section 13.4(D)
- XX. “Infertility” – Section 9.8(C)
- YY. “Injury” – Section 9.2(E)
- ZZ. “Intensive Care Unit” – Section 9.12(G)
- AAA. “Loss of Coverage” - Section 5.3(A)(iv)(a)
- BBB. “Maintenance Care” - Section 9.22(A)
- CCC. “Medically Necessary” – Section 8.4(A)
- DDD. “Mental Health” – Section 9.16(E)
- EEE. “Named Fiduciary” – Section 14.1
- FFF. “OBGYN” – Section 7.1(A)(iii)
- GGG. “Orthodontic Services” – Addendum B
- HHH. “Out-Of-Pocket Maximum” - Section 8.1(B)

III. “PBM” – Section 10.1(A)

JJJ. “Physician” – Section 9.17(C)

KKK. “Placed for Adoption” - Section 1.3(B)

LLL. “Plan Administrator” – Section 14.1

MMM. “Plan Sponsor” - Section 14.1

NNN. “Plan Year” – Section 14.3(C)

OOO. “Post-Service Claim” – Section 13.1(F)(i)

PPP. “Preauthorization” – Section 7.1(A)(i)

QQQ. “Prescription Drugs” - Section 10.5(C)

RRR. “Pre-Service Claim” – Section 13.1(E)(i)

SSS. “Preventive Care Services” - Section 9.18(A)(i)

TTT. “Primary Plan” – Section 16.3(A)(v)

UUU. “Protected Health Information or (PHI)” – Section 14.7(A)(i)

VVV. “Qualified Beneficiary” - Section 5.3(A)(i)

WWW. “Qualifying Event” - Sections 5.3(A)(ii) and (iii)

XXX. “Qualified Individual” – Section 8.5(D)

YYY. “Relevant” – Section 13.2(B)

ZZZ. “Reliable Evidence” – Section 8.5(C)

AAAA. “Rescind” – Section 4.2

BBBB. “Routine Patient Costs” – Section 8.5(D)

CCCC. “Secondary Plan” - Section 16.3(A)(vi)

DDDD. “Sexual Dysfunction” – Section 9.8(C)

EEEE. “Skilled Nursing Facility” – Section 9.18(B)

FFFF. “Special Enrollee” - Section 3.3(B)

GGGG. “Specialty Drugs” – Section 10.8(A)

HHHH. “Spouse” – Section 1.2(A)

IIII. “Standard of care” - Section 8.4(A)(vii)(a)

JJJJ. “Subrogation” – Section 16.4

KKKK. “Substance Abuse” – Section 9.16(F)

LLLL. “Supportive Care” - Section 9.22(A)

MMMM. “Telehealth Services” – Section 9.29

NNNN. “This Plan” – Section 16.3(A)(vii)

OOOO. “Transitional Treatment Program” - Section 9.16(C)

PPPP. “Transplant Benefit Period” - Section 9.25(E).

QQQQ. “Treatment or Procedure” - Section 8.5(B)

RRRR. “Trust” – Section 14.2(B)

SSSS. “Urgent Care Center” – Section 9.26(B)

TTTT. “Urgent Care Claim” – Section 13.1(C)(i)

UUUU. “USERRA” – Section 5.2

VVVV. “Usual and Customary Fee” – Section 8.3

WWWW. “Waiting Period” – Section 2.1

Date: _____

COOK GROUP INCORPORATED

By: _____

Title:

Addendum A

Preventive Coverage Schedules, Panels and Recommendations

Section 1. Recommendations of the United States Preventive Services Task Force

Citation:

U. S. Preventive Services Task Force A and B Recommendations

<http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

A & B Recommendations

A listing of all the Recommendations with a grade of either A or B.

A and B grade recommendations are services that the Task Force most highly recommends implementing for preventive care and that are also relevant for implementing the Affordable Care Act. These preventive services have a high or moderate net benefit for patients.

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked	The USPSTF recommends 1-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged 65 to 75 years who have ever smoked.	B	December 2019 *
Anxiety Disorders in Adults: Screening: adults 64 years or younger, including pregnant and postpartum persons	The USPSTF recommends screening for anxiety disorders in adults, including pregnant and postpartum persons.	B	June 2023
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.	B	October 2022
Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication: pregnant persons at high risk for preeclampsia	The USPSTF recommends the use of low-dose aspirin (81 mg/day) as preventive medication after 12 weeks of gestation in persons who are at high risk for preeclampsia. See the Practice Considerations section for information on high risk and aspirin dose.	B	September 2021 *
Asymptomatic Bacteriuria in Adults: Screening: pregnant persons	The USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons.	B	September 2019 *

BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brca1/2 gene mutation	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.	B	August 2019 *
Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer aged 35 years or older	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.	B	September 2019 *
Breast Cancer: Screening: women aged 40 to 74 years	The USPSTF recommends biennial screening mammography for women aged 40 to 74 years. †	B	April 2024 *
Breastfeeding: Primary Care Behavioral Counseling Interventions: pregnant and postpartum women	The USPSTF recommends providing interventions or referrals, during pregnancy and after birth, to support breastfeeding.	B	April 2025 *
Cervical Cancer: Screening: women aged 21 to 65 years	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). See the Clinical Considerations section for the relative benefits and harms of alternative screening strategies for women 21 years or older.	A	August 2018 *
Chlamydia and Gonorrhea: Screening: sexually active women, including pregnant persons	The USPSTF recommends screening for gonorrhea in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.	B	September 2021 *
Chlamydia and Gonorrhea: Screening: sexually active women, including pregnant persons	The USPSTF recommends screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.	B	September 2021 *
Colorectal Cancer: Screening: adults aged 45 to 49 years	The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	B	May 2021 *

Colorectal Cancer: Screening: adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	A	May 2021 *
Depression and Suicide Risk in Adults: Screening: adults, including pregnant and postpartum persons, and older adults (65 years or older)	The USPSTF recommends screening for depression in the adult population, including pregnant and postpartum persons, as well as older adults.	B	June 2023 *
Depression and Suicide Risk in Children and Adolescents: Screening: adolescents aged 12 to 18 years	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.	B	October 2022 *
Falls Prevention in Community- Dwelling Older Adults: Interventions: community-dwelling adults 65 years or older	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.	B	June 2024
Folic Acid Supplementation to Prevent Neural Tube Defects: Preventive Medication: persons who plan to or could become pregnant	The USPSTF recommends that all persons planning to or who could become pregnant take a daily supplement containing 0.4 to 0.8 mg (400 to 800 mcg) of folic acid.	A	August 2023 *
Gestational Diabetes: Screening: asymptomatic pregnant persons at 24 weeks of gestation or after	The USPSTF recommends screening for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or after.	B	August 2021 *
Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions: adults with cardiovascular disease risk factors	The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.	B	November 2020 *
Healthy Weight and Weight Gain In Pregnancy: Behavioral Counseling Interventions: 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.	B	May 2021
Hepatitis B Virus Infection in Adolescents and Adults: Screening: adolescents and adults at increased risk for infection	The USPSTF recommends screening for hepatitis B virus (HBV) infection in adolescents and adults at increased risk for infection. See the Practice Considerations section for a description of adolescents and adults at increased risk for infection.	B	December 2020 *

Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women	The USPSTF recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit	A	July 2019 *
Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years	The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.	B	March 2020 *
High Body Mass Index in Children and Adolescents: Interventions: children and adolescents 6 years or older	The USPSTF recommends that clinicians provide or refer children and adolescents 6 years or older with a high body mass index (BMI) (≥ 95 th percentile for age and sex) to comprehensive, intensive behavioral interventions. See the Practice Considerations section for more information about behavioral interventions.	B	June 2024 *

Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened. See the Clinical Considerations section for more information about assessment of risk, screening intervals, and rescreening in pregnancy.	A	June 2019 *
Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons	The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.	A	June 2019 *
Hypertension in Adults: 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 (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A	April 2021 *
Hypertensive Disorders of Pregnancy: Screening: asymptomatic pregnant persons	The USPSTF recommends screening for hypertensive disorders in pregnant persons with blood pressure measurements throughout pregnancy.	B	September 2023 *
Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults: Screening: women of reproductive age, including pregnant and postpartum women	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age, including those who are pregnant and postpartum. See the "Practice Considerations" section for information on evidence-based multicomponent interventions and for information on IPV in men.	B	June 2025 *
Latent Tuberculosis Infection in Adults: Screening: asymptomatic adults at increased risk of latent tuberculosis infection (ltbi)	The USPSTF recommends screening for LTBI in populations at increased risk. See the "Assessment of Risk" section for additional information on adults at increased risk.	B	May 2023 *
Lung Cancer: Screening: 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	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.	B	March 2021 *
Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.	A	January 2019 *

Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years with 1 or more risk factors for osteoporosis	The USPSTF recommends screening for osteoporosis to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk for an osteoporotic fracture as estimated by clinical risk assessment. See the "Practice Considerations" section for more information on risk assessment and screening tests.	B	January 2025 *
Osteoporosis to Prevent Fractures: Screening: women 65 years or older	The USPSTF recommends screening for osteoporosis to prevent osteoporotic fractures in women 65 years or older. See the "Practice Considerations" section for more information on screening tests.	B	January 2025 *
Perinatal Depression: Preventive Interventions: pregnant and postpartum persons	The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.	B	February 2019
Prediabetes and Type 2 Diabetes: Screening: asymptomatic adults aged 35 to 70 years who have overweight or obesity	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.	B	August 2021 *
Prevention of Acquisition of HIV: Preexposure Prophylaxis: adolescents and adults at increased risk of hiv	The USPSTF recommends that clinicians prescribe preexposure prophylaxis using effective antiretroviral therapy to persons who are at increased risk of HIV acquisition to decrease the risk of acquiring HIV. See the Practice Considerations section for more information about identification of persons at increased risk and about effective antiretroviral therapy.	A	August 2023 *
Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions: children younger than 5 years	The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	B	December 2021 *
Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions: children younger than 5 years	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.	B	December 2021 *
Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit	The USPSTF strongly recommends Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004 *
Rh(D) Incompatibility: Screening: unsensitized rh(d)-negative pregnant women	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.	B	February 2004 *

Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults at increased risk	The USPSTF recommends behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs). See the Practice Considerations section for more information on populations at increased risk for acquiring STIs.	B	August 2020 *
Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children	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.	B	March 2018 *
Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years who have 1 or more cardiovascular risk factors and an estimated 10-year cardiovascular disease (cvd) 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.	B	August 2022 *
Syphilis Infection During Pregnancy: Screening: asymptomatic pregnant women	The USPSTF recommends early, universal screening for syphilis infection during pregnancy; if an individual is not screened early in pregnancy, the USPSTF recommends screening at the first available opportunity.	A	May 2025 *
Syphilis Infection in Nonpregnant Adolescents and Adults: Screening: asymptomatic, nonpregnant adolescents and adults who are at increased risk for syphilis infection	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.	A	September 2022 *
Tobacco Smoking Cessation in Adults, Including Pregnant Persons: 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 US Food and Drug Administration (FDA)--approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.	A	January 2021 *
Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions: 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.	A	January 2021 *

Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco	The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.	B	April 2020 *
Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: 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.	B	November 2018 *
Unhealthy Drug Use: Screening: adults age 18 years or older	The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)	B	June 2020
Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years	The USPSTF recommends vision screening at least once in all children aged 3 to 5 years to detect amblyopia or its risk factors.	B	September 2017 *
Weight Loss to Prevent Obesity- Related Morbidity and Mortality in Adults: Behavioral Interventions: adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.	B	September 2018 *

†The Department of Health and Human Services, under the standards set out in revised Section 2713(a)(5) of the Public Health Service Act and Section 223 of the 2021 Consolidated Appropriations Act, utilizes the [2002 recommendation on breast cancer screening](#) of the U.S. Preventive Services Task Force. To see the USPSTF 2016 recommendation on breast cancer screening, go to <http://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening1>.

*Previous recommendation was an “A” or “B.”

Section 2. Recommendations of the Advisory Committee on Immunization Practices (Advisory Committee) adopted by the Director of the Centers for Disease Control and Prevention

A. Figures 1-3: Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, (Addendum updated August 7, 2025)

Citation:

Child and Adolescent Schedule, Comprehensive Version

<https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-combined-schedule-bw.pdf>

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger

UNITED STATES
2025

Vaccines and Other Immunizing Agents in the Child and Adolescent Immunization Schedule*

Monoclonal antibody	Abbreviation(s)	Trade name(s)
Respiratory syncytial virus monoclonal antibody (Nirsevimab)	RSV-mAb	Beyfortus
Vaccine	Abbreviation(s)	Trade name(s)
COVID-19 vaccine	1vCOV-mRNA	Comirnaty, mRNA1273, Spikevax
	1vCOV-aPS	Nuvaxovid
Dengue vaccine	DEN4CYD	Dengvaxia
Diphtheria, tetanus, and acellular pertussis vaccine	DTaP	Daptacel Infanrix
<i>Haemophilus influenzae</i> type b vaccine	Hib (PRP-T)	ActHIB Hiberix PedvaxHIB
	Hib (PRP-OMP)	
Hepatitis A vaccine	HepA	Havrix Vaqta
Hepatitis B vaccine	HepB	Engerix-B Recombivax HB
Human papillomavirus vaccine	HPV	Gardasil 9
Influenza vaccine (inactivated: egg-based)	IV3	Multiple
Influenza vaccine (inactivated: cell-culture)	cdIV3	Flucelvax
Influenza vaccine (live, attenuated)	LAIV3	FluMist
Measles, mumps, and rubella vaccine	MMR	M-M-R II Priorix
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-CRM	Menveo
	MenACWY-TT	MenQuadfi
Meningococcal serogroup B vaccine	MenB-4C	Bexsero
	MenB-FHbp	Trumenba
Meningococcal serogroup A, B, C, W, Y vaccine	MenACWY-TT/ MenB-FHbp	Penbraya
Monkeypox vaccine	Mpox	Jynneos
Pneumococcal conjugate vaccine	PCV15 PCV20	Vaxneuvance Pneumovax 20
Pneumococcal polysaccharide vaccine	PPSV23	Pneumovax 23
Poliovirus vaccine (inactivated)	IPV	Ipov
Respiratory syncytial virus vaccine	RSV	Abrysvo
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 ACIP or CDC.

Revised October 07, 2025

How to use the child and adolescent immunization schedule

- 1** Determine recommended vaccine by age (Table 1)
- 2** Determine recommended interval for catch-up vaccination (Table 2)
- 3** Assess need for additional recommended vaccines by medical condition or other indication (Table 3)
- 4** Review vaccine types, frequencies, intervals, and considerations for special situations (Notes)
- 5** Review contraindications and precautions for vaccine types (Appendix)
- 6** Review new or updated ACIP guidance (Addendum)

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/hcp/immz-schedules/app.html

Helpful Information

- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/acip-recs/hcp/vaccine-specific/index.html
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.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/surv-manual/php/



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CS31 0020-E

Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

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 and other immunizing agents	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	
Respiratory syncytial virus (RSV-mAb [Nirsevimab])	1 dose depending on maternal RSV vaccination status (See Notes)					1 dose (8–19 months). See Notes												
Hepatitis B (HepB)	1st dose	← 2nd dose →			← 3rd dose →													
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	See Notes													
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1st dose	2nd dose	3rd dose			← 4th dose →				5th dose						
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See Notes			← 3rd or 4th dose (See Notes) →										
Pneumococcal conjugate (PCV15, PCV20)			1st dose	2nd dose	3rd dose			← 4th dose →										
Inactivated poliovirus (IPV)			1st dose	2nd dose	← 3rd dose →							4th dose					See Notes	
COVID-19 (1vCOV-mRNA, 1vCOV-aPS)					See Notes													
Influenza (IIV3, ccIIV3)					1 or 2 doses annually									or 1 dose annually				
Influenza (LAIV3)												1 or 2 doses annually		or 1 dose annually				
Measles, mumps, rubella (MMR)					See Notes		← 1st dose →					2nd dose						
Varicella (VAR)							← 1st dose →					2nd dose						
Hepatitis A (HepA)					See Notes		2-dose series (See Notes)											
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)														1 dose				
Human papillomavirus (HPV)														See Notes				
Meningococcal (MenACWY-CRM ≥2 mos, MenACWY-TT ≥2 years)			See Notes										1st dose		2nd dose			
Meningococcal B (MenB-4C, MenB-FHbp)														See Notes				
Respiratory syncytial virus vaccine (RSV [Abrysvo])														Seasonal administration during pregnancy (See Notes)				
Dengue (DEN4CYD: 9–16 yrs)													Seropositive in endemic dengue areas (See Notes)					
Mpox																		

Range of recommended ages for all children

Range of recommended ages for catch-up vaccination

Range of recommended ages for certain high-risk groups or populations

Recommended vaccination can begin in this age group

Vaccination is based on shared clinical decision-making

No Guidance/ 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, 2025**

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

Children age 4 months through 6 years					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B	Birth	4 weeks	8 weeks and at least 16 weeks after first dose minimum age for the final dose is 24 weeks		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	4 weeks	4 weeks maximum age for final dose is 8 months, 0 days		
Diphtheria, tetanus, and acellular pertussis	6 weeks	4 weeks	4 weeks	6 months	6 months A fifth dose is not necessary if the fourth dose was administered at age 4 years or older and at least 6 months after dose 3
<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 1st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months.	No further doses needed if previous dose was administered at age 15 months or older 4 weeks if current age is younger than 12 months and first dose was administered at younger than age 7 months and at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix), Vaxelis or unknown 8 weeks and age 12–59 months (as final dose) if current age is younger than 12 months and first dose was administered at age 7–11 months; OR if current age is 12–59 months and first dose was administered before the 1st birthday and second dose was administered at younger than 15 months; OR if both doses were PedvaxHIB and were administered before the 1st birthday	8 weeks (as final dose) This dose only necessary for children age 12–59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	No further doses needed for healthy children if first dose was administered at age 24 months or older 4 weeks if first dose was administered before the 1st birthday 8 weeks (as final dose for healthy children) if first dose was administered at the 1st birthday or after	No further doses needed for healthy children if previous dose was administered at age 24 months or older 4 weeks if current age is younger than 12 months and previous dose was administered at <7 months old 8 weeks (as final dose for healthy children) if previous dose was administered between 7–11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was administered before age 12 months	8 weeks (as final dose) This dose is only necessary for children age 12–59 months regardless of risk, or age 60–71 months with any risk, who received 3 doses before age 12 months.	
Inactivated poliovirus	6 weeks	4 weeks	4 weeks if current age is <4 years 6 months (as final dose) if current age is 4 years or older	6 months (minimum age 4 years for final dose)	
Measles, mumps, rubella	12 months	4 weeks			
Varicella	12 months	3 months			
Hepatitis A	12 months	6 months			
Meningococcal ACWY	2 months MenACWY-CRM 2 years MenACWY-TT	8 weeks	See Notes	See Notes	
Children and adolescents age 7–18 years					
Meningococcal ACWY	Not applicable (N/A)	8 weeks			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1st birthday 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday	6 months if first dose of DTaP/DT was administered before the 1st birthday	
Human papillomavirus	9 years	Routine dosing intervals are recommended.			
Hepatitis A	N/A	6 months			
Hepatitis B	N/A	4 weeks	8 weeks and at least 16 weeks after first dose		
Inactivated poliovirus	N/A	4 weeks	6 months A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years OR if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	4 weeks			
Varicella	N/A	3 months if younger than age 13 years. 4 weeks if age 13 years or older			
Dengue	9 years	6 months	6 months		

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2025

Always use this table in conjunction with Table 1 and the Notes that follow. Medical conditions are often not mutually exclusive. If multiple conditions are present, refer to guidance in all relevant columns. See Notes for medical conditions not listed.

Vaccine and other immunizing agents	Pregnancy	Immunocompromised (excluding HIV infection)	HIV Infection CD4 percentage and count ^a		CSF leak or cochlear implant	Asplenia or persistent complement component deficiencies	Heart disease or chronic lung disease	Kidney failure, End-stage renal disease or on dialysis	Chronic liver disease	Diabetes
			<15% or <200/mm ³	≥15% and ≥200/mm ³						
RSV-mAb (nirsevimab)		2nd RSV season	1 dose depending on maternal RSV vaccination status (See Notes)				2nd RSV season for chronic lung disease (See Notes)			1 dose depending on maternal RSV vaccination status (See Notes)
Hepatitis B										
Rotavirus		SCID ^b								
DTaP/Tdap	DTaP Tdap: 1 dose each pregnancy									
Hib		HSCT: 3 doses	See Notes			See Notes				
Pneumococcal										
IPV										
COVID-19	See Notes	Additional doses may be necessary (See Notes)					See Notes			
Influenza inactivated		Solid organ transplant: 18yrs (See Notes)								
LAIV3							Asthma, wheezing: 2–4 years ^c			
MMR	•									
VAR	•									
Hepatitis A										
HPV	•	3-dose series (See Notes)								
MenACWY										
MenB										
RSV (Abrysvo)	Seasonal administration (See Notes)									
Dengue										
Mpox	See Notes									

Recommended for all age-eligible children who lack documentation of a complete vaccination series
Not recommended for all children, but recommended for some children based on increased risk for or severe outcomes from disease
Vaccination is based on shared clinical decision-making
Additional doses may be necessary based on medical condition or other indications. See Notes.
Precaution: Might be indicated if benefit of protection outweighs risk of adverse reaction
Contraindicated or not recommended
*Vaccinate after pregnancy, if indicated
No Guidance/Not Applicable

a. For additional information regarding HIV laboratory parameters and use of live vaccines, see the General Best Practice Guidelines for Immunization, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote J) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

b. Severe Combined Immunodeficiency

c. LAIV3 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2025.

Additional Information

- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥ 4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as “through.”
- Vaccine doses administered ≤ 4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥ 5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-2, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/immunz-best-practices/timing-spacing-immunobiologics.html.
- Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Barnett ED, Lynfield Ruth, Sawyer MH, eds. *Red Book: 2021–2024 Report of the Committee on Infectious Diseases*. 32nd ed. Itasca, IL: American Academy of Pediatrics; 2021:72–86).
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All vaccines included in the child and adolescent vaccine schedule are covered by VICP except dengue, PPSV23, RSV, Mpox and COVID-19 vaccines. Mpox and COVID-19 vaccines are covered by the Countermeasures Injury Compensation Program (CICP). For more information, see www.hrsa.gov/vaccinecompensation or www.hrsa.gov/cicp.

COVID-19 vaccination

(minimum age: 6 months [Spikevax], 5 years [Comirnaty], 12 years [mNexspike, Novavax])

Shared clinical decision-making

Vaccination based on individual-based decision-making—with an emphasis that the risk-benefit of vaccination is most favorable for individuals who are at an increased risk for severe COVID-19 disease and lowest for individuals who are not at an increased risk according to the CDC list of COVID-19 risk factors (see www.cdc.gov/covid/hcp/clinical-care/underlying-conditions.html). For additional information on shared clinical decision-making, see www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html.

Current COVID-19 schedule and dosage formulation available at www.cdc.gov/covidschedule.

Administer an age-appropriate COVID-19 vaccine product for each dose. There is no preferential recommendation for the use of one COVID-19 vaccine over another when more than one recommended age-appropriate vaccine is available.

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Dengue vaccination

(minimum age: 9 years)

Routine vaccination

- Age 9–16 years living in areas with endemic dengue **AND** have laboratory confirmation of previous dengue infection
 - 3-dose series administered at 0, 6, and 12 months
- Endemic areas include Puerto Rico, American Samoa, US Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau. For updated guidance on dengue endemic areas and pre-vaccination laboratory testing see www.cdc.gov/mmwr/volumes/70/rr/rr7006a1.htm?s_cid=rr7006a1_w and www.cdc.gov/dengue/index.html
- Dengue vaccine should not be administered to children traveling to or visiting endemic dengue areas.

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

Routine vaccination

- 5-dose series (3-dose primary series at age 2, 4, and 6 months, followed by booster doses at ages 15–18 months and 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

- Children younger than age 7 years with a contraindication specific to the pertussis component of DTaP:** May administer Td for all recommended remaining doses in place of DTaP. Encephalopathy within 7 days of vaccination when not attributable to another identifiable cause is the only contraindication specific to the pertussis component of DTaP. For additional information, see www.cdc.gov/pertussis/hcp/vaccine-recommendations/td-offlabel.html.
- Wound management in children younger 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.

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

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

Routine vaccination

- **ActHIB, Hiblrix, Pentacel, or Vaxelis:** 4-dose series (3-dose primary series at age 2, 4, and 6 months, followed by a booster dose* at age 12–15 months)
 - *Vaxelis is not recommended for use as a booster dose. A different Hib-containing vaccine should be used for the booster dose.
- **PedvaxHIB:** 3-dose series (2-dose primary series at age 2 and 4 months, followed by a booster dose at age 12–15 months)
- **American Indian and Alaska Native Infants:** Vaxelis and PedvaxHIB preferred over other Hib vaccines for the primary series.

Catch-up vaccination

- **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) at least 8 weeks after dose 2.
- **2 doses of PedvaxHIB before age 12 months:** Administer dose 3 (final dose) at age 12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 1 dose.
- **Previously unvaccinated children age 60 months or older who are not considered high risk:** Catch-up vaccination not required.

For other catch-up guidance, see Table 2. Vaxelis can be used for catch-up vaccination in children younger than age 5 years. Follow the catch-up schedule even if Vaxelis is used for one or more doses. For detailed information on use of Vaxelis see www.cdc.gov/mmwr/volumes/69/wr/mm6905a5.htm.

Special situations

• Chemotherapy or radiation treatment:

Age 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.

• Hematopoietic stem cell transplant (HSCT):

- 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history

• Anatomic or functional asplenia (including sickle cell disease):

Age 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated* persons age 5 years or older

- 1 dose

• Elective splenectomy:

Unvaccinated* persons age 15 months or older

- 1 dose (preferably at least 14 days before procedure)

• HIV Infection:

Age 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated* persons age 5–18 years

- 1 dose

• Immunoglobulin deficiency, early component complement deficiency, or early component complement inhibitor use:

Age 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

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

Hepatitis A vaccination

(minimum age: 12 months for routine vaccination)

Routine vaccination

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

Catch-up vaccination

- **Unvaccinated persons through age 18 years should complete a 2-dose series** (minimum interval: 6 months).

- Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.
- Adolescents age 18 years or older may receive HepA-HepB (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.

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Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Hepatitis B vaccination (minimum age: birth)

Routine vaccination

• **Mother is HBsAg-negative**

- 3-dose series at age 0, 1–2, 6–18 months (use monovalent HepB vaccine for doses administered before age 6 weeks)
- Birth weight $\geq 2,000$ grams: 1 dose within 24 hours of birth if medically stable
- Birth weight $< 2,000$ grams: 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still $< 2,000$ grams)
- Infants who did not receive a birth dose should begin the series as soon as possible (see Table 2 for minimum intervals).
- Administration of 4 doses is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum intervals (see Table 2):** when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations.
- **Final (3rd or 4th) dose:** age 6–18 months (minimum age 24 weeks)

• **Mother is HBsAg-positive**

- **Birth dose (monovalent HepB vaccine only):** administer HepB vaccine and hepatitis B Immune globulin (HBIG) in separate limbs within 12 hours of birth, regardless of birth weight.
- **Birth weight $< 2,000$ grams:** administer 3 additional doses of HepB vaccine beginning at age 1 month (total of 4 doses).
- **Final (3rd or 4th) dose:** administer at age 6 months (minimum age 24 weeks).
- Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.

• **Mother is HBsAg-unknown**

- If other evidence suggestive of maternal hepatitis B infection exists (e.g., presence of HBV DNA, HBeAg-positive, or mother known to have chronic hepatitis B infection), manage infant as if mother is HBsAg-positive.
- **Birth dose (monovalent HepB vaccine only):**
 - Birth weight $\geq 2,000$ grams: administer HepB vaccine within 12 hours of birth. Determine mother's HBsAg status as soon as possible. If mother is determined to be HBsAg-positive, administer HBIG as soon as possible (in separate limb), but no later than 7 days of age.

- Birth weight $< 2,000$ grams: administer HepB vaccine and HBIG (in separate limbs) within 12 hours of birth. Administer 3 additional doses of HepB vaccine beginning at age 1 month (total of 4 doses).
- **Final (3rd or 4th) dose:** administer at age 6 months (minimum age 24 weeks).
- If mother is determined to be HBsAg-positive or if status remains unknown, test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.

Catch-up vaccination

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months. See Table 2 for minimum intervals.
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombinax HB** only).
- Adolescents age 18 years may receive:
 - **HepBisav-B:** 2-dose series at least 4 weeks apart
 - **PreHevrio:** 3-dose series at 0, 1, and 6 months
 - **HepA-HepB (Twintrix):** 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

Special situations

- Revaccination is generally not recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Post-vaccination serology testing and revaccination** (if anti-HBs < 10 mIU/mL) is recommended for certain populations, including:
 - Infants born to HBsAg-positive mothers
 - Persons who are predialysis or on maintenance dialysis
 - Other immunocompromised persons
 - For detailed revaccination recommendations, see www.cdc.gov/mmwr/volumes/67/rr/rr6701a1.htm.

***Note:** PreHevrio is not recommended in pregnancy due to lack of safety data in pregnant women.

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)
- No additional dose recommended when any HPV vaccine series of **any valency** has been completed using recommended dosing intervals.

Special situations

- **Immunocompromising conditions, including HIV infection:** 3-dose series, even for those who initiate vaccination at age 9–14 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

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Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Influenza vaccination (minimum age: 6 months [IIV3], 2 years [LAIV3], 18 years [recombinant influenza vaccine, RIV3])

Routine vaccination

- Use any influenza vaccine appropriate for age and health status annually:
 - **Age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2024, or whose influenza vaccination history is unknown: 2 doses, separated by at least 4 weeks. Administer dose 2 even if the child turns 9 years between receipt of dose 1 and dose 2.
 - **Age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2024: 1 dose.
 - **Age 9 years or older:** 1 dose
 - **Age 18 years solid organ transplant recipients receiving immunosuppressive medications:** high-dose inactivated (HD-IIV3) and adjuvanted inactivated (aIIV3) influenza vaccines are acceptable options. No preference over other age-appropriate IIV3 or RIV3.
- For the 2024–25 season, see www.cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm.
- For the 2025–26 season, see the 2025–26 ACIP influenza vaccine recommendations.

Special situations

- **Close contacts (e.g., household contacts) of severely immunosuppressed persons who require a protected environment:** should not receive LAIV3. If LAIV3 is given, they should avoid contact with, or caring for such immunosuppressed persons for 7 days after vaccination.

Note: Persons with an egg allergy can receive any influenza vaccine (egg-based or non-egg based) appropriate for age and health status.

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

Catch-up vaccination

- **Unvaccinated children and adolescents:** 2-dose series at least 4 weeks apart*

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.*
- **Children age 12 months or older:**
 - Unvaccinated: 2-dose series (separated by at least 4 weeks*) before departure
 - Previously received 1 dose: administer dose 2 at least 4 weeks after dose 1*

• In mumps outbreak settings, for information about additional doses of MMR (including 3rd dose of MMR), see www.cdc.gov/mmwr/volumes/67/wr/mm6701a7.htm

***Note:** MMRV not recommended for ages 12–47 months or ages 13–18 years. Minimum interval between MMRV doses is 3 months.

Meningococcal serogroup A,C,W,Y vaccination (minimum age: 2 months [MenACWY-CRM, Menveo], 2 years [MenACWY-TT, MenQuadfi], 10 years [MenACWY-TT/MenB-FHbp, Penbraya])

Routine vaccination

- 2-dose series at age 11–12 years; 16 years

Catch-up vaccination

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

Special situations

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

• Menveo*

- Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6, and 12 months)
- Dose 1 at age 3–6 months: 3- or 4-dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
- Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
- Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

• MenQuadfi

- Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

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

• Children younger 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)

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Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Meningococcal serogroup A,C,W,Y vaccination

- continued

- **Children age 2 years or older:** 1 dose Menveo* 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* or MenQuadfi

Adolescent vaccination of children who received MenACWY prior to age 10 years:

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

*Menveo has two formulations: lyophilized and liquid. The liquid formulation should not be used before age 10 years. See www.cdc.gov/vaccines/vpd/mening/downloads/menveo-single-vial-presentation.pdf.

Note: For MenACWY booster dose recommendations for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Children age 10 years or older may receive a single dose of Penbraya as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day (see "Meningococcal serogroup B vaccination" section below for more information).

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

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 or Trumenba (use same brand for all doses):** 2-dose series at least 6 months apart (if dose 2 is administered earlier than 6 months, administer dose 3 at least 4 months after dose 2)

*To optimize rapid protection (e.g., for students starting college in less than 6 months), a 3-dose series (0, 1–2, 6 months) may be administered.

For additional information on shared clinical decision-making for MenB, see www.cdc.gov/vaccines/hcp/admin/downloads/isd-job-aid-scdm-mening-b-shared-clinical-decision-making.pdf

Special situations

Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use.

- **Bexsero or Trumenba (use same brand for all doses including booster doses)** 3-dose series at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed; if dose 3 is administered earlier than 4 months after dose 2, a 4th dose should be administered at least 4 months after dose 3)

For MenB booster dose recommendations for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Note: MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, if feasible.

Children age 10 years or older may receive a dose of Penbraya (MenACWY-TT/MenB-FHbp) as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day. For age-eligible children not at increased risk, if Penbraya is used for dose 1 MenB, MenB-FHbp (Trumenba) should be administered for dose 2 MenB. For age-eligible children at increased risk of meningococcal disease, Penbraya may be used for additional MenACWY and MenB doses (including booster doses) if both would be given on the same clinic day **and** at least 6 months have elapsed since most recent Penbraya dose.

Monkeypox virus vaccination (minimum age: 18 years [Jynneos])

Special situations

- **Age 18 years and at risk for monkeypox infection:** complete 2-dose series, 28 days apart.

Risk factors for monkeypox infection include:

- Gay, bisexual, or other MSM, or a person who has sex with gay, bisexual, or other MSM who in the past 6 months have had one of the following:
- A new diagnosis of at least 1 sexually transmitted disease
- More than 1 sex partner
- Sex at a commercial sex venue
- Sex in association with a large public event in a geographic area where monkeypox virus transmission is occurring
- Persons who are sexual partners of the persons described above
- Persons who anticipate experiencing any of the situations described above

- **Pregnancy:** There is currently no ACIP recommendation for Jynneos use in pregnancy due to lack of safety data in pregnant women. Pregnant women with any risk factor described above may receive Jynneos.

For detailed information, see www.cdc.gov/mpox/hcp/vaccine-considerations/vaccination-overview.html

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Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Pneumococcal vaccination

(minimum age: 6 weeks [PCV15], [PCV20]; 2 years [PPSV23])

Routine vaccination with PCV

- 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV

- Healthy children ages 2–4 years with any incomplete* PCV series: 1 dose PCV
- For other catch-up guidance, see Table 2.

Note: For children **without** risk conditions, PCV20 is not indicated if they have received 4 doses of PCV13 or PCV15 or another age appropriate complete PCV series.

Special situations

Children and adolescents with cerebrospinal fluid leak; chronic heart disease; chronic kidney disease (excluding maintenance dialysis and nephrotic syndrome); chronic liver disease; chronic lung disease (including moderate persistent or severe persistent asthma); cochlear implant; or diabetes mellitus:

Age 2–5 years

- Any incomplete* PCV series with:
 - 3 PCV doses: 1 dose PCV (at least 8 weeks after the most recent PCV dose)
 - Less than 3 PCV doses: 2 doses PCV (at least 8 weeks after the most recent dose and administered at least 8 weeks apart)
- Completed recommended PCV series but have not received PPSV23.
 - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
 - Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 administer at least 8 weeks after the most recent PCV dose.

Age 6–18 years

- Not previously received any dose of PCV13, PCV15, or PCV20: administer 1 dose of PCV15 or PCV20. If PCV15 is used and no previous receipt of PPSV23, administer 1 dose of PPSV23 at least 8 weeks after the PCV15 dose.**
- Received PCV before age 6 years but have not received PPSV23
 - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
 - Not previously received PCV20: 1 dose PCV20 or 1 dose PPSV23 administer at least 8 weeks after the most recent PCV dose.
- Received PCV13 only at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose.
- Received 1 dose PCV13 and 1 dose PPSV23 at or after age 6 years: no further doses of any PCV or PPSV23 indicated.

Children and adolescents on maintenance dialysis, or with immunocompromising conditions such as nephrotic syndrome; congenital or acquired asplenia or splenic dysfunction; congenital or acquired immunodeficiencies; diseases and conditions treated with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and solid organ transplant; HIV infection; or sickle cell disease or other hemoglobinopathies:

Age 2–5 years

- Any incomplete* PCV series:
 - 3 PCV doses: 1 dose PCV (at least 8 weeks after the most recent PCV dose)
 - Less than 3 PCV doses: 2 doses PCV (at least 8 weeks after the most recent dose and administered at least 8 weeks apart)
- Completed recommended PCV series but have not received PPSV23
 - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
 - Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV dose. If PPSV23 is used, administer 1 dose of PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.

Age 6–18 years

- Not previously received any dose of PCV13, PCV15, or PCV20: administer 1 dose of PCV15 or 1 dose of PCV20. If PCV15 is used and no previous receipt of PPSV23, administer 1 dose of PPSV23 at least 8 weeks after the PCV15 dose.**
- Received PCV before age 6 years but have not received PPSV23
 - Previously received at least 1 dose of PCV20: no additional dose of PCV or PPSV23
 - Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV dose. If PPSV23 is used, administer either PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.
- Received PCV13 only at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose. If PPSV23 is used, administer 1 dose of PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.
- Received 1 dose PCV13 and 1 dose PPSV23 at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose and at least 5 years after dose 1 PPSV23.

Pregnancy: no recommendation for PCV or PPSV23 due to limited data. Summary of existing data on pneumococcal vaccination during pregnancy can be found at www.cdc.gov/mmwr/volumes/72/rr/rr7203a1.htm

For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app, which can be downloaded here: wcm-wp.cdc.gov/pneumococcal/hcp/vaccine-recommendations/app.html

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series. See Table 2 in ACIP pneumococcal recommendations at stacks.cdc.gov/view/cdc/133252

***When both PCV15 and PPSV23 are indicated, administer all doses of PCV15 first. PCV15 and PPSV23 should not be administered during the same visit.*

Notes

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

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.
- **Adolescents age 18 years known or suspected to be unvaccinated or incompletely vaccinated:** administer remaining doses (1, 2, or 3 IPV doses) to complete a 3-dose primary series.* Unless there are specific reasons to believe they were not vaccinated, most persons aged 18 years or older born and raised in the United States can assume they were vaccinated against polio as children.

Series containing oral poliovirus 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.

Special situations

- **Adolescents aged 18 years at increased risk of exposure to poliovirus and completed primary series*:** may administer one lifetime IPV booster

***Note:** Complete primary series consist of at least 3 doses of IPV or trivalent oral poliovirus vaccine (tOPV) in any combination.

For detailed information, see: www.cdc.gov/vaccines/vpd/polio/hcp/recommendations.html

Respiratory syncytial virus immunization (minimum age: birth [Nirsevimab, RSV-mAb, Beyfortus])

Routine immunization

• Infants born October – March in most of the continental United States*

- Mother did not receive RSV vaccine or mother's RSV vaccination status is unknown or mother received RSV vaccine in previous pregnancy: administer 1 dose nirsevimab within 1 week of birth—ideally during the birth hospitalization.
- Mother received RSV vaccine **less than 14 days** prior to delivery: administer 1 dose nirsevimab within 1 week of birth—ideally during the birth hospitalization.
- Mother received RSV vaccine **at least 14 days** prior to delivery: nirsevimab not needed but can be considered in rare circumstances at the discretion of healthcare providers (see www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html)

• Infants born April–September in most of the continental United States*

- Mother did not receive RSV vaccine or mother's RSV vaccination status is unknown or mother received RSV vaccine in previous pregnancy: administer 1 dose nirsevimab shortly before start of RSV season.*
- Mother received RSV vaccine **less than 14 days** prior to delivery: administer 1 dose nirsevimab shortly before start of RSV season.*
- Mother received RSV vaccine **at least 14 days** prior to delivery: nirsevimab not needed but can be considered in rare circumstances at the discretion of healthcare providers (see www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html)

Infants with prolonged birth hospitalization** (e.g., for prematurity) discharged October through March should be immunized shortly before or promptly after discharge.

Special situations

- **Ages 8–19 months with chronic lung disease of prematurity requiring medical support (e.g., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) any time during the 6-month period before the start of the second RSV season; severe immunocompromise; cystic fibrosis with either weight for length <10th percentile or manifestation of severe lung disease (e.g., previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable)**:**
 - 1 dose nirsevimab shortly before start of second RSV season*
- **Ages 8–19 months who are American Indian or Alaska Native:** 1 dose nirsevimab shortly before start of second RSV season*
- **Age-eligible and undergoing cardiac surgery with cardiopulmonary bypass**:** 1 additional dose of nirsevimab after surgery. See www.accessdata.fda.gov/drugsatfda_docs/label/2023/761328s0001bl.pdf

***Note:** While the timing of the onset and duration of RSV season may vary, administration of nirsevimab is recommended October through March in most of the continental United States (optimally October through November or within 1 week of birth). Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdiction with tropical climate) should follow guidance from public health authorities (e.g., CDC, health departments) or regional medical centers on timing of administration based on local RSV seasonality.

****Note:** Nirsevimab can be administered to children who are eligible to receive palivizumab. Children who have received nirsevimab should not receive palivizumab for the same RSV season.

For further guidance, see www.cdc.gov/mmwr/volumes/72/wr/mm7234a4.htm and www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html

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Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Respiratory syncytial virus vaccination (RSV [Abrysvo])

Routine vaccination

• **Pregnant at 32 weeks 0 days through 36 weeks and 6 days gestation from September through January in most of the continental United States*:** 1 dose Abrysvo. Administer RSV vaccine regardless of previous RSV infection.

- Either maternal RSV vaccination with Abrysvo or infant immunization with nirsevimab (RSV monoclonal antibody) is recommended to prevent severe respiratory syncytial virus disease in infants.

• **All other pregnant women:** RSV vaccine not recommended

• **Subsequent pregnancies:** additional doses not recommended. No data are available to inform whether additional doses are needed in subsequent pregnancies. Infants born to pregnant women who received RSV vaccine during a previous pregnancy should receive nirsevimab.

***Note:** Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdictions with tropical climate) should follow guidance from public health authorities (e.g., CDC, health departments) or regional medical centers on timing of administration based on local RSV seasonality.

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

• **Age 11–12 years:** 1 dose Tdap (adolescent booster)

• **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36

Note: Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination

• **Age 13–18 years who have not received Tdap:** 1 dose Tdap (adolescent booster)

• **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:**

- **Age 7–9 years** who receive Tdap should receive the adolescent Tdap booster dose at age 11–12 years

- **Age 10 years** who receive Tdap do not need the adolescent Tdap booster dose at age 11–12 years

• **DTaP inadvertently administered on or after age 7 years:**

- **Age 7–9 years:** DTaP may count as part of catch-up series. Administer adolescent Tdap booster dose at age 11–12 years.

- **Age 10–18 years:** Count dose of DTaP as the adolescent Tdap booster dose.

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

Special situations

• **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.

• For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm.

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

Varicella vaccination (minimum age: 12 months)

Routine vaccination

• 2-dose series at age 12–15 months, 4–6 years

- 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).

Catch-up vaccination

• Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have a 2-dose series:

- **Age 7–12 years:** Routine interval: 3 months (a dose inadvertently administered after at least 4 weeks may be counted as valid)

- **Age 13 years and older:** Routine interval: 4–8 weeks (minimum interval: 4 weeks)

Note: MMRV not recommended for ages 12–47 months or ages 13–18 years (administer MMR and varicella vaccines separately for these age groups). Minimum interval between MMRV doses is 3 months.

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Appendix

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

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, Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices—United States, 2024–25 Influenza Season | MMWR (cdc.gov), and Contraindications and Precautions for COVID-19 Vaccination

Vaccines and other Immunizing Agents	Contraindicated or Not Recommended ¹	Precautions ²
COVID-19 mRNA vaccines (Comirnaty, mRNA Spikevax)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of an mRNA COVID-19 vaccine ³	• Diagnosed non-severe allergy (e.g., urticaria beyond the injection site) to a component of an mRNA COVID-19 vaccine³; or non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of an mRNA COVID-19 vaccine • Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine • Multisystem inflammatory syndrome in children (MIS-C) or multisystem inflammatory syndrome in adults (MIS-A) • Moderate or severe acute illness, with or without fever
COVID-19 protein subunit vaccine (Nuvaxovid)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of a Nuvaxovid ³	• Diagnosed non-severe allergy (e.g., urticaria beyond the injection site) to a component of Nuvaxovid³; or non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of a Nuvaxovid • Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine • Multisystem inflammatory syndrome in children (MIS-C) or multisystem inflammatory syndrome in adults (MIS-A) • Moderate or severe acute illness, with or without fever
Influenza, egg-based, inactivated injectable (IIV3)	• 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)	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable (ccIIV3) (Flucelvax)	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component ³ of ccIIV3	• 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 ccIIV3, 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 (RIV3) (Flublok)	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component ³ of RIV3	• 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 RIV3, 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 (LAIV3) (Flumist)	• 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) • Children age 2–4 years with a history of asthma or wheezing • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear or any other cranial CSF leak • Children and adolescents receiving aspirin or salicylate-containing medications • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons age 5 years old or older • Persons with underlying medical conditions other than those listed under contraindications that might predispose to complications after wild-type influenza virus infection, e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus) • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should **NOT** be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization.

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.

3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. See Package inserts for U.S.-licensed vaccines.

Appendix

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Vaccines and other Immunizing Agents	Contraindicated or Not Recommended ¹	Precautions ²
Dengue (DENACYD)	- 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) - Lack of laboratory confirmation of a previous dengue infection	- Pregnancy - HIV infection without evidence of severe immunosuppression - Moderate or severe acute illness with or without fever
Diphtheria, tetanus, pertussis (DTaP)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP or DTaP	- Guillain-Barré syndrome (GBS) within 6 weeks after previous dose of tetanus-toxoid-containing vaccine - History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid-containing or tetanus-toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid-containing vaccine - For DTaP only: Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP until neurologic status clarified and stabilized - Moderate or severe acute illness with or without fever
<i>Haemophilus influenzae</i> type b (Hib)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Younger than age 6 weeks	Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ including neomycin	Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ including yeast - Pregnancy: PreHevBrio is not recommended due to lack of safety data in pregnant women. Use other hepatitis B vaccines if HepB is indicated⁴	Moderate or severe acute illness with or without fever
Hepatitis A-Hepatitis B vaccine (HepA-HepB) [Twinrix]	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ including neomycin and yeast	Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Pregnancy: HPV vaccination not recommended	Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR) Measles, mumps, rubella, and varicella (MMRV)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine 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 - For MMRV only: HIV infection of any severity and children younger than age 4 years	- Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) - History of thrombocytopenia or thrombocytopenic purpura - Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing - Moderate or severe acute illness with or without fever - For MMRV only: Personal or family (i.e., sibling or parent) history of seizures of any etiology - If using MMRV, see Varicella/MMRV for additional precautions
Meningococcal ACWY (MenACWY) MenACWY-CRM (Menveo) MenACWY-TT (MenQuadri)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - For MenACWY-CRM only: severe allergic reaction to any diphtheria toxin— or CRM197—containing vaccine - For MenACWY-TT only: severe allergic reaction to a tetanus toxin-containing vaccine	- For MenACWY-CRM only: Preterm birth if younger than age 9 months - Moderate or severe acute illness with or without fever
Meningococcal B (MenB) MenB-4C (Bexsero) MenB-FHbp (Trumenb)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³	- Pregnancy - For MenB-4C only: Latex sensitivity - Moderate or severe acute illness with or without fever
Meningococcal ABCWY (MenACWY-TT/MenB-FHbp) [Penbraya]	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Severe allergic reaction to a tetanus toxin-containing vaccine	Moderate or severe acute illness, with or without fever
Mpox [Jynneos]	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³	Moderate or severe acute illness, with or without fever
Pneumococcal conjugate (PCV)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxin-containing vaccine or its component³	Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³	Moderate or severe acute illness with or without fever
Poliovirus vaccine, inactivated (IPV)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³	- Pregnancy - Moderate or severe acute illness with or without fever
RSV monoclonal antibody (RSV-mAb)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³	Moderate or severe acute illness with or without fever
Respiratory syncytial virus vaccine (RSV)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³	Moderate or severe acute illness with or without fever
Rotavirus (RV) RV1 (Rotarix) RV5 (RotaTeq)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component³ - Severe combined immunodeficiency (SCID) - History of intussusception	- Altered immunocompetence other than SCID - Chronic gastrointestinal disease - RV1 only: Spina bifida or bladder exstrophy - Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	- Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine 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	- Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid-containing vaccine - History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid-containing or tetanus-toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid-containing vaccine - For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized - Moderate or severe acute illness with or without fever
Varicella (VAR) Measles, mumps, rubella, and varicella (MMRV)	- 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 - For MMRV only: HIV infection of any severity and children younger than age 4 years	- Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) - Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) - Use of aspirin or aspirin-containing products - Moderate or severe acute illness with or without fever - If using MMRV, see MMR/MMRV for additional precautions

- 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.
- For information on the pregnancy exposure registry for persons who were inadvertently vaccinated with PreHevBrio while pregnant, please visit www.prehevbrio.com/safety.
- Full prescribing information for BEYFORTUS (nirsevimab-alip) www.accessdata.fda.gov/drugsatfda_docs/label/2023/761328s000lbl.pdf.

Addendum

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

In addition to the recommendations presented in the previous sections of this immunization schedule, ACIP has approved the following recommendations by majority vote since October 24, 2024.

Vaccines	Recommendations	Effective Date of Recommendation*
Meningococcal (MenACWYCRM/ MenB-4C, Penmenvyr)	MenABCWY vaccine may be used when both MenACWY and MenB are indicated at the same visit in: 1. healthy persons aged 16–23 years (routine schedule) when shared clinical decision-making favors administration of MenB vaccine and 2. persons aged ≥ 10 years who are at increased risk for meningococcal disease (e.g., because of persistent complement deficiencies, complement inhibitor use, or functional or anatomic asplenia)	June 25, 2025
Influenza	ACIP reaffirms the recommendations for routine annual influenza vaccination of all persons aged ≥ 6 months who do not have contraindications for the 2025–2026 season	July 22, 2025
Influenza	ACIP recommends only single-dose formulations of annual influenza vaccines that are free of thimerosal as a preservative for three populations: - Children 18 years or younger - Pregnant women - All adults	July 22, 2025
RSV monoclonal antibody (Clesrovimab)	ACIP recommends infants aged < 8 months born during or entering their first RSV season who are not protected by maternal vaccination receive one dose of clesrovimab.	August 4, 2025
Note: As of May 29, 2025, the schedule incorporates the HHS directive regarding COVID-19 vaccine recommendations. (Changes were made to tables and notes for COVID-19 vaccines in pregnant women and children/adolescents ages 6 months through 17 years who are not moderately or severely immunocompromised).		

*The effective date is the date when the recommendation was adopted and became official.

B. Figures 1 and 2: Recommended Immunization Schedule for Adults Aged 19 Years or Older, United States, (Addendum updated August 7, 2025)

Citation:

Adult Immunization Schedule, Comprehensive Version

<https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf>

Recommended Adult Immunization Schedule for Ages 19 Years or Older

UNITED STATES
2025

Vaccines in the Adult Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
COVID-19 vaccine	1vCOV-mRNA 1vCOV-aPS	Comirnaty, mNexspike, Spikevax Nuvaxovid
<i>Haemophilus influenzae</i> type b vaccine	Hib	ActHIB, Hibberix, PedvaxHIB
Hepatitis A vaccine	HepA	Havrix, Vaqta
Hepatitis A and hepatitis B vaccine	HepA-HepB	Twinrix
Hepatitis B vaccine	HepB	Engerix-B, Heplisav-B, PreHevbrio, Recombivax HB
Human papillomavirus vaccine	HPV	Gardasil 9
Influenza vaccine (inactivated, egg-based)	IIV3 aIIV3 HD-IIV3	Multiple Fluad Fluzone High-Dose
Influenza vaccine (inactivated, cell-culture)	ccIIV3	Flucelvax
Influenza vaccine (recombinant)	RIV3	Flublok
Influenza vaccine (live, attenuated)	LAIV3	FluMist
Measles, mumps, and rubella vaccine	MMR	M-M-R II, Priorix
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-CRM MenACWY-TT	Menveo MenQuadfi
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero Trumenba
Meningococcal serogroup A, B, C, W, Y vaccine	MenACWY-TT/ MenB-FHbp	Penbraya
Monkeypox vaccine	Mpox	Jynneos
Pneumococcal conjugate vaccine	PCV15 PCV20 PCV21	Vaxneuvance Prevnar 20 Capvaxive
Pneumococcal polysaccharide vaccine	PPSV23	Pneumovax 23
Poliovirus vaccine (inactivated)	IPV	Ipol
Respiratory syncytial virus vaccine	RSV	Abrysvo, Arexvy, mResvia
Tetanus and diphtheria vaccine	Td	Tenivac
Tetanus, diphtheria, 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 ACIP or CDC.

Revised October 07, 2025

How to use the adult immunization schedule

- 1 Determine recommended vaccinations by age (**Table 1**)
- 2 Assess need for additional recommended vaccinations by medical condition or other indication (**Table 2**)
- 3 Review vaccine types, dosing frequencies and intervals, and considerations for special situations (**Notes**)
- 4 Review contraindications and precautions for vaccine types (**Appendix**)
- 5 Review new or updated ACIP guidance (**Addendum**)

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to the local or state health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System 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/hcp/immunization-schedules/app.html.

Helpful information

- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/acip-recs/hcp/vaccine-specific/
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html
- General Best Practice Guidelines for Immunization: www.cdc.gov/vaccines/hcp/immunization-best-practices/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/surv-manual/php/index.html



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Table 1 Recommended Adult Immunization Schedule by Age Group, United States, 2025

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years	
COVID–19	1 or more doses of 2025–2026 vaccine (See Notes)			2 or more doses of 2025–2026 vaccine (See Notes)	
Influenza inactivated (IIV3, ccIIV3) Influenza recombinant (RIV3)	1 dose annually			1 dose annually (HD–IIV3, RIV3, or aIIV3 preferred)	
Influenza inactivated (aIIV3; HD–IIV3) Influenza recombinant (RIV3)	Solid organ transplant (See Notes)				
Influenza live, attenuated (LAIV3)	1 dose annually				
Respiratory syncytial virus (RSV)	Seasonal administration during pregnancy (See Notes)			60–74 years (See Notes)	≥75 years
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management (See Notes)				
	1 dose Tdap, then Td or Tdap booster every 10 years				
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (If born in 1957 or later)			For health care personnel (See Notes)	
Varicella (VAR)	2 doses (if born in 1980 or later)		2 doses		
Zoster recombinant (RZV)	2 doses for immunocompromising conditions (See Notes)		2 doses		
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27–45 years			
Pneumococcal (PCV15, PCV20, PCV21, PPSV23)			See Notes		
			See Notes		
Hepatitis A (HepA)	2, 3, or 4 doses depending on vaccine				
Hepatitis B (HepB)	2, 3, or 4 doses depending on vaccine or condition				
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication (See Notes for booster recommendations)				
Meningococcal B (MenB)	2 or 3 doses depending on vaccine and indication (See Notes for booster recommendations)				
	19–23 years				
Haemophilus influenzae type b (Hib)	1 or 3 doses depending on indication				
Mpox	2 doses				
Inactivated poliovirus (IPV)	Complete 3-dose series if incompletely vaccinated. Self-report of previous doses acceptable (See Notes)				

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

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

Vaccination is based on shared clinical decision-making

No Guidance/
Not Applicable

Table 2 Recommended Adult Immunization Schedule by Medical Condition or Other Indication, United States, 2025

Always use this table in conjunction with Table 1 and the Notes that follow. Medical conditions or indications are often not mutually exclusive. If multiple medical conditions or indications are present, refer to guidance in all relevant columns. See Notes for medical conditions or indications not listed.

VACCINE	Pregnancy	Immunocompromised (excluding HIV infection)	HIV infection CD4 percentage and count		Men who have sex with men	Asplenia, complement deficiency	Heart or lung disease	Kidney failure, End-stage renal disease or on dialysis	Chronic liver disease; alcoholism ^a	Diabetes	Health care Personnel ^b	
			<15% or <200/mm ³	≥15% and ≥200/mm ³								
COVID-19	See Notes	Additional doses may be necessary (See Notes)		See Notes								
Influenza inactivated Influenza recombinant		Solid organ transplant (See Notes)	1 dose annually									
LAIV3				1 dose annually if age 19–49 years		1 dose annually if age 19–49 years						
RSV	Seasonal administration (See Notes)	See Notes			See Notes				Liver disease (See Notes)	See Notes		
Tdap or Td	Tdap: 1 dose each pregnancy	1 dose Tdap, then Td or Tdap booster every 10 years										
MMR	*											
VAR	*		See Notes									
RZV		See Notes										
HPV	*	3-dose series if indicated										
Pneumococcal												
HepA												
Hep B	See Notes									Age ≥ 60 years		
MenACWY												
MenB												
Hib		HSCT: 3 doses ^c			Asplenia: 1 dose							
Mpox	See Notes			See Notes							See Notes	
IPV		Complete 3-dose series if incompletely vaccinated. Self-report of previous doses acceptable (See Notes)										
Recommended for all adults who lack documentation of vaccination, OR lack evidence of immunity		Not recommended for all adults, but recommended for some adults based on either age OR increased risk for or severe outcomes from disease		Vaccination is based on shared clinical decision-making		Additional doses may be necessary based on medical condition or other indications. See Notes.		Precaution: Might be indicated if benefit of protection outweighs risk of adverse reaction		Contraindicated or not recommended ^a Vaccinate after pregnancy, if indicated		No Guidance/ Not Applicable

a. Precaution for LAIV3 does not apply to alcoholism.

b. See Notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations.

c. Hematopoietic stem cell transplant.

Notes

Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

For vaccination recommendations for persons ages 18 years or younger, see the Recommended Child and Adolescent Immunization Schedule, 2025: www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html

Additional Information

- 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. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3–2, Recommended and minimum ages and intervals between vaccine doses, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8–1, Vaccination of persons with primary and secondary immunodeficiencies, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All vaccines included in the adult immunization schedule except PPSV23, RSV, RZV, Mpox, and COVID–19 vaccines are covered by the National Vaccine Injury Compensation Program (VICP). Mpox and COVID–19 vaccines are covered by the Countermeasures Injury Compensation Program (CICP). For more information, see www.hrsa.gov/vaccinecompensation or www.hrsa.gov/cicp.

COVID–19 vaccination

Shared clinical decision-making

Vaccination based on individual-based decision-making—with an emphasis that the risk-benefit of vaccination is most favorable for individuals who are at an increased risk for severe COVID-19 disease and lowest for individuals who are not at an increased risk according to the CDC list of COVID-19 risk factors (see www.cdc.gov/covid/hcp/clinical-care/underlying-conditions.html). For additional information on shared clinical decision-making, see www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html

Current COVID-19 schedule and dosage formulation available at www.cdc.gov/covidschedule.

Administer an age-appropriate COVID-19 vaccine product for each dose. There is no preferential recommendation for the use of one COVID-19 vaccine over another when more than one recommended age-appropriate vaccine is available.

Haemophilus influenzae type b vaccination

Special situations

- **Anatomical or functional asplenia (including sickle cell disease):** 1 dose if previously did not receive Hib vaccine
- **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

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Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Hepatitis A vaccination

Routine vaccination

- **Any person who is not fully vaccinated and requests vaccination** (identification of risk factor not required): complete 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

- **Any person who is not fully vaccinated and who is at risk for hepatitis A virus infection or severe disease from hepatitis A virus infection:** complete 2-dose series HepA or 3-dose series HepA–HepB as above. Risk factors include:
 - **Chronic liver disease** including 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: dose 1 as soon as adoption is planned; preferably 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 setting serving persons who use injection or noninjection drugs, or group homes and nonresidential day care facilities for developmentally disabled persons (individual risk factor screening not required)

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Hepatitis B vaccination

Routine vaccination

- **Age 19–59 years:** complete a 2- or 3- or 4-dose series
 - 2-dose series only applies when 2 doses of Heplisav–B are used at least 4 weeks apart
 - 3-dose series Engerix–B, PreHevbrio*, or Recombivax HB at 0, 1, 6 months (minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 8 weeks; dose 1 to dose 3 = 16 weeks)
 - 3-dose series HepA–HepB (Twinrix) at 0, 1, 6 months (minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 5 months)
 - 4-dose series HepA–HepB (Twinrix) accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months
- ***Note:** PreHevbrio is not recommended in pregnancy due to lack of safety data in pregnant women.
- **Age 60 years or older without known risk factors** for hepatitis B virus infection **may** receive a HepB vaccine series.
- **Age 60 years or older with known risk factors** for hepatitis B virus infection **should** receive a HepB vaccine series.
- **Any adult age 60 years of age or older** who requests HepB vaccination **should** receive a HepB vaccine series.
- **Risk factors for hepatitis B virus infection include:**
 - **Chronic liver disease** including persons with 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**
 - **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

Notes

Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Hepatitis B vaccination - continued

- **Current or recent injection drug use**
- **Percutaneous or mucosal risk for exposure to blood** e.g., household contacts of HBsAg-positive persons, residents and staff of facilities for developmentally disabled persons, health care and public safety personnel with reasonably anticipated risk for exposure to blood or blood-contaminated body fluids, persons on maintenance dialysis (including in-center or home hemodialysis and peritoneal dialysis), persons who are predialysis, and patients with diabetes**
- **Incarceration**
- **Travel in countries with high or intermediate endemic hepatitis B**

****Age 60 years or older with diabetes:** Based on shared clinical decision making, 2-, 3-, or 4-dose series as above.

Special situations

- **Patients on dialysis:** complete a 3- or 4-dose series
 - 3-dose series Recombivax HB at 0, 1, 6 months (Note: Use Dialysis Formulation 1 mL = 40 mcg)
 - 4-dose series Engerix-B at 0, 1, 2, and 6 months (Note: Use 2 mL dose instead of the normal adult dose of 1 mL)
- **Age 20 years or older with an immunocompromising condition:** complete a 2- or 3- or 4-dose series.
 - 3-dose series Recombivax HB at 0, 1, 6 months (Note: Use Dialysis Formulation 1 mL = 40 mcg)
 - 4-dose series Engerix-B at 0, 1, 2, and 6 months (Note: Use 2 mL dose instead of the normal adult dose of 1 mL)
 - 2-doses series Heplisav-B at 0, 1 months
 - 3-dose series PreHevbrio* at 0, 1, 6 months

Human papillomavirus vaccination

Routine vaccination

- **All persons through age 26 years:** complete 2- or 3-dose series depending on age at initial vaccination or condition.
- **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
- **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)

- No additional dose recommended when any HPV vaccine series of any valency has been completed using the recommended dosing intervals.

Shared clinical decision-making

- **Adults age 27–45 years:** Based on shared clinical decision-making, complete a 2-dose series (if initiated age 9–14 years) or 3-dose series (if initiated ≥15 years).

For additional information on shared clinical decision-making for HPV; see www.cdc.gov/vaccines/hcp/admin/downloads/isd-job-aid-scdm-hpv-shared-clinical-decision-making-hpv.pdf

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:** complete 3-dose series, even for those who initiate vaccination at age 9–14 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
- **Solid organ transplant recipients aged 19–64 years receiving immunosuppressive medications:** HD-IIV3 and aIIV3 are acceptable options. No preference over other age-appropriate IIV3 or RIV3.
- **Age 65 years or older:** Any one of HD-IIV3, RIV3, or aIIV3 is preferred. If none of these three vaccines is available, then any other age-appropriate influenza vaccine should be used.
- For the 2024–25 season, see www.cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm
- For the 2025–26 season, see the 2025–26 ACIP influenza vaccine recommendations.

Special situations

- **Close contacts (e.g., caregivers, healthcare workers) of severely immunosuppressed persons who require a protected environment:** should not receive LAIV3. If LAIV3 is given, they should avoid contact with/caring for such immunosuppressed persons for 7 days after vaccination.

Note: Persons with an egg allergy can receive any influenza vaccine (egg-based or non-egg based) appropriate for age and health status.

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Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Measles, mumps, and rubella vaccination

Routine vaccination

- **No evidence of immunity to measles, mumps, or rubella:** 1 dose
- **Evidence of immunity:** Born before 1957 (except for 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:** complete 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:** complete 2-dose series at least 4 weeks apart if previously did not receive any doses of MMR or 1 dose if previously received 1 dose MMR
- **In mumps outbreak settings,** for information about additional doses of MMR (including 3rd dose of MMR), see www.cdc.gov/mmwr/volumes/67/wr/mm6701a7.htm

Health care personnel:

- **Born before 1957 with no evidence of immunity to measles, mumps, or rubella:** Consider 2-dose series at least 4 weeks apart for protection against measles or mumps or 1 dose for protection against rubella.
- **Born in 1957 or later with no evidence of immunity to measles, mumps, or rubella:** complete 2-dose series at least 4 weeks apart for protection against measles or mumps or at least 1 dose for protection against rubella.

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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 primary series Menveo or MenQuadfi at least 8 weeks apart; 1 booster dose 5 years after primary series and every 5 years if risk remains
- **Travel in countries with hyperendemic or epidemic meningococcal disease, or for microbiologists routinely exposed to *Neisseria meningitidis*:** 1 dose Menveo or MenQuadfi; 1 booster dose 5 years after primary series and 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 Menveo or MenQuadfi

For MenACWY recommendations in outbreak setting (e.g., in community or organizational settings, or among men who have sex with men) and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Shared clinical decision-making for MenB

- **Adolescents and young adults age 16–23 years (age 16–18 years preferred)* not at increased risk for meningococcal disease:** based on shared clinical decision-making
- **Bexsero or Trumenba (use same brand for all doses):** 2-dose series at least 6 months apart (if dose 2 is administered earlier than 6 months, administer dose 3 at least 4 months after dose 2)

*To optimize rapid protection (e.g., for students starting college in less than 6 months), a 3-dose series (0, 1–2, 6 months) may be administered.

For additional information on shared clinical decision-making for MenB, see www.cdc.gov/vaccines/media/pdfs/2025/03/2024-isd-job-aid-scdm-menb-508-remediated.pdf

Notes

Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Meningococcal vaccination - continued

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***.
- **Bexsero or Trumenba** (use same brand for all doses including booster doses): 3-dose primary series at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed; if dose 3 is administered earlier than 4 months after dose 2, a 4th dose should be administered at least 4 months after dose 3).
- **Booster doses:** 1 booster dose one year after primary series and every 2–3 years if risk remains
- **Pregnancy:** Delay MenB until after pregnancy due to lack of safety data in pregnant women. May administer if at increased risk and vaccination benefits outweigh potential risks.

For MenB recommendations in outbreak setting (e.g., in community or organizational settings, or among men who have sex with men) and **additional meningococcal vaccination** information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Note: MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, if feasible.

Adults may receive a single dose of Penbraya (MenACWY-TT/MenB-FHbp) as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day. For adults not at increased risk, if Penbraya is used for dose 1 MenB, then MenB-FHbp (Trumenba) should be administered for dose 2 MenB. For adults at increased risk of meningococcal disease, Penbraya may be used for additional MenACWY and MenB doses (including booster doses) if both would be given on the same clinic day **and** at least 6 months have elapsed since most recent Penbraya dose.

Monkeypox virus vaccination

Special situations

- **Any person at risk for monkeypox infection:** complete 2-dose series, 28 days apart.
 - Risk factors for monkeypox infection include:**
 - Gay, bisexual, or other MSM, or a person who has sex with gay, bisexual, or other MSM who in the past 6 months have had one of the following:
 - A new diagnosis of at least 1 sexually transmitted disease
 - More than 1 sex partner
 - Sex at a commercial sex venue
 - Sex in association with a large public event in a geographic area where monkeypox virus transmission is occurring
 - Persons who are sexual partners of the persons described above
 - Persons who anticipate experiencing any of the situations described above
 - **Pregnancy:** There is currently no ACIP recommendation for Jynneos use in pregnancy due to lack of safety data in pregnant women. Pregnant women with any risk factor described above may receive Jynneos.
 - **Health care personnel:** Vaccination to protect against occupational risk in healthcare settings is not routinely recommended.
- For detailed information, see www.cdc.gov/mpox/hcp/vaccine-considerations/vaccination-overview.html.

Pneumococcal vaccination

Routine vaccination

- **Age 50 years or older who have:**
 - **Not previously received a dose of PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown:** 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21
 - If PCV15 is used, administer 1 dose PPSV23 at least 1 year after the PCV15 dose (may use minimum interval of 8 weeks for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak).
 - **Previously received only PCV7:** follow the recommendation above.
 - **Previously received only PCV13:** 1 dose PCV20 or 1 dose PCV21 at least 1 year after the last PCV13 dose
 - **Previously received only PPSV23:** 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21, at least 1 year after the last PPSV23 dose.
 - If PCV15 is used, no additional PPSV23 doses are recommended.
 - **Previously received both PCV13 and PPSV23 but NO PPSV23 was received at age 65 years or older:** 1 dose PCV20 or 1 dose PCV21 at least 5 years after the last pneumococcal vaccine dose.
 - **Previously received both PCV13 and PPSV23, AND PPSV23 was received at age 65 years or older:** Based on shared clinical decision-making, 1 dose of PCV20 or 1 dose of PCV21 at least 5 years after the last pneumococcal vaccine dose.

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Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Pneumococcal vaccination - continued

Special situations

- **Age 19–49 years with certain underlying medical conditions or other risk factors** who have:**
 - **Not previously received a PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown:** 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21
 - If PCV15 is used, administer 1 dose PPSV23 at least 1 year after the PCV15 dose (may use minimum interval of 8 weeks for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak).
 - **Previously received only PCV7:** follow the recommendation above.
 - **Previously received only PCV13:** 1 dose PCV20 or 1 dose PCV21 at least 1 year after the last PCV13 dose
 - **Previously received only PPSV23:** 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21, at least 1 year after the last PPSV23 dose.
 - If PCV15 is used, no additional PPSV23 doses are recommended.
 - **Previously received PCV13 and 1 dose of PPSV23:**
 - Cochlear implant, cerebrospinal fluid leak, or an immunocompromising condition*: 1 dose PCV20 or 1 dose PCV21 at least 5 years after the last pneumococcal vaccine dose.
 - Alcoholism, chronic heart/liver/lung disease, cigarette smoking, or diabetes mellitus: no additional PCV or PPSV23 doses recommended at this time. Review pneumococcal recommendations when age 50 years or older.

Adults aged 19 years and older who have received PCV20 or PCV21: no additional pneumococcal vaccine dose recommended.

Pregnancy: no recommendation for PCV or PPSV23 due to limited data. Summary of existing data on pneumococcal vaccination during pregnancy can be found at www.cdc.gov/mmwr/volumes/72/rr/rr7203a1.htm.

PPSV23 not available: adults aged 19 years or older who received PCV15 but have not yet completed PPSV23 series, can complete the series with either 1 dose of PCV20 or 1 dose of PCV21 if they no longer have access to PPSV23.

For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app which can be downloaded here: www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/app.html.

***Note:** Immunocompromising conditions include chronic renal failure, nephrotic syndrome, immunodeficiencies, iatrogenic immunosuppression, generalized malignancy, HIV infection, Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplant, congenital or acquired asplenia, or 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 infection, Hodgkin disease, immunodeficiencies, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplant, or sickle cell disease or other hemoglobinopathies.

Poliovirus vaccination

Routine vaccination

- **Adults known or suspected to be unvaccinated or incompletely vaccinated:** administer remaining doses (1, 2, or 3 IPV doses) to complete a 3-dose primary series.* Unless there are specific reasons to believe they were not vaccinated, most adults who were born and raised in the United States can assume they were vaccinated against polio as children.

Special situations

- **Adults at increased risk for exposure to poliovirus who completed primary series*:** may administer one lifetime IPV booster.

***Note:** Complete primary series consists of at least 3 doses of IPV or trivalent oral poliovirus vaccine (tOPV) in any combination.

For detailed information, see www.cdc.gov/vaccines/vpd/polio/hcp/recommendations.html

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Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Respiratory syncytial virus vaccination

Routine vaccination

• Pregnant women of any age:

- **Pregnant at 32 weeks 0 days through 36 weeks and 6 days gestation from September through January in most of the continental United States*:** 1 dose **Abrysvo**. Administer RSV vaccine regardless of previous RSV infection.
- Either maternal RSV vaccination with Abrysvo or infant immunization with nirsevimab (RSV monoclonal antibody) is recommended to prevent severe respiratory syncytial virus disease in infants.
- **All other pregnant women:** RSV vaccine not recommended
- **Subsequent pregnancies:** additional doses not recommended. No data are available to inform whether additional doses are needed in subsequent pregnancies. Infants born to pregnant women who received RSV vaccine during a previous pregnancy should receive nirsevimab.

***Note:** Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdictions with tropical climate) should follow guidance from public health authorities on timing of administration. Refer to the 2025 Child and Adolescent Immunization Schedule for considerations regarding nirsevimab administration to infants.

Age 75 years or older

- **Unvaccinated:** 1 dose (Arexvy or Abrysvo or mResvia). Additional doses not recommended
- **Previously vaccinated:** additional doses not recommended. No data are available to inform whether additional doses are needed.

Special situations

• Age 60–74 years:

- **Unvaccinated and at increased risk of severe RSV disease**:** 1 dose (Arexvy or Abrysvo or mResvia). Additional doses not recommended.
- **Previously vaccinated:** additional doses not recommended. No data are available to inform whether additional doses are needed.

Persons 60 years and older can get RSV vaccine at any time but it is best to administer in late summer and early fall before RSV spreads in communities—ideally August through October in most of continental United States. For further guidance, see www.cdc.gov/mmwr/volumes/73/wr/mm7332e1.htm.

****Note: People can self-attest to the presence of a risk factor. The following medical and other conditions increase the risk of severe RSV disease:**

- Chronic cardiovascular disease e.g., heart failure, coronary artery disease, congenital heart disease. Excludes isolated hypertension.
- Chronic lung or respiratory disease e.g., chronic obstructive pulmonary disease, emphysema, asthma, interstitial lung disease, cystic fibrosis
- End stage renal disease or dependence on hemodialysis or other renal replacement therapy
- Diabetes mellitus complicated by chronic kidney disease, neuropathy, retinopathy, or other end-organ damage
- Diabetes mellitus requiring treatment with insulin or sodium–glucose cotransporter 2 (SGLT2) inhibitor
- Neurologic or neuromuscular conditions causing impaired airway clearance or respiratory muscle weakness e.g., post-stroke dysphagia, amyotrophic lateral sclerosis, muscular dystrophy. Excludes history of stroke without impaired airway clearance.
- Chronic liver disease e.g., cirrhosis

- Chronic hematologic conditions e.g., sickle cell disease, thalassemia
- Severe obesity (body mass index ≥ 40 kg/m²)
- Moderate or severe immune compromise
- Residence in a nursing home
- Other chronic medical conditions or risk factors that a health care provider determines would increase the risk of severe disease due to viral respiratory infection e.g., frailty, concern for presence of undiagnosed chronic medical conditions, residence in a remote or rural community where escalation of medical care is challenging.

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Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Tetanus, diphtheria, and pertussis vaccination

Routine vaccination

- **Completed primary series and received at least 1 dose Tdap at age 10 years or older:** Td or Tdap every 10 years thereafter
- **Completed primary series and did NOT receive Tdap at age 10 years or older:** 1 dose Tdap, then Td or Tdap every 10 years thereafter
- **Unvaccinated or incomplete primary vaccination series for tetanus, diphtheria, or pertussis:** administer remaining doses (1, 2, or 3 doses) to complete 3-dose primary series. 1 dose Tdap followed by 1 dose Td or Tdap at least 4 weeks later, and a third dose of Td or Tdap 6–12 months later (Tdap is preferred as first dose and can be substituted for any Td dose), then Td or Tdap every 10 years thereafter.

Special situations

- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- **Wound management:** Persons with 3 or more doses of tetanus–toxoid–containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus–toxoid–containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus–toxoid–containing vaccine. Tdap is preferred for persons who have not previously received Tdap or whose Tdap history is unknown. If a tetanus–toxoid–containing vaccine is indicated for a pregnant woman, use Tdap. For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm

Varicella vaccination

Routine vaccination

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

Special situations

- **Pregnancy with no evidence of immunity to varicella:** VAR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose if previously received 1 dose varicella–containing vaccine or dose 1 of 2-dose series (dose 2: 4–8 weeks later) if previously did not receive any varicella–containing vaccine, regardless of whether U.S.–born before 1980.
- **Health care personnel with no evidence of immunity to varicella:** 1 dose if previously received 1 dose varicella–containing vaccine; 2-dose series 4–8 weeks apart if previously did not receive any varicella–containing vaccine, regardless of whether U.S.–born before 1980.
- **HIV infection with CD4 percentages $\geq 15\%$ and CD4 count ≥ 200 cells/mm³ with no evidence of immunity:** Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 percentage $< 15\%$ or CD4 count < 200 cells/mm³.
- **Severe immunocompromising conditions:** VAR contraindicated

Zoster vaccination

Routine vaccination

- **Age 50 years or older*:** 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon), regardless of previous herpes zoster or history of zoster vaccine live (ZVL, Zostavax) vaccination.
- **Note:** Serologic evidence of prior varicella is not necessary for zoster vaccination. However, if serologic evidence of varicella susceptibility becomes available, providers should follow ACIP guidelines for varicella vaccination first. RZV is not indicated for the prevention of varicella, and there are limited data on the use of RZV in persons without a history of varicella or varicella vaccination.

Special situations

- **Pregnancy:** There is currently no ACIP recommendation for RZV use in pregnancy. Consider delaying RZV until after pregnancy.
- **Immunocompromising conditions (including persons with HIV regardless of CD4 count)**:** 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon). For detailed information, see www.cdc.gov/shingles/hcp/vaccine-considerations/immunocompromised-adults.html
- **Note:** If there is no documented history of varicella, varicella vaccination, or herpes zoster, providers should refer to the clinical considerations for use of RZV in immunocompromised adults aged ≥ 19 years and the ACIP varicella vaccine recommendations for further guidance: www.cdc.gov/mmwr/volumes/71/wr/mm7103a2.htm

Appendix

Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

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, Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices—United States, 2024–25 Influenza Season | MMWR (cdc.gov), and Contraindications and Precautions for COVID–19 Vaccination

Vaccines and Other Immunizing Agents	Contraindicated or Not Recommended ¹	Precautions ²
COVID–19 mRNA vaccines [Comirnaty, mRNA1273, Spikevax]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of an mRNA COVID–19 vaccine ³	• Diagnosed non-severe allergy (e.g., urticaria beyond the injection site) to a component of an mRNA COVID–19 vaccine ³ ; or non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of an mRNA COVID–19 vaccine • Myocarditis or pericarditis within 3 weeks after a dose of any COVID–19 vaccine • Multisystem inflammatory syndrome in children (MIS–C) or multisystem inflammatory syndrome in adults (MIS–A) • Moderate or severe acute illness, with or without fever
COVID–19 protein subunit vaccine [Nuvaxovid]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of a Nuvaxovid ³	• Diagnosed non-severe allergy (e.g., urticaria beyond the injection site) to a component of Nuvaxovid ³ ; or non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of Nuvaxovid • Myocarditis or pericarditis within 3 weeks after a dose of any COVID–19 vaccine • Multisystem inflammatory syndrome in children (MIS–C) or multisystem inflammatory syndrome in adults (MIS–A) • Moderate or severe acute illness, with or without fever
Influenza, egg-based, inactivated injectable (IIV3)	• 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 component ³ (excluding egg)	• Guillain–Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Moderate or severe acute illness with or without fever
Influenza, cell culture–based inactivated injectable (ccIIV3) [Flucelex]	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component ³ of ccIIV3	• 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 ccIIV3, 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 (RIV3) [Flublok]	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component ³ of RIV3	• 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 RIV3, 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 (LAIV3) [Flumist]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component ³ (excluding egg) • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear, or any other cranial CSF leak • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days.	• Guillain–Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons aged 5 years or older • Persons with underlying medical conditions (other than those listed under contraindications) that might predispose to complications after wild-type influenza virus infection [e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus)] • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization.

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.

3. Vaccination providers should check FDA–approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. See Package inserts for U.S.–licensed vaccines.

Appendix

Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

Vaccine	Contraindicated or Not Recommended ¹	Precautions ²
<i>Haemophilus influenzae</i> type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ including yeast • Pregnancy: PreHevrio is not recommended due to lack of safety data in pregnant women. Use other hepatitis B vaccines if HepB is indicated ⁴	• Moderate or severe acute illness with or without fever
Hepatitis A–Hepatitis B vaccine (HepA–HepB) [Twinrix]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • Pregnancy: HPV vaccination not recommended	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing or interferon-γ release assay (IGRA) testing • Moderate or severe acute illness with or without fever
Meningococcal ACWY (MenACWY) (MenACWY–CRM) [Menveo] (MenACWY–TT) [MenQuadfi]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • For MenACWY–CRM only: severe allergic reaction to any diphtheria toxoid- or CRM197-containing vaccine • For MenACWY–TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• Moderate or severe acute illness with or without fever
Meningococcal B (MenB) MenB–4C [Bexsero] MenB–FHbp [Trumenba]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³	• Pregnancy • For MenB–4C only: Latex sensitivity • Moderate or severe acute illness with or without fever
Meningococcal ABCWY (MenACWY–TT/MenB–FHbp) [Penbraya]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • Severe allergic reaction to a tetanus toxoid-containing vaccine	• Moderate or severe acute illness, with or without fever
Mpox [Jynneos]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³	• Moderate or severe acute illness, with or without fever
Pneumococcal conjugate (PCV15, PCV20, PCV21)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria–toxoid-containing vaccine or to its vaccine component ³	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³	• Moderate or severe acute illness with or without fever
Poliovirus vaccine, inactivated (IPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³	• Pregnancy • Moderate or severe acute illness with or without fever
Respiratory syncytial virus vaccine (RSV)	• Severe allergic reaction (e.g., anaphylaxis) to a vaccine component	• Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP, DTaP, or Tdap	• Guillain–Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus–toxoid-containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria–toxoid-containing or tetanus–toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus–toxoid-containing vaccine • Moderate or severe acute illness with or without fever • For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized
Varicella (VAR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³ • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • Moderate or severe acute illness with or without fever
Zoster recombinant vaccine (RZV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ³	• Moderate or severe acute illness with or without fever • Current episode of herpes zoster

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.–licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.

4. For information on the pregnancy exposure registry for persons who were inadvertently vaccinated with PreHevrio while pregnant, please visit www.prehevrio.com/#safety.

Addendum

Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2025

In addition to the recommendations presented in the previous sections of this immunization schedule, ACIP has approved the following recommendations by majority vote since October 24, 2024.

Vaccines	Recommendations	Effective Date of Recommendation*
Meningococcal (MenACWY-CRM/MenB-4C, Penmenvay)	MenABCWY vaccine may be used when both MenACWY and MenB are indicated at the same visit in: 1. healthy persons aged 16–23 years (routine schedule) when shared clinical decision-making favors administration of MenB vaccine and 2. persons aged = 10 years who are at increased risk for meningococcal disease (e.g., because of persistent complement deficiencies, complement inhibitor use, or functional or anatomic asplenia)	June 25, 2025
RSV (Abrysvo, Arexvy, mResvia)	Adults 50–59 years of age who are at increased risk of severe RSV disease ^a may receive a single dose of RSV vaccine ^{b,c} . a. CDC will publish Clinical Considerations that describe chronic medical conditions and other risk factors for severe RSV disease for use in this risk-based recommendation. b. At this time, RSV vaccination is recommended as a single dose only. Persons who have already received RSV vaccination are NOT recommended to receive another dose. c. RSV vaccine can be administered with any product licensed in this age group. As of March 27, 2025, that includes GSK's Arexvy and Pfizer's Abrysvo. There is no preferential recommendation for any licensed product over another.	June 25, 2025
Influenza	ACIP reaffirms the recommendations for routine annual influenza vaccination of all persons aged = 6 months who do not have contraindications for the 2025–2026 season	July 22, 2025
Influenza	ACIP recommends only single-dose formulations of annual influenza vaccines that are free of thimerosal as a preservative for three populations: - Children 18 years or younger - Pregnant women - All adults	July 22, 2025
Note: As of May 29, 2025, the schedule incorporates the HHS directive regarding COVID-19 vaccine recommendations. (Changes were made to tables and notes for COVID-19 vaccines in pregnant women).		

*The effective date is the date when the recommendation was adopted and became official.

Section C. Periodicity Schedule from Bright Futures / American Academy of Pediatrics

Figure 1: Recommendations for Preventive Pediatric Health Care.

Citation:

Bright Futures/American Academy of Pediatrics
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns. These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics, 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

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AGE ¹	Prenatal ²	Newborn ²	3-5 d ³	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Weight for Length	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Body Mass Index ⁴																																
Blood Pressure ⁴		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
SENSORY SCREENING																																
Vision ⁵	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Hearing ⁶	● ¹	● ¹	→	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening ⁷				●	●	●	●																									
Developmental Screening ⁸								●				●	●																			
Autism Spectrum Disorder Screening ⁹																																
Developmental Surveillance	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening ¹⁰	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment ¹¹																						★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening ¹²																						★	★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAMINATION¹³	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES¹⁴																																
Newborn Blood	● ¹⁵	● ¹⁶	→																													
Newborn Bilirubin ¹⁷	●																															
Critical Congenital Heart Defect ¹⁸	●																															
Immunization ¹⁹	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia ²⁰					★				★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Legs ²¹									● or ★ ²⁴		★	● or ★ ²⁴		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Tuberculosis ²²			★			★			★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia ²³												★		★								★	★	★	★	★	★	★	★	★	★	★
Sexually Transmitted Infection ²⁴																						★	★	★	★	★	★	★	★	★	★	★
HIV ²⁵																						★	★	★	★	★	★	★	★	★	★	★
Hepatitis B Virus Infection ²⁶	★																															
Hepatitis C Virus Infection ²⁷																																
Sudden Cardiac Arrest/Death ²⁸																						★										
Cervical Dysplasia ²⁹																																
ORAL HEALTH³⁰								● ³¹	● ³¹	★		★	★	★	★	★	★															
Fluoride Varnish ³²								→																								
Fluoride Supplementation ³³								★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

- If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
- A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (<https://doi.org/10.1542/peds.2018-1218>).
- Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
- Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Policy Statement: Breastfeeding and the Use of Human Milk" (<https://doi.org/10.1542/peds.2022-057988>). Newborns discharged less than 48 hours after delivery must be examined within

- 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (<https://doi.org/10.1542/peds.2015-0699>).
- Screen, per "Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents with Obesity" (<https://doi.org/10.1542/peds.2022-260649>).
- Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (<https://doi.org/10.1542/peds.2017-1904>). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
- A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (<https://doi.org/10.1542/peds.2015-3596>) and "Procedures for the Evaluation of the Visual System by Pediatricians" (<https://doi.org/10.1542/peds.2015-3597>).
- Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (<https://doi.org/10.1542/peds.2007-2339>).

- Verify results as soon as possible, and follow up, as appropriate.
- Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (<https://www.sciencedirect.com/science/article/pii/S1054139816000463>).
- Screening should occur per "Incorporating Recognition and Management of Perinatal Depression into Pediatric Practice" (<https://doi.org/10.1542/peds.2018-3259>).
- Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (<https://doi.org/10.1542/peds.2019-3449>).
- Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (<https://doi.org/10.1542/peds.2019-3447>).

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KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ← or → = range during which a service may be provided

(continued)

14. Screen for behavioral and social-emotional problems per "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (<https://doi.org/10.1542/peds.2014-3719>). "Mental Health Competencies for Pediatric Practice" (<https://doi.org/10.1542/peds.2019-2757>). "Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders" (<https://pubmed.ncbi.nlm.nih.gov/32439401/>). "Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative" (<https://pubmed.ncbi.nlm.nih.gov/32510992/>). and "Anxiety in Children and Adolescents: Screening" (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-anxiety-children-adolescents>). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See "Poverty and Child Health in the United States" (<https://doi.org/10.1542/peds.2016-0929>). The Impact of Racism on Child and Adolescent Health" (<https://doi.org/10.1542/peds.2019-1765>) and "Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health" (<https://doi.org/10.1542/peds.2021-052589>).
15. A recommended tool to assess use of alcohol, tobacco and nicotine, marijuana, and other substances, including opioids is available at <http://aiaa.org>. If there is a concern for substance or opioid use, providers should consider recommending or prescribing Naloxone (see <https://www.cdc.gov/one/search/pages/2018-evidence-based-strategies.html> and <https://nida.nih.gov/publications/drugfacts/naloxone>).
16. Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management" (<https://doi.org/10.1542/peds.2017-4061>). "Mental Health Competencies for Pediatric Practice" (<https://doi.org/10.1542/peds.2019-2757>). "Suicide and Suicide Attempts in Adolescents" (<https://doi.org/10.1542/peds.2016-1420>). and "The 21st Century Cures Act & Adolescent Confidentiality" (https://adolescenthealth.org/press_release/haspaq-21st-century-cures-act-adolescent-confidentiality/).
17. At each visit, age-appropriate physical examination is essential, with infant totally undressed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (<https://doi.org/10.1542/peds.2011-0329>).
18. These may be modified, depending on entry point into schedule and individual need.
19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (<https://www.hrsa.gov/advisory-committees/heritable-disorders/usp/index.html>), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (<https://www.babyfriendly.org>) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Clinical Practice Guideline Revision: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation" (<https://doi.org/10.1542/peds.2022-058899>).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (<https://doi.org/10.1542/peds.2011-3211>).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at <https://publications.aap.org/redbook/pages/immunization-schedules>. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP Pediatric Nutrition Policy of the American Academy of Pediatrics (Iron chapter).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (<https://doi.org/10.1542/peds.2016-1493>) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (<https://stacks.cdc.gov/view/cdc/11859>).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.html).
29. Adolescent should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases.
30. Screen adolescents for HIV at least once between the ages of 15 and 21, making every effort to preserve confidentiality of the adolescent, as per "Human Immunodeficiency Virus (HIV) Infection: Screening" (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening>) after initial screening, youth at increased risk of HIV infection should be retested annually or more frequently, as per "Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis" (<https://doi.org/10.1542/peds.2021-055207>).
31. Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening>) and in the 2021–2024 edition of the AAP Red Book: Report of the Committee on Infectious Diseases, making every effort to preserve confidentiality of the patient.
32. All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening>) and Centers for Disease Control and Prevention (CDC) recommendations (<https://www.cdc.gov/mmwr/volumes/69/11/6902a1.html>) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.
33. Perform a risk assessment, as appropriate, per "Sudden Death in the Young: Information for the Primary Care Provider" (<https://doi.org/10.1542/peds.2021-052044>).
34. See USPSTF recommendations (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening>). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (<https://doi.org/10.1542/peds.2010-1564>).
35. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (<https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools>) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (<https://doi.org/10.1542/peds.2022-060417>).
36. Perform a risk assessment (<https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools>). See "Maintaining and Improving the Oral Health of Young Children" (<https://doi.org/10.1542/peds.2022-060417>).
37. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions>). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (<https://doi.org/10.1542/peds.2020-094637>).
38. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (<https://doi.org/10.1542/peds.2020-094637>).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects recommendations approved in December 2024 and published in February 2025. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

RECOMMENDATIONS APPROVED IN DECEMBER 2024

No changes have been made to clinical guidance or footnotes in the recommendations published in 2025.



HRSA

Department of Health and Human Services
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Section D. Uniform Panel of the Discretionary Advisory Committee on Heritable Disorders in Newborns and Children - 2024

Figure 1: Uniform Screening Panel.

Citation:

Discretionary Advisory Committee on Heritable Disorders in Newborns and Children Uniform Screening Panel
<http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf>

Recommended Uniform Screening Panel
Core Conditions
(As of July 2024)

X: Condition is in this category --: Condition is not in this category

Core Condition	Metabolic Disorder - Organic acid condition	Metabolic Disorder - Fatty acid oxidation disorder	Metabolic Disorder - Amino acid disorder	Endocrine Disorder	Hemoglobin Disorder	Other Disorder
3-Hydroxy-3-Methylglutaric Aciduria	X	--	--	--	--	--
3-Methylcrotonyl-CoA Carboxylase Deficiency	X	--	--	--	--	--
β-Ketothiolase Deficiency	X	--	--	--	--	--
Glutaric Acidemia Type I	X	--	--	--	--	--
Holocarboxylase Synthase Deficiency	X	--	--	--	--	--
Isovaleric Acidemia	X	--	--	--	--	--
Methylmalonic Acidemia (Cobalamin disorders)	X	--	--	--	--	--
Methylmalonic Acidemia (methylmalonyl-CoA mutase)	X	--	--	--	--	--
Propionic Acidemia	X	--	--	--	--	--
Carnitine Uptake Defect/Carnitine Transport Defect	--	X	--	--	--	--
Long-chain L-3 Hydroxyacyl-CoA Dehydrogenase Deficiency	--	X	--	--	--	--
Medium-chain Acyl-CoA Dehydrogenase Deficiency	--	X	--	--	--	--
Trifunctional Protein Deficiency	--	X	--	--	--	--
Very Long-chain Acyl-CoA Dehydrogenase Deficiency	--	X	--	--	--	--
Argininosuccinic Aciduria	--	--	X	--	--	--
Citrullinemia, Type I	--	--	X	--	--	--
Classic Phenylketonuria	--	--	X	--	--	--
Homocystinuria	--	--	X	--	--	--
Maple Syrup Urine Disease	--	--	X	--	--	--
Tyrosinemia, Type I	--	--	X	--	--	--
Congenital adrenal hyperplasia	--	--	--	X	--	--
Primary Congenital Hypothyroidism	--	--	--	X	--	--
S, β-thalassemia	--	--	--	--	X	--
S,C Disease	--	--	--	--	X	--
S,S Disease (Sickle Cell Anemia)	--	--	--	--	X	--
Biotinidase Deficiency	--	--	--	--	--	X
Classic Galactosemia	--	--	--	--	--	X

Core Condition	Metabolic Disorder - Organic acid condition	Metabolic Disorder - Fatty acid oxidation disorder	Metabolic Disorder - Amino acid disorder	Endocrine Disorder	Hemoglobin Disorder	Other Disorder
Critical Congenital Heart Disease	--	--	--	--	--	X
Cystic Fibrosis	--	--	--	--	--	X
Glycogen Storage Disease Type II (Pompe)	--	--	--	--	--	X
Guanidinoacetate Methyltransferase Deficiency	--	--	--	--	--	X
Hearing Loss	--	--	--	--	--	X
Infantile Krabbe Disease (low galactocerebrosidase [GALC] and psychosine $\geq 10\text{nM}$)						X
Mucopolysaccharidosis Type I	--	--	--	--	--	X
Mucopolysaccharidosis Type II	--	--	--	--	--	X
Severe Combined Immunodeficiencies	--	--	--	--	--	X
Spinal Muscular Atrophy due to homozygous deletion of exon 7 in SMN1	--	--	--	--	--	X
X-linked Adrenoleukodystrophy	--	--	--	--	--	X

Recommended Uniform Screening Panel¹
SECONDARY² CONDITIONS³
(As of July 2024)

Secondary Condition	Metabolic Disorder - Organic acid condition	Metabolic Disorder - Fatty acid oxidation disorder	Metabolic Disorder - Amino acid disorder	Endocrine Disorder	Hemoglobin Disorder	Other Disorder
2-Methyl-3-hydroxybutyric aciduria	X	--	--	--	--	--
2-Methylbutyrylglycinuria	X	--	--	--	--	--
3-Methylglutaconic aciduria	X	--	--	--	--	--
Isobutyrylglycinuria	X	--	--	--	--	--
Malonic acidemia	X	--	--	--	--	--
Methylmalonic acidemia with homocystinuria	X	--	--	--	--	--
2,4 Dienoyl-CoA reductase deficiency	--	X	--	--	--	--
Carnitine acylcarnitine translocase deficiency	--	X	--	--	--	--
Carnitine palmitoyltransferase type I deficiency	--	X	--	--	--	--
Carnitine palmitoyltransferase type II deficiency	--	X	--	--	--	--
Glutaric acidemia type II	--	X	--	--	--	--
Medium/short-chain L-3-hydroxyacyl-CoA dehydrogenase deficiency	--	X	--	--	--	--

Secondary Condition	Metabolic Disorder - Organic acid condition	Metabolic Disorder - Fatty acid oxidation disorder	Metabolic Disorder - Amino acid disorder	Endocrine Disorder	Hemoglobin Disorder	Other Disorder
Medium-chain ketoacyl-CoA thiolase deficiency	–	X	–	–	–	–
Short-chain acyl-CoA dehydrogenase deficiency	–	X	–	–	–	–
Argininemia	–	–	X	–	–	–
Benign hyperphenylalaninemia	–	–	X	–	–	–
Biopterin defect in cofactor biosynthesis	–	–	X	–	–	–
Biopterin defect in cofactor regeneration	–	–	X	–	–	–
Citrullinemia, type II	–	–	X	–	–	–
Hypermethioninemia	–	–	X	–	–	–
Tyrosinemia, type II	–	–	X	–	–	–
Tyrosinemia, type III	–	–	X	–	–	–
Various other hemoglobinopathies	–	–	–	–	X	–
Galactosepimerase deficiency	–	–	–	–	–	X
Galactokinase deficiency	–	–	–	–	–	X
T-cell related lymphocyte deficiencies	–	–	–	–	–	X

1. Selection of conditions based upon "Newborn Screening: Towards a Uniform Screening Panel and System." *Genetic Med.* 2006; 8(5) Suppl: S12-S252" as authored by the American College of Medical Genetics (ACMG) and commissioned by the Health Resources and Services Administration (HRSA).
2. Disorders that can be detected in the differential diagnosis of a core disorder.
3. Nomenclature for Conditions based upon "Naming and Counting Disorders (Conditions) Included in Newborn Screening Panels." *Pediatrics.* 2006; 117 (5) Suppl: S308-S314.

Secondary Condition	Metabolic Disorder - Organic acid condition	Metabolic Disorder - Fatty acid oxidation disorder	Metabolic Disorder - Amino acid disorder	Endocrine Disorder	Hemoglobin Disorder	Other Disorder
Argininaemia	--	--	X	--	--	--
Benign hyperphenylalaninemia	--	--	X	--	--	--
Biopterin defect in cofactor biosynthesis	--	--	X	--	--	--
Biopterin defect in cofactor regeneration	--	--	X	--	--	--
Citrullinemia, type II	--	--	X	--	--	--
Hypermethioninemia	--	--	X	--	--	--
Tyrosinemia, type II	--	--	X	--	--	--
Tyrosinemia, type III	--	--	X	--	--	--
Various other hemoglobinopathies	--	--	--	--	X	--
Galactosephosphase deficiency	--	--	--	--	--	X
Galactokinase deficiency	--	--	--	--	--	X
T-cell related lymphocyte deficiencies	--	--	--	--	--	X

1. Selection of conditions based upon "Newborn Screening: Towards a Uniform Screening Panel and System." Genetic Med. 2008; 10(5) Suppl: S12-S252" as authored by the American College of Medical Genetics (ACMG) and commissioned by the Health Resources and Services Administration (HRSA).
2. Disorders that can be detected in the differential diagnosis of a core disorder.
3. Nomenclature for Conditions based upon "Naming and Counting Disorders (Conditions) Included in Newborn Screening Panels." Pediatrics. 2006; 117 (5) Suppl: S208-S214.

Section 5. Recommendations of the Health Resources and Services Administration (HRSA) for Women

HRSA-supported Women's Preventive Services Guidelines

Citation:

Health Resources and Services Administration Women's Preventive Services Guidelines

<https://www.hrsa.gov/womens-guidelines>

Type of Preventive Service	Guideline
Screening and Counseling for Intimate Partner and Domestic Violence	The Women's Preventive Services Initiative recommends screening adolescent and adult women for intimate partner and domestic violence, at least annually, and, when needed, providing or referring to intervention services. Intimate partner and domestic violence includes physical violence, sexual violence, stalking and psychological aggression (including coercion), reproductive coercion, neglect, and the threat of violence, abuse, or both. Intervention services include, but are not limited to, counseling, education, harm reduction strategies, and appropriate supportive services.
Breast Cancer Screening for Women at Average Risk	The Women's Preventive Services Initiative recommends that women at average risk of breast cancer initiate mammography screening no earlier than age 40 years and no later than age 50 years. Screening mammography should occur at least biennially and as frequently as annually. Women may require additional imaging to complete the screening process or to address findings on the initial screening mammography. If additional imaging (e.g., magnetic resonance imaging (MRI), ultrasound, mammography) and pathology evaluation are indicated, these services also are recommended to complete the screening process for malignancies. Screening should continue through at least age 74 years, and age alone should not be the basis for discontinuing screening. Women at increased risk also should undergo periodic mammography screening, however, recommendations for additional services are beyond the scope of this recommendation.
Patient Navigation Services for Breast and Cervical Cancer Screening	The Women's Preventive Services Initiative recommends patient navigation services for breast and cervical cancer screening and follow-up, as relevant, to increase utilization of screening recommendations based on an assessment of the patient's needs for navigation services. Patient navigation services involve person-to-person (e.g., in-person, virtual, hybrid models) contact with the patient. Components of patient navigation services should be individualized. Services include, but are not limited to, person-centered assessment and planning, health care access and health system navigation, referrals to appropriate support services (e.g., language translation, transportation, and social services), and patient education.
Screening for Anxiety	WPSI recommends screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum. Optimal screening intervals are unknown and clinical judgement should be used to determine screening frequency. Given the high prevalence of anxiety disorders, lack of recognition in clinical practice, and multiple problems associated with untreated anxiety, clinicians should consider screening women who have not been recently screened.
Screening for Cervical Cancer	WPSI recommends cervical cancer screening for average-risk women aged 21 to 65 years. For women aged 21 to 29 years, the Women's Preventive Services Initiative recommends cervical cancer screening using cervical cytology (Pap test) every 3 years. Cotesting with cytology and human papillomavirus testing is not recommended for women younger than 30 years. Women aged 30 to 65 years should be screened with cytology and human papillomavirus testing every 5 years or cytology alone every 3 years. Women who are at average risk should not be screened more than once every 3 years.
Obesity Prevention in Midlife Women	WPSI recommends counseling midlife women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.5-29.9

	kg/m2) to maintain weight or limit weight gain to prevent obesity. Counseling may include individualized discussion of healthy eating and physical activity.
Breastfeeding Services and Supplies	WPSI recommends comprehensive lactation support services (including consultation; counseling; education by clinicians and peer support services; and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to optimize the successful initiation and maintenance of breastfeeding.
Contraception *	WPSI recommends that adolescent and adult women have access to the full range of contraceptives and contraceptive care to prevent unintended pregnancies and improve birth outcomes. Contraceptive care includes screening, education, counseling, and provision of contraceptives (including in the immediate postpartum period).** Contraceptive care also includes follow-up care (e.g., management, evaluation and changes, including the removal, continuation, and discontinuation of contraceptives). WPSI recommends that the full range of U.S. Food and Drug Administration (FDA)- approved, - granted, or -cleared contraceptives, effective family planning practices, and sterilization procedures be available as part of contraceptive care. The full range of contraceptives includes those currently listed in the FDA's Birth Control Guide***: (1) sterilization surgery for women, (2) implantable rods, (3) copper intrauterine devices, (4) intrauterine devices with progestin (all durations and doses), (5) injectable contraceptives, (6) oral contraceptives (combined pill), 7) oral contraceptives (progestin only), (8) oral contraceptives (extended or continuous use), (9) the contraceptive patch, (10) vaginal contraceptive rings, (11) diaphragms, (12) contraceptive sponges, (13) cervical caps, (14) condoms, (15) spermicides, (16) emergency contraception (levonorgestrel), and (17) emergency contraception (ulipristal acetate), and any additional contraceptives approved, granted, or cleared by the FDA. Additionally, instruction in fertility awareness-based methods, including the lactation amenorrhea method, although less effective, should be provided for women desiring an alternative method.****
Counseling for Sexually Transmitted Infections (STIs)	WPSI recommends directed behavioral counseling by a health care clinician or other appropriately trained individual for sexually active adolescent and adult women at an increased risk for STIs. WPSI recommends that clinicians review a woman's sexual history and risk factors to help identify those at an increased risk of STIs. Risk factors include, but are not limited to, age younger than 25, a recent history of an STI, a new sex partner, multiple partners, a partner with concurrent partners, a partner with an STI, and a lack of or inconsistent condom use. For adolescents and women not identified as high risk, counseling to reduce the risk of STIs should be considered, as determined by clinical judgment.
Human Immunodeficiency Virus Infection (HIV)	WPSI recommends all adolescent and adult women, ages 15 and older, receive a screening test for HIV at least once during their lifetime. Earlier or additional screening should be based on risk, and rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection.
Well-Woman Preventative Visits	WPSI recommends that women receive at least one preventive care visit per year beginning in adolescence and continuing across the lifespan to ensure the provision of all recommended preventive services, including preconception and many services necessary for prenatal and interconception care, are obtained. The primary purpose of these visits should be the delivery and coordination of recommended preventive services as determined by age and risk factors. These services may be completed at a single or as part of a series of visits that take place over time to obtain all necessary services depending on a woman's age, health status, reproductive health needs, pregnancy status, and risk factors. Well-women visits also include prepregnancy, prenatal, postpartum and interpregnancy visits.
Screening for Diabetes in Pregnancy	The Women's Preventive Services Initiative 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.
Screening for Diabetes after Pregnancy	The 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.
Screening for Urinary Incontinence	The Women's Preventive Services Initiative recommends screening women for urinary incontinence annually. Screening should assess whether women experience urinary incontinence and whether it impacts their activities and quality of life. If indicated, facilitating further evaluation and treatment is recommended.

** Education and counseling includes all methods of contraception, including but not limited to, hormonal, devices, surgical, barrier, and fertility-based awareness methods, including lactation amenorrhea.

*** FDA's Birth Control Guide

This refers to FDA's Birth Control Guide as posted on December 22, 2021 with the exception of sterilization surgery for men, which is beyond the scope of the WPSI.

**** Notice

This sentence, included at the end of the "Contraception" section of the previous Guidelines, remains at the conclusion of the "Contraception" section of the 2021 Guidelines per a Final Order issued on December 6, 2022, in *Tice-Harouff v. Johnson*, Eastern District of Texas (Tyler Division), Case No. 6:22-cv-201-JDK. This is consistent with footnote **above, which indicates that education and counseling within the "Contraception" section of the 2021 Guidelines includes fertility awareness-based methods, including lactation amenorrhea.

Addendum B Dental Benefits



Delta Dental PPO™ (Point-of-Service) Summary of Dental Benefits For Group# 1040-0001, 0002, 0099, 1099 Cook

This Summary of Dental Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental benefits, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan - Delta Dental of Indiana

Benefit Year - January 1 through December 31

Covered Services -

	Delta Dental PPO™ Dentist Plan Pays	Delta Dental Premier® Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, and fluoride	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Bitewing Radiographs - bitewing X-rays	100%	100%	100%
Basic Services			
Space Maintainers - appliances to prevent tooth movement	80%	80%	80%
Palliative Treatment - to temporarily relieve pain	80%	80%	80%
Sealants - to prevent decay of permanent teeth	80%	80%	80%
All Other Radiographs - other X-rays	80%	80%	80%
Minor Restorative Services - fillings and crown repair	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Relines and Repairs - to prosthetic appliances	80%	80%	80%
Major Services			
Major Restorative Services - crowns	50%	50%	50%
Prosthodontic Services - bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	Dependent Children through age 18 and under	Dependent Children through age 18 and under	Dependent Children through age 18 and under

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people age 18 and under.
- Space maintainers are payable once per area per lifetime for people age 17 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any three-year period.
- Sealants are payable once per tooth per lifetime for first and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.
- Inlays (any material) are Covered Services.
- Porcelain and resin facings on crowns are payable on posterior teeth.
- Porcelain and resin facings on bridges are payable on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.
- Therapeutic parenteral drugs are a Covered Service.

- People with special health care needs may be eligible for additional services including exams, hygiene visits, dental case management, and sedation/anesthesia. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.
- Coverage includes cosmetic treatment related to accidental injuries to sound natural teeth rendered, provided the treatment was rendered within 24 months of the date of the accident, or for functional repair or restoration when necessary to achieve normal oral function, or to correct a congenital deformity or anomaly.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of Dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – \$1,500 per person total per Benefit Year on all services, except oral exams, prophylaxes (cleanings), fluoride, brush biopsy, bitewing X-rays, surgical extractions of impacted teeth, local or general anesthesia, implants and orthodontics. \$1,500 per person total per lifetime on orthodontic services. \$3,000 per person total per lifetime on implants.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 50% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per month fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist.

Deductible – None.

Waiting Period – Enrollees who are eligible for Benefits are covered as defined in the Cook Group Health Plan.

Eligible People – The dental benefits are provided under the Cook Group Health Plan. All employees who enroll in the Cook Group Health Plan are automatically enrolled in the dental benefits.

Also eligible are your legal spouse and your children (natural born, adopted, step, foster or under guardianship of the employee or under a Qualified Medical Child Support Order) to the end of the month in which they turn 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled. You and your eligible dependents generally must enroll for a minimum of 12 months. Your dependents may only enroll if you are enrolled (except under COBRA) and must be enrolled in the same plan option as you. Plan changes are only allowed during open enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under the Cook Group Health Plan and the Cook Cafeteria Plan.

If you and your spouse are both eligible for coverage, you may be enrolled together as an employee and spouse or separately each as an employee, but not both. Your dependent children may only be enrolled as the children of one of you. Delta Dental will not coordinate benefits if you and your spouse are both covered under this Contract.

The medical and Delta Dental plans are offered as a package. Employees enrolled in either plan are automatically enrolled in both plans with the same type of coverage. For example, employees enrolled with single coverage under the medical plan must also be enrolled with single coverage under the Delta Dental plan.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate Benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease when you lose coverage in the Cook Group Medical Plan, but you may be able to continue coverage under the COBRA provisions of the Cook Group Health Plan. You may not, however, elect to continue only your dental benefits. If you elect to continue coverage in the Cook Group Health Plan, you will automatically continue these dental benefits.

Customer Service Toll-Free Number: 800-524-0149 (TTY users call 711)
<https://www.DeltaDentalIN.com>
 Document Creation Date: April 10, 2024

Addendum C
VISION BENEFITS

Vision Certificate of Coverage

BLUE VIEW VISION
FS.B.0.0.200.200

COOK GROUP INCORPORATED

Anthem Insurance Companies, Inc.

220 Virginia Ave

Indianapolis, Indiana 46204

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Welcome!

Thank you for choosing Anthem Blue Cross and Blue Shield (Anthem) for your vision care coverage. The following materials make up your plan:

- this booklet;
- your application, if any; and
- any endorsements or riders.

Your employer (also referred to as your group) has the following documents which are part of the terms of your plan:

- the group contract; and
- the group master application.

This certificate contains important information such as what vision care services are covered and how they will be covered. It replaces any older certificates issued to you for this vision plan.

Within this certificate members are referred to as “you” or “your”. Anthem is referred to as “we,” “us” or “our.” All italicized words have special meanings that are defined in the Definitions section of this certificate.

Please review this certificate so you know where to find the information that you may need. Store it in a convenient place and refer to it whenever you have questions about your vision care coverage. See the section Contact Us for information on important phone numbers, addresses and websites.

Questions regarding your policy or coverage should be directed to:
Anthem Blue Cross and Blue Shield

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395 Complaints can be filed electronically at www.in.gov/idoi.

CONTACT US

If you have questions about your coverage or need assistance finding a Blue View Vision *network provider*, please contact us.

For Customer Service

Anthem Blue View Vision

P.O. Box 8504

Mason, OH 45040-7111

(866) 723-0515

Hours of Operation

Monday – Saturday:

8:30 a.m. to 11:00 p.m. Eastern Time

Visit us on-line

www.anthem.com

Sunday:

11:00 a.m. to 8:00 p.m. Eastern Time

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Schedule of Benefits

This schedule is an outline of your benefits. You need to refer to the entire *certificate* for complete information about the benefits, conditions, limitations and exclusions of your *plan*.

CHOICE OF VISION CARE PROVIDER: Nothing contained in this *certificate* restricts or interferes with your right to select the vision care provider of your choice, but your benefits are reduced when you use a *non-network provider*. See the section How Your Benefits Work for more information.

COVERED SERVICES COPAYMENTS/MAXIMUMS		
Network Providers	Non-Network Providers	
Routine Eye Exam Limited to one exam Once every calendar year	\$0 Copay	Reimbursed Up To \$42
Prescription Lenses Includes factory scratch coating, polycarbonate lenses for children under 19 years old and Photochromic lenses for children under 19 years old when received from network providers. Limited to one set of lenses per member Once every calendar year. Basic Lenses (Pair)		
Single Vision lenses	\$0 Copay	Reimbursed Up To \$40
Bifocal lenses	\$0 Copay	Reimbursed Up To \$60
Trifocal lenses	\$0 Copay	Reimbursed Up To \$80
Factory Scratch Coating	\$0 Copay	Not Covered
Polycarbonate – Pediatric (up to age 19)	\$0 Copay	Not Covered
Standard Progressive	\$65 Copay	Reimbursed Up To \$60
Photochromic – Pediatric (up to age 19)	\$0 Copay	Not Covered
Frame Limited to one set of frames per member Once every other calendar year	\$200 Allowance	Reimbursed Up To \$42
Prescription Contact Lenses (traditional or disposable) Note: Contact lenses are in lieu of your eyeglass lens benefit. If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in this Schedule of Benefits.		
Elective Contact Lenses Availability Once every calendar year	\$200 Allowance	Reimbursed Up To \$105
Non-Elective Contact Lenses Availability Once every calendar year	Covered in full	Reimbursed Up To \$210

Laser Vision Correction Services

Participating LASIK/ photorefractive keratectomy (PRK) surgical centers offer a discounted rate. For members enrolled

under this plan, you are responsible for any remaining charges.

Eligibility and Enrollment

Who is Eligible

This section will tell you who is eligible to enroll for coverage, as well as when you can enroll for coverage.

Subscriber. You are eligible to be a subscriber and have coverage under this plan if you are an employee or other member of the group of the group and meet the group's eligibility criteria. See your group for more information on specific eligibility requirements.

Dependents. You may enroll your eligible dependents for coverage under this plan. Your dependents are only eligible for coverage if they are one of the following:

- Spouse: Your spouse under a legally valid marriage.
- Domestic partner: Your domestic partner under a legally registered and valid domestic partnership. Check with your group's human resources or benefits department to see if your domestic partner is eligible for coverage under this plan.

Children: Your or your spouse's or domestic partner's child by blood or by law up to age 26. This includes your natural children, stepchildren, legally adopted children, children placed for adoption, foster children or children for whom you are the legal guardian or have been court-ordered to provide coverage.

Your children may continue coverage beyond the above stated age limit if:

- they are unmarried and incapable of self-support due to an intellectual disability or physical handicap;
- are financially dependent on you or your spouse or domestic partner for support and maintenance; and
- were enrolled and disabled prior to reaching the limiting age of this plan.

You and the child's physician must fill out a disabled dependent form and provide it to us. Contact us to obtain the form. After two years from when you initially provided proof, we may ask for continued proof of the child's disability, but no more than once a year.

Newborn and Adopted Child Coverage. You or your spouse's or domestic partner's newborn or adopted children will be covered for an initial period of 31 days from the date of birth, placement for adoption, or adoption. For an adopted child, the date of adoption is the date you assume or retain a legal obligation to support the child. If you want your newborn or adopted child to continue coverage beyond this time, you must contact your group within 31 days of the date of birth, placement for adoption, or adoption to add them to this plan.

Enrollment

Initial Enrollment. Your group will have an initial enrollment period for newly eligible and their dependents to enroll for coverage. You may need to meet a waiting period established by the group before you can enroll for coverage. See your group's human resources or benefits department to determine if there are any waiting periods.

If you or your dependents do not enroll during the initial enrollment period you will only be able to enroll during an open enrollment or special enrollment period. Keep reading for more information on open and special enrollment periods.

Open Enrollment. At least once a year your employer will hold an open enrollment period. During the open enrollment period you and your dependents can enroll for coverage. If you do not enroll during the open enrollment period, you may have to wait until the next open enrollment period, unless you qualify for a special enrollment period. See below for more information on special enrollment.

Special Enrollment. Your plan elections chosen during initial or open enrollment are intended to remain the same until the next open enrollment period. However, there may be times when you or your dependents can enroll for coverage outside of the open enrollment period. This is allowed if you have certain qualifying events that happen. Qualifying events are:

- You or your dependents did not previously enroll for coverage because you had coverage under another group plan (including COBRA or other continuation coverage) and have since become ineligible for that plan. You must request enrollment within 31 days of this qualifying event.

You have a change in the number of dependents due to marriage, birth, adoption, court order, legal guardianship, or death. You must request enrollment within 31 days of this qualifying event.

- You or your dependents lost coverage under Medicaid or a Children's Health Insurance Program (CHIP), or became eligible for a subsidy (state premium assistance program) under Medicaid or CHIP. You must request enrollment within 60 days of this qualifying event.

Notice of Changes in Eligibility. You must tell your group if there are any changes that will affect your or your dependent's eligibility. This includes a change in address or a change in the number of your dependents. The group is then responsible to notify us of any changes according to the terms of the group contract. If your group fails to notify us of your changes in eligibility, it does not obligate us to pay for your vision care.

Your Effective Date. Your coverage begins at 12:01 a.m. Eastern Time on the effective date. Your effective date and enrollment requirements are described in the group contract. See your employer's human resources or benefits department for more information on your specific effective date under this plan.

Statements and Forms. Subscribers or applicants for membership shall complete and submit applications, questionnaires or other forms or statements the plan may reasonably request. Applicants for membership understand that all rights to benefits under this certificate are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a member may result in termination of coverage as provided in the Termination and Continuation of Coverage section. We will not use a statement made by a member to terminate the member's contract after two years have passed since the enrollment date. This does not apply, however, to fraudulent misstatements.

Delivery of Documents. We will provide an identification card and a certificate for each subscriber.

Termination and Continuation of Coverage

Except as otherwise provided, your coverage will terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your *group's* agreement with us and your specific circumstances, such as whether premium has been paid in full:

If Your Group Cancels Coverage. Your coverage will end if your employer cancels coverage or on the date the *group contract* between us and your employer ends.

If You Cancel Your Coverage. If you want to cancel your or your *dependent's* coverage you need to notify your *group*. See your *group's* human resources or benefits department for more information on how to cancel your coverage. If you cancel, your *group* will be responsible to notify us in writing of the cancellation.

If You or Your Dependents Are No Longer Eligible. Coverage will end when you and/or your *dependents* no longer meet the eligibility requirements as outlined under the section Eligibility and Enrollment. When you or your *dependents* are no longer eligible, the date coverage ends is determined by the *group* in accordance with its eligibility requirements.

Fraud, Intentional Misrepresentation, Misuse of an ID Card. We will cancel this coverage if you or the *group* participates in any kind of intentional misrepresentation of material fact (knowingly provide false information) or fraud during the application and/or enrollment process. Subject to the incontestability provision, we will cancel this coverage if you or the *group* participates in any kind of intentional misrepresentation of material fact (knowingly provide false information) or fraud during the application and/or enrollment process. We may also cancel your coverage for other types of fraud, such as if you allow any other person to use your ID card to obtain benefits, or if you use another *member's* ID card (including one of your *dependent's* ID card) to obtain benefits. You will be held liable for any payments we make as a result of fraud. For any fraud or intentional misrepresentation, coverage will end on the date we send the written notice of cancellation.

If Your Group Does Not Pay the Premium. We must receive the premium no later than the end of the grace period for your coverage to remain in force. If your employer does not pay your premium by the end of the grace period as stated in the *group contract*, we may cancel this coverage.

If You Fail to Pay the Premium. If you fail to pay or fail to make satisfactory arrangements with the *group* to pay your portion of the premium, coverage will end as of the last date for which premium was paid.

We Cease to Offer This Coverage. If we cease to offer coverage in the group employer market, we will cancel your coverage in accordance with the terms and conditions of state laws.

Continuation of Coverage

COBRA Continuation of Coverage. Your employer is subject to COBRA if they have more than 20 employees.

COBRA allows you and your dependents to continue coverage for either 18, 29 or 36 months depending on the event.

COBRA coverage is available to you and your *dependents* for 18 months for the following events:

- You lose coverage due to a reduction in working hours, a layoff, or strike.

- You lose coverage because your employment ends (for voluntary or involuntary loss, except for gross misconduct).

COBRA coverage is available to you and your dependents for 29 months for the following events:

You or your dependent was disabled when coverage ended or within 60 days after the coverage ended. However, you or your dependent must continue to be disabled after 18 months has passed. The Social Security Administration must determine if you are disabled.

COBRA coverage is available to your dependents for 36 months for the following events:

Your death.

You become eligible for Medicare in the 18 months before an event listed above.

You divorce or separate from your spouse.

Your dependent children no longer qualify as dependents.

You must notify your employer within 60 days if you or your dependents wish to continue coverage under COBRA after an event. Once notified, your employer will provide the information on how coverage under COBRA may continue, and must give us notice within 30 days of the event that you wish to continue coverage. Contact your employer for more information.

How Continuation of Coverage Ends. Your continuation of coverage ends when the time period that you qualified for runs out. However, coverage may end before that time if one of the following occurs:

The group contract between us and the employer ends. If your employer switches coverage you will be able to continue coverage under their new plan.

You fail to pay the premium (subject to the grace period).

You tell us in writing to cancel your coverage.

The date your spouse remarries and becomes eligible under the new spouse's plan.

Coverage may also end for COBRA if the following occurs:

You are eligible for coverage with another group. However, if your COBRA plan covers something that the other group doesn't then you may continue coverage. Your coverage will continue until the group covers that exclusion or you are no longer eligible.

You get Medicare

Your coverage was extended to 29 months and you are now no longer disabled.

How Your Benefits Work

This section tells you how we set the payment amount for *covered services*. It will also tell you more about what you pay out-of-pocket for *covered services*, as well as how your choice of *provider* may affect your out-of-pocket costs. The portion you must pay for *covered services* is stated in the Schedule of Benefits at the beginning of this *certificate*.

Choosing a Provider

Please read the following information so you will know from whom or what group of providers vision care may be obtained.

Important Note: We do not restrict or interfere with your right to select the *provider* of your choice, but your benefits are reduced when you use a *provider* who is not a *network provider*.

Network Providers. We have a network of vision care providers for you to use. We call them network providers, because they have agreed to take part in our Blue View Vision network. They have agreed to provide *covered services* to you for a negotiated rate. *Covered services* you receive from a network provider are considered In-Network care.

IMPORTANT: If you opt to receive optometric services or procedures that are NOT covered services under this plan, a network provider may charge you his or her usual and customary rate for such services or should provide you with a treatment plan that includes each anticipated service or procedure to be given a procedures. Prior to providing you with optometric services or procedures that are not covered services, the provider should provide you with the estimated cost of each service or procedure. To fully understand your coverage, you may wish to review your *certificate*.

Non-Network Providers. Non-network providers are vision care providers that did not agree to participate in our Blue View Vision network. They have not agreed to a negotiated rate and do not have a provider contract with us. Using a non-network provider will typically increase your out of pocket costs. Covered services you receive from non-network providers are considered Out-of-Network care.

Please call us or visit our website listed in the Contact Us section for help in finding a network provider.

Benefit Maximums, Allowances and Frequency Limits

The amount we pay for your benefits is subject to your benefit maximums, allowances and frequency limits. We will not pay for vision care services that go over your benefit maximums or allowances, or for services that are received more than the allowed frequency limits. Benefit maximums, allowances, and frequency limits are stated in the Schedule of Benefits at the beginning of this certificate.

Your Cost Share Requirements

We will pay up to the maximum allowable amount for covered services. You may be required to pay a part of the maximum allowable amount. This is called your cost share amount. Copayments are an example of a cost share amount. See the Schedule of Benefits to help determine your cost share amount for covered services.

Your cost share amount may vary depending on whether you receive vision care from a network or non-network provider. You may be required to pay higher cost sharing amounts when using non-network providers.

We will not pay for vision care that is not covered under this plan. You are required to pay all charges for vision care that is not covered. Vision care received after you have met any benefit maximums or benefit frequency limits are also not covered.

Covered Services

This section describes the covered services available under your vision care benefits when received by a provider. All covered services are subject to the exclusions listed in the Exclusions section and all other conditions and limitations of the certificate.

Routine Eye Exam. Your plan covers a complete eye exam with dilation as needed. The exam is used to check all aspects of your vision. An eye exam does not include a contact lens fitting fee. Your plan covers a refraction in

conjunction with an eye exam. A refraction is your prescription based on your eye exam. Network providers should not bill the refraction separately from the routine exam.

Eyeglass Lenses. You have a choice in your eyeglass lenses. Eyeglass lenses include factory scratch coating at no additional cost. Your dependent children under 19 may also receive polycarbonate and photochromic eyeglass lenses at no additional cost when received from a network provider.

Covered eyeglass lenses include plastic (CR39) lenses up to 55 mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- standard progressive lenses

Frames. You have a benefit allowance towards your choice of frames. You may apply the allowance toward the purchase of any frame. If your frame choice is more than your allowance, then you are responsible for the balance. The Schedule of Benefits lists your allowance and benefit frequency.

Contact Lenses. This plan covers elective or non-elective contact lenses. You may receive a benefit for elective contact lenses or non-elective contact lenses, but not both. The contact lens allowance must be completely used at the time of initial service. No amount of the allowance may be carried forward to use during another service date. The Schedule of Benefits lists the contact lens allowance available under this plan.

Note: Contact lenses are in lieu of your eyeglass lenses benefit. If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in the Schedule of Benefits.

Elective Contact Lenses. Elective contact lenses are contacts that you choose for appearance or comfort.

Non-Elective Contact Lenses. Non-elective contact lenses are prescribed by your provider for diagnoses listed below:

- Extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses; or
- Keratoconus-unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or
- High Ametropia-unusually high levels of near sightedness, far sightedness, or astigmatism are identified; or
- Anisometropia-when one eye requires a much different prescription than the other eye

Important Note: We will not reimburse for non-elective contact lenses for any member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Additional Options. Benefits are available for additional services in accordance with the Additional Savings Program. For additional information on available discounts please contact your network provider or call customer service.

Exclusions

We will not pay for services incurred for, or in connection with, any of the items below.

- Not specifically listed. Services not listed in the Covered Services section of this certificate.
- Sunglasses. Sunglass lenses or accompanying frames.
- Excess amounts. Any amounts in excess of the maximum benefits stated in this certificate.
- Premium contact lenses fittings. This includes fittings for more complex applications, including toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable lenses. It also includes extended/overnight wear lenses.
- Cosmetic Options. Cosmetic lens options not specifically listed in the Schedule of Benefits or the covered services section of this certificate. This includes non-prescription eyewear and lenses, plano lenses or lenses that have no refractive power.
- Eye surgery. Any diagnostic testing or medical or surgical treatment of the eyes, including any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. We also will not cover any contact lenses or eyeglasses required as a result of this surgery.
- Lost or broken lenses or frames. Any lost or broken lenses or frames, unless you have reached a new benefit period.
- Experimental or investigative. Any experimental or investigative services or materials.
- Uninsured. Services received before your effective date or after your coverage ends.
- Voluntary payment. Services for which you are not legally obligated to pay, for which you are not charged, or for which no charge is made in the absence of insurance coverage.
- Work-related. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation law or similar law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those condition pursuant to any workers' compensation law or similar law, we will provide the benefits of this plan for such condition, subject to our right to a lien or other recovery applicable law.
- Government treatment. Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- Non-licensed vision care providers. Treatment or services rendered by non-licensed providers and treatment or services for which the provider of services is not required to be licensed. This

includes treatment or services from a non-licensed vision care provider under the supervision of a licensed physician or licensed vision care provider, except as specifically provided or arranged by us.

- Services of relatives. Professional services or supplies received from a person who lives in your home or who is related to you by blood or marriage.
- Hospital care. Inpatient or outpatient hospital vision care.
- Orthoptics. Orthoptics or vision training and any associated supplemental testing.
- Missed or Cancelled Appointments. We will not pay for appointments a member has missed or cancelled.
- Services or Supplies Combined with Discounts. We will not pay for services or supplies when combined with any other offer, coupons or in-store advertisement. We will also not pay for certain brands of frames where the manufacturer does not allow discounts.

How to Submit a Claim

This section describes how you submit a claim and what information you should include on your claim. When you receive care from a *network provider*, you do not need to file a claim. The *network provider* will do this for you. However, if you receive vision care from a *non-network provider*, you will need to submit a claim to us.

Notice of Claim. After you receive vision care you will need to contact us, either by phone or mail (see contact information listed below). You should contact us within 20 days of the date you received vision care so we can provide to you claim forms for filing. Notice given by someone on your behalf, or to any agent authorized by us, within information to identify you will be deemed notice to us. If you are unable to contact us within 20 days, it does not mean we will not pay for your claim. Just contact us as soon as reasonably possible.

Claim Forms. We will provide claim forms within 15 days after you notify us. The claim form will have instructions on how to fill it out and where to submit. If you do not receive the claim form within 15 days of your notice, you may send us other written proof of your loss instead, such as an itemized bill from your *provider*. To make it easier to process your claim, the other proof of loss should include the following:

- the date of service
- the patient's name, date of birth, and identification number
- the type and place of service
- your signature and the provider's signature

Proof of Loss. Your written proof of loss as described above should be provided to us within 90 days after the date of you received vision care. If it is not reasonably possible to provide your written proof of loss within this time, we will not invalidate or reduce your claim. However, you must send it as soon as reasonably possible, and in no event later than a year from when it was due, unless you are legally incapacitated.

Notice of claim, claim forms and other proof of loss can be sent to the following address:

Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111
Phone: (866) 723-0515

Time of Payment of Claims. We will pay claims immediately once we receive written proof of your claim, but not later than 30 days after we receive your proper written proof of loss.

Payment of Claims. We will pay claims directly to *providers* if they have an assignment of benefits on file. If the *provider* does not have an assignment of benefits on file then we will pay claims to you. If you pass away, we will pay claims to your designated beneficiary or to your estate if there is no assignment of benefits.

General Provisions

Entire Contract. The law of the state in which the *group contract* was issued will apply unless otherwise stated herein.

Entire Contract – Changes. Your plan is the entire contract of insurance. Your *plan* is made up of this *certificate*, your application (if any), and any amendments. In addition, your employer has the *group contract* and the group master application, which are also a part of your *plan*. No agent of the plan is authorized to change the form or content of this plan or waive any of its provisions. Any changes to the *plan* must be endorsed by an executive officer. All statements made by you or your employer shall be deemed representations and not warranties. No written statement made by you will be used in any context to deny a claim unless a copy of the statement is furnished to you, your beneficiary or personal representative.

Incontestability. The validity of this *plan* will not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue. No statement made by you or your *dependents* relating to you or your *dependent's* insurability will be used to contest the validity of this *certificate* unless the statement is contained in a written instrument signed by you or your *dependents*.

Change of Beneficiary. You have the right to choose your own beneficiary.

Independent Contractors. *Providers* are not our agents or employees. They do not have the ability to waive or alter your *plan*. We are not responsible for any damages or injuries as a result of receiving care from any provider.

Right of Recovery. When we overpay a claim, we have the right to recover our overpayment. We may recover our overpayment from you, the person we paid, or another plan. We may deduct any overpayment from pending or future claims.

Benefits not Transferable. You are the only person able to receive benefits under this *plan*. You are not able to transfer your benefits to anyone else.

Legal Actions. No action at law or in equity shall be brought to recover on this *plan* prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this *plan*. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Coordination of Benefits. We consider this *plan* primary in all circumstances.

Grace Period. Your *group* is responsible to pay premiums on your behalf. After the first premium payment, your *group* has a grace period of 31 days to pay any *premium* due. During the grace period, your coverage will continue in force unless your *group* has given us written notice to cancel the coverage in accordance with the terms of the *group contract*. Your *group* is responsible to pay any premium to the plan. However, you may be required to pay a portion of the premium to your *group*. See your *group* for more information on premiums.

Conformity with the Law. Any provision of this *plan* which is in conflict with the laws of the state in which the *group contract* is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Modifications. We may change this *plan*, including the premiums, at any time by providing notice to the *group* at least 30 days before the change takes effect.

Notice of Privacy Practices. We maintain a privacy program designed to protect your health information consistent with applicable law. In addition to various laws governing your privacy, we have our own privacy policies and procedures in place that are designed to protect your information. We are required by law to provide individuals with notice of our legal duties and privacy practices. To obtain a copy of this notice, call us or visit the website listed in the Contact Us section of this *certificate*.

Reservation of Discretionary Authority

The following provision only applies where the interpretation of this *certificate* is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq. The *plan*, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, has complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation determination of whether the services, care, treatment, or supplies are covered. However, a *member* may utilize all applicable grievance and appeals procedures.

The *plan*, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of the *certificate*. This includes, without limitation, the power to construe the *group contract*, to determine all questions arising under the *certificate*, to resolve member grievances and Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this *certificate*. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the *group contract* the *certificate*, provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Complaints and Appeals

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint. During those times, please contact our Customer Service Department. This section explains and offers instructions on what to do if you have a complaint or request.

Complaints

We provide quality member satisfaction services through our customer service center. All of our customer service representatives are responsible for addressing your concerns in a manner that is accurate, courteous, respectful and prompt. They are available to:

- answer questions you have about your benefits, our network of *providers*, information about claims, and our policies and procedures;
- make sure your suggestions are brought to the attention of appropriate person; and
- provide assistance to you when you want to file an appeal.

Please have your identification number (found on your ID card) handy when you contact customer service. We use this number to locate your important records with the least amount of inconvenience to you.

Members are encouraged to file complaints within 60 days of an initial, adverse action, but must file within six months after receipt of notice of the initial, adverse action. The time required to review complaints does not extend the time in which appeals must be filed.

Appeals

If you do not agree with a claim denial made by us, you have a right to a full and fair review. A coverage denial means our determination that a service, treatment, drug or device is specifically limited or excluded under this plan.

You must submit your appeal to us in writing within 180 days from the date you received our claim denial notification. In support of your appeal, you may submit written comments, documents, records, or other information you think is relevant. Send your appeal to:

Blue View Vision
PO Box 9304
Minneapolis, MN 55440-9304
Phone: (866) 723-0515

Upon request and without charge, you will be provided reasonable access to and copies of all documents, records and other information relevant to or considered in our initial claim denial.

The person reviewing your appeal will not be the same person(s) who made the initial claim denial, nor will they be a subordinate or supervisor of the person(s) who made the initial claim denial. The person reviewing will also have appropriate medical and professional expertise and credentials to make a determination on your appeal. We will notify you of our determination in your appeal within 30 days upon receipt.

If you are not satisfied with the determination of your appeal, you may submit a second level appeal. The second level appeal must be submitted in writing within 180 days of the notice of our determination in the first appeal. You do not have to re-send the information that you submitted for your first appeal, but you are encouraged to submit any additional information that you think is important for review. We will notify you of our determination in your second level appeal within 30 days upon receipt.

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding any specific claims or appeals. No authorization is required for treating provider to make a claim or appeal on your behalf. To authorize another person to represent you, contact our customer

service department via the phone number listed in the Contact Us section. You can revoke the authorized representative at any time. You can authorize only one person as your representative at a time.

Definitions

This section defines terms that have special meanings. If a word or phrase has a special meaning or is a title, it will be italicized. The word or phrase is defined in this section or at the place in the text where it is used.

Allowance. A dollar amount available to apply towards materials or services.

Calendar Year. The period of time between January 1st and December 31st in which benefits are tracked. You must wait until the calendar year interval of which they can receive covered services again under the plan. See the Schedule of Benefits for more information.

Certificate. This summary of the terms of your benefits. It is attached to and is a part of the group contract and is subject to the terms of the group contract.

Copayment (or copay). A specific dollar amount indicated in the Schedule of Benefits for which you are responsible.

Covered Services. Services and supplies or treatment as described in the certificate which are performed, prescribed, directed or authorized by a provider. A covered service is incurred on the date the service, supply or treatment was provided to you. To be a covered service the service, supply or treatment must be:

- Within the scope of the license of the provider performing the service;
- Rendered while coverage under this certificate is in force;
- Within the maximum allowable amount;
- Not specifically excluded or limited by the certificate;
- Specifically included as a benefit within the certificate.

Dependent. A member of the subscriber's family who is eligible for coverage under the plan as described in the Eligibility and Enrollment section of this certificate.

Effective Date. The date when your coverage begins under this certificate.

Group. The employer that has entered into a group contract with us to provide the benefits of the plan.

Group Contract. The contract issued by us to the group as a means of providing certain benefits to the group's employees and eligible dependents.

Maximum Allowable Amount. The maximum amount allowed for covered services you receive based on the fee schedule. The maximum allowable amount is subject to any copayments, coinsurance, limitations or exclusions listed in this certificate.

For a network provider, the maximum allowable amount is equal to the amount that constitutes payment in full under the network provider's participation agreement for this product. If a network provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the maximum allowable amount.

For a non-network provider who is a physician or other non-facility provider, even if the provider has a participation agreement with us for another product, the maximum allowable amount is the lesser of the actual charge or the standard rate under the participation agreement used with network providers for this plan.

The maximum allowable amount is reduced by any penalties for which a provider is responsible as a result of its agreement with us.

Member. A subscriber or dependent who has satisfied the eligibility conditions; applied for coverage; been accepted by us for coverage; and for whom premium payment has been made. Members are sometimes called “you” and “your.”

Network Provider. A provider who has entered into a contractual agreement or is otherwise engaged by us to provide covered services and certain administration functions for the network associated with this plan.

Non-Network Provider. A provider who has not entered into a contractual agreement with us for the network associated with this plan.

Plan. The entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this certificate, your application (if any), any endorsements, the group contract, and the group master application.

Provider. A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that we approve. This includes any provider rendering services that are required by applicable state law to be covered when rendered by such provider.

Subscriber. The employee or other member of the group that has enrolled and been accepted for coverage under this plan.

Addendum D Eligibility Policy

Eligibility Policy for Health Plan Coverage Offered by Cook (Not Applicable to Employees of Blue Sky Casino, LLC)

New Employees

Initial Measurement Period = From date of hire to first anniversary; for example, February 12, 2023 through February 11, 2024

Initial Stability Period = From first anniversary to second anniversary; for example, February 12, 2024 through February 11, 2025

- 1) A person is a “New Employee” until they have completed a full calendar year of work – a full Standard Measurement Period.
- 2) Unless otherwise excluded, New Employees who are classified as Full-Time Employees are eligible to enroll in health plan coverage offered by Cook (“Health Coverage”) following 30 days of continuous employment (“Waiting Period”). If they enroll within the 30 day Waiting Period, coverage is effective on the day of completing the Waiting Period.
- 3) New Employees who are classified as Part-Time Employees or Seasonal Employees will be tracked during their first 12 months of employment – called the “Initial Measurement Period.” The Initial Measurement Period will begin on their first day of employment. If a New Part-Time Employee or Seasonal Employee completes at least 1560 hours during their Initial Measurement Period, the Employee will be eligible to enroll in Health Coverage for an Initial Stability Period, so long as they enroll within 30 days after the end of their Initial Measurement Period. The Initial Stability Period starts on the Employee’s first anniversary. The Employee will be in the Initial Stability Period for 12 months from this date and if enrolled, will remain eligible regardless of the number of hours worked during the Initial Stability Period, provided the Employee timely pays required premiums and is still employed. For example, a Seasonal Employee hired on February 12, 2023 will be tracked through February 11, 2024 (Initial Measurement Period), and if the Employee completes 1560 hours during that 12-month period, will be eligible for Health Coverage from February 12, 2024 through February 11, 2025 (Initial Stability Period), regardless how much they work during their Initial Stability Period.
- 4) If a New Part-Time Employee or Seasonal Employee does not complete at least 1560 hours during their Initial Measurement Period, the Employee will not be eligible to enroll in Health Coverage during the next 12 months (their Initial Stability Period) unless the Employee changes job classification. *See rules for changes in job classification below.*

Ongoing Employees

Standard Measurement Period = January 1 – December 31; for example January 1, 2024 through December 31, 2024.

Standard Stability Period = January 1 – December 31; for example, January 1, 2025 through December 31, 2025.

- 1) Ongoing Employees are persons who have been employed for an entire calendar year, i.e. a Standard Measurement Period. For example, if an Employee is hired on February 12, 2023, the Employee becomes an Ongoing Employee on January 1, 2025.
- 2) Unless otherwise excluded, all Ongoing Employees who are classified as Full-Time Employees shall be eligible to enroll in Health Coverage. They remain eligible to the end of each calendar year (Standard Stability Period), regardless of how much they work, and even if they are reclassified as a Part-Time Employee or Seasonal Employee during the year (Standard Stability Period). Employees who are classified as Full-Time Employees are eligible to enroll each calendar year, regardless of the number of hours they work.
- 3) All Ongoing Employees classified as Part-Time Employees or Seasonal Employees who work at least 1560 hours during a Standard Measurement Period (each January 1 – December 31) will be eligible to enroll in Health Coverage for the immediately following calendar year (the Standard Stability Period). They must enroll during the Annual Open Enrollment period, and coverage will be effective at the beginning of the next Standard Stability Period, i.e. on January 1.
 - *See rules for leaves of absence, special unpaid leaves of absence and counting hours below.*
 - Those who enroll will be in a Standard Stability Period for the entire calendar year (Standard Stability Period) and will remain eligible for the entire year (Standard Stability Period) regardless the number of hours they work during the year (Standard Stability Period).
 - Those who are eligible to enroll, but do not timely enroll, will not be eligible to enroll during the Standard Stability Period, regardless of the number of hours they work during the Standard Stability Period, unless they experience a HIPAA special enrollment right.
- 4) Any Ongoing Employee who is classified as a Part-Time Employee or Seasonal Employee who does not work at least 1560 hours during a Standard Measurement Period, will not be eligible to enroll in Health Coverage during the next calendar year (Standard Stability Period). These Employees will remain ineligible for the entire year (Standard Stability Period), regardless how much they work during the year (Standard Stability Period), unless they experience a change in job classification. *See rules for changes in job classification below.*

Transition from New Employee to Ongoing Employee

- 1) A New Part-Time Employee or Seasonal Employee will either be eligible or not eligible for Health Coverage after the Employee's Initial Measurement Period and will retain this designation through the end of the Employee's Initial Stability Period. This is true for the portion of the Initial Stability Period which overlaps with the Employee's first Standard Stability Period (January 1 – December 31).
- 2) Once the New Part-Time Employee or Seasonal Employee has been employed for an entire Standard Measurement Period (January 1 – December 31), the Employee is an Ongoing Employee and their hours are measured based on the Standard Measurement

Period (one calendar year), which will determine their eligibility during the related Standard Stability Period (the next calendar year).

- 3) If an Employee is eligible based on their hours during either the Initial Measurement Period or the Standard Measurement Period, they are eligible for coverage during the entire related Stability Period unless they don't timely pay the active employee premium or their employment is terminated.
- 4) If an Employee experiences a gap between the end of their Initial Stability Period and the start of their first Standard Stability Period, the Employee's designation during the Initial Stability Period continues through the gap period until the beginning of the Standard Stability Period.

Changes in Job Classification

- 1) If an Ongoing Full-Time Employee is re-classified as a Part-Time Employee or Seasonal Employee during the year (Standard Stability Period), Health Coverage will continue to the end of the calendar year (Standard Stability Period) if the Employee is enrolled in coverage because the Employee will be in a Standard Stability Period. If the Employee did not enroll in coverage, the Employee will not be eligible to enroll during the year (Standard Stability Period) because of the change in job classification unless they also experience a HIPAA special enrollment event.
- 2) If a New Full-Time Employee is re-classified as a Part-Time Employee or Seasonal Employee before the Employee becomes an Ongoing Employee, the Employee will remain eligible until the end of the year (Initial Stability Period).
- 3) If an Ongoing Part-Time Employee or Seasonal Employee is re-classified as a Full-Time Employee, the Employee will be eligible for Health Coverage on the date of the reclassification.
- 4) If a New Part-Time Employee or Seasonal Employee is re-classified as a Full-Time Employee before they become an Ongoing Employee, the Employee will be eligible for Health Coverage on the date of the reclassification, provided the Employee has been employed for longer than the Waiting Period. If not, the Employee will become eligible immediately following the Waiting Period.

Rehired Employees

- 1) To be considered a New Employee and be measured under a new Initial Measurement Period, a rehired Employee must have a break in service that is at least 13 consecutive weeks long.
- 2) A break in service is a period of time during which the Employee is not credited with any hours of service. (See Section 23 below for when hours of service are credited.)
- 3) If a rehired Employee (New or Ongoing) has not had a break in service as described in #17 above, the Measurement Period they were in when they left resumes, and their designation for the Stability Period (eligible or not eligible) remains the same.

Leaves of Absence and Special Unpaid Leaves of Absence

- 1) This Policy uses Employee classifications (e.g., Full-Time) or hours (e.g., Part-Time and Seasonal) to determine if an Employee will be eligible for Health Coverage during an Initial or Standard Stability Period.
- 2) Full-Time Employees are eligible for Health Coverage during paid and unpaid leaves and when they return from the leave, without regard to the hours credited to or paid to them during the leave or during the calendar year that includes the leave.
- 3) Part-Time Employees and Seasonal Employees who are enrolled in Health Coverage who go on a leave remain eligible for Health Coverage to the end their Stability Period. Their eligibility for the next Stability Period is determined by the hours credited to them during the year of the leave. If at the beginning of the next Stability Period they had enough hours during the related Measurement Period, they are eligible to enroll for coverage for the Stability Period.
- 4) Counting Hours. For Part-Time Employees and Seasonal Employees, the following hours are counted during the Measurement Period to determine their eligibility for the following Stability Period: a) hours for which the Employee is paid; b) PTO hours; c) hours on paid leave, including paid disability leaves and any leave while receiving workers compensation benefits; and d) hours on unpaid FMLA, USERRA or jury duty leave. During unpaid FMLA, USERRA or jury duty leave, hours must be credited at a rate equal to the Employee's average weekly hours during the rest of the Measurement Period that does not include the FMLA, USERRA or jury duty leave.

Phased Retirement Program (PRP)

- 1) The Phased Retirement Program (PRP) is designed to offer Ongoing Full-Time Employees the option of part-time hours in order to bridge the gap between full time employment and full time retirement. Employees who are in the PRP shall have Health Coverage eligibility as follows:
 - Employees who move directly from being a Full Time Employee to being a Part-Time Employee in the PRP:
 - Remain eligible for Health Coverage through the end of the year (Standard Stability Period) in which they become a Part-Time Employee in the PRP;
 - Remain eligible for Health Coverage for additional years (Standard Stability Periods) only if they completed 1560 hours during the year (Standard Measurement Period) immediately before. The Employee will be offered COBRA when they lose Health Coverage eligibility.
 - Employees who move from being a Full Time Employee to being on a PTO leave and then become a Part-Time Employee in the PRP:
 - Remain eligible for Health Coverage while on leave so long as they are on PTO;
 - Lose Health Coverage when their PTO is exhausted, unless they return to work as a Part-Time Employee in the PRP; if they do not return to work when their PTO is exhausted, their employment will be terminated and they will be offered COBRA;

- Are subject to the Rehired Employee rules in Sections 17-19 upon rehire.
- Employees who are Full Time Employees and terminate employment and then return to work as a Part-Time Employee in the PRP:
 - Are subject to the Rehired Employee rules in Sections 17-19 upon rehire.

Miscellaneous Provisions

- 1) The employer may classify some Employees as not eligible for Health Coverage, such as interns, regardless of the number of hours they work.
- 2) Employee Definitions:
 - Full-Time Employee – an Employee who is classified as a Full-Time Employee.
 - Part-Time Employee = an Employee who is reasonably expected to be employed less than 1560 hours during their first 12 months based on facts and circumstances on their start date. For example, the following employees are classified as Part-Time:
 - High School Equivalency Program
 - ICE Students
 - Project Search Program
 - Professional Experience Program
 - Seasonal Employee = an Employee whose customary annual employment is: a) for a fixed term; b) six months or less; b) tied to a season; and c) for recurrent time periods. For example, the following employees are classified as Seasonal:
 - Summer Help
 - Co-Ops (unless working full-time for two or more consecutive semesters)
- 3) Loss of Coverage: Even if a New Employee or Ongoing Employee is enrolled in Health Coverage and is in the middle of a Stability Period, the Employee's Health Coverage will end if their employment terminates. It will also end during a Stability Period if the Employee is on an unpaid leave and the Employee does not pay their share of the Health Coverage premiums. In both situations, the Employee will be eligible to re-enroll in Health Coverage if they return to work.
- 4) Enrollment: An Employee who becomes eligible for Health Coverage must enroll for the coverage within 30 days of becoming eligible (e.g., within 30 days of the end of the Waiting Period or the end of the Initial or Standard Measurement Period). An Employee may also be required to enroll or re-enroll during any annual open enrollment period that occurs during a Stability Period.

Addendum E UTAH PLAN

UTAH SCHEDULE OF BENEFITS

Medical Benefits
Cost Sharing
<i>Section 8.1 in Manual</i>
The following deductibles, maximums and limits apply to the services listed in the schedule of benefits unless otherwise noted.

Medical Deductible		Network and Out-of-Network	
Individual (per calendar year)		\$500	
Family (per calendar year)		\$1,000	
Network and out-of-network charges apply toward the deductible.			
Charges for the following do not apply toward the medical deductible: prescription drugs, dental services, vision services, copayments, charges that apply toward other deductibles, second and third surgical opinion charges, and non-covered services. No more than \$500 on any one individual applies toward the family deductible.			
Annual Out-of-Pocket Maximum		Network and Out-of-Network	
Individual (per calendar year)		\$2,000 (includes deductible)	
Family (per calendar year)		\$4,000 (includes deductible)	
Charges for the following <u>do not</u> apply toward the annual out-of-pocket maximum: dental benefits, adult vision benefits, family planning, charges in excess of allowed amounts, amounts reimbursed through the pharmacy benefit manager Specialty Care Assistance Program and non-covered services.			
When you have met your out-of-pocket maximum, for the remainder of the year you will no longer have office visit copays, deductibles or coinsurance for covered medical services and covered prescription drugs.			
Physician Office Services <i>Section 9.15 in Manual</i>		Network	Out-of-Network
Office Visits Primary care* and specialists		\$15 copayment	80% after deductible
Office surgery, X-rays and lab tests by primary care* and specialists		80% after deductible	80% after deductible
*Traditional Plan participants may use the Cook Family Health Center for primary care.			

Preventive Care <i>Section 9.16 in Manual</i>	Network	Out-of-Network
Annual Physical Exam Including laboratory services	100%	100%
Annual Gynecological Exam Including pap smear	100%	100%
Well-Baby and Child Care	100%	100%
Routine Childhood Immunizations	100%	100%
HPV Immunization For males and females ages 9-26	100%	100%
Specified Adult Immunizations	100%	100%
Meningococcal Immunization For college freshmen not previously vaccinated	100%	100%
Maternity Preventive Services Including dependent child Breast feeding support and counseling Breast feeding pumps and supplies – retail and online purchases are not covered	100%	100%
Mammograms Routine baseline mammogram for females ages 35 and 39 Annual screens for females age 40 and older Annual screens for females age 35 and older if you are in the high risk category Annual Magnetic Resonance Imaging (MRI) screens for certain high risk persons	100%	100%
Prostate-Specific Antigen Test (PSA) Annual screens for males age 50 and older Annual screens for males age 45 and older if you are in the high risk category	100%	100%
Screening Flexible Sigmoidoscopy Once every 5 years for those age 45 and older	100%	100%
Screening Colonoscopy Once every 10 years for those age 45 and older	100%	100%
Screening CT Colonography Limited to once every 5 years for persons age 45 and older	100%	100%
Contraceptive Services All FDA-approved contraceptives, sterilization procedures and education and counseling for women with reproductive capacity	100%	100%
Therapies <i>Section 9.22 in Manual</i>	Network	Out-of-Network
Chiropractic Services Limited to 20 visits per person per calendar year	80% after deductible	80% after deductible

Physical, Occupational and Speech Therapy	80% after deductible	80% after deductible
Outpatient Infusion Therapy	80% after deductible	80% after deductible
Chemotherapy and Radiation Therapy	80% after deductible	80% after deductible
Mental Health and Substance Abuse Services <i>Section 9.14 in Manual</i>	Network	Out-of-Network
Office Visits	\$15 copayment	80% after deductible
Transgender Therapy and Treatments	80% after deductible	80% after deductible
Inpatient, Outpatient and Transitional Services, Supplies and Testing	80% after deductible	80% after deductible
Residential Treatment for Behavioral Health	80% after deductible	80% after deductible
Family Planning Services* <i>Section 9.8 in Manual</i>	Network	Out-of-Network
Lifetime Maximum of \$25,000 per person**		
Primary Care and Specialist Office Visits	\$15 copayment	80% after deductible
Hospital Services	80% after deductible	80% after deductible
Inpatient and Outpatient Professional Services	80% after deductible	80% after deductible
*All FDA-approved contraceptive and sterilization procedures and all education and counseling for women with reproductive capacity are no longer included in this Family Planning Benefit. See the Preventive Care Benefit section.		
**Any services in excess of this lifetime maximum are not covered charges. Infertility drugs are included in this lifetime maximum.		
Urgent Care Centers and Emergency Rooms <i>Sections 9.7 and 9.24 in Manual</i>	Network	Out-of-Network
Urgent Care Centers	\$50 copayment then 80% after deductible*	\$50 copayment, then 80% after deductible**
Emergency Room Visits	\$100 copayment, then 80% after deductible*	\$100 copayment, then 80% after deductible**
* If you are admitted to the hospital from the emergency room or an urgent care center, the copayment does not apply. If you are sent to the emergency room from an urgent care center and you are not admitted to the hospital, you pay only one copayment.		

****Emergency services in an urgent care center or hospital emergency room for an emergency medical condition will always be paid at the network level.**

Ambulatory Surgical Center <i>Section 9.3 in Manual</i>	Network	Out-of-Network
Professional Services	80% after deductible	80% after deductible
Facility Charge	80% after deductible	80% after deductible
Hospital Inpatient and Outpatient Services, including mental health and substance abuse services <i>Section 9.12 in Manual</i>	Network	Out-of-Network
Hospital and Hospital-Based Services and Supplies	80% after deductible	80% after deductible
Physician Services	80% after deductible	80% after deductible
Facility Charges and Supplies	80% after deductible	80% after deductible
Diagnostic Procedures Computerized Tomography (CT) Scans Computerized Tomography Angiography (CTA) Magnetic Resonance Imaging (MRI) Magnetic Resonance Angiography (MRA) Positron Emission Tomography (PET) Electroencephalogram (EEG) Electrocardiogram (EKG) X-rays and Ultrasounds	80% after deductible	80% after deductible
Lab Tests	80% after deductible	80% after deductible
Other Services <i>Article IX in Manual</i>	Network	Out-of-Network
Ambulance	80% after deductible	80% after deductible
Air Ambulance	80% after deductible	80% after deductible
Durable Medical Equipment	80% after deductible	80% after deductible
Foot Orthotics (if authorized)	80% after deductible	80% after deductible
Hearing aids, services and supplies Limited to \$3000 maximum benefit per person every five years	80% after deductible	80% after deductible
Home Health Care	80% after deductible	80% after deductible
Hospice	80% after deductible	80% after deductible

Medical Supplies	80% after deductible	80% after deductible
Private Duty Nursing	80% after deductible	80% after deductible
Skilled Nursing Facility Including private duty nursing	80% after deductible	80% after deductible
Support Hose By prescription Two pair per calendar year	80% after deductible	80% after deductible
Temporomandibular Joint Dysfunction (TMJ) Must be medically necessary	80% after deductible	80% after deductible
Wigs If required due to cancer or related illness One per illness, unless approved	80% after deductible	80% after deductible
Transplants <i>Section 9.23 in Manual</i>	Heart, lung, bone marrow, liver, pancreas and kidney transplants are covered. See the Plan Manual for more information.	
Prescription Drug Benefits <i>Article X in Manual</i>		
Pharmacy Benefit Manager – TrueScripts (www.truescripts.com)		
Pharmacy deductible (per family per calendar year) is \$300. There is only one pharmacy deductible for network and out-of-network charges. All network and out-of-network charges apply toward this pharmacy deductible. Pharmacy drug benefits count toward the out-of-pocket maximum.		
Prescription Drugs	Network and Out-of-Network	
For generic drugs	After deductible, you pay 20% up to: - \$100 maximum per 30-day supply -\$200 maximum per 60-day supply -\$300 maximum per 90-day supply	
For brand name drugs	After deductible, you pay 20% up to: - \$100 maximum per 30-day supply -\$200 maximum per 60-day supply -\$300 maximum per 90-day supply Plus you pay the difference in cost between the brand name and generic drug*	

*If the prescriber writes a prescription for a brand name drug and indicates “Dispense as Written” on the prescription, there is no additional charge for the cost difference between the brand name drug and the generic drug. However, if the prescriber allows a generic drug to be dispensed, but you choose a brand name drug rather than the generic equivalent, you will be responsible for the brand name drug coinsurance, plus the cost difference between the brand name drug and the generic drug. Additionally, only the amount you would have paid had you accepted the generic drug will apply toward your drug deductible and out-of-pocket maximum. Certain classes of medications are subject to Step Therapy where a covered person who is using the drug for the first time must try a generic medication before purchasing a brand name medication, unless a prior authorization is approved from the prescriber.

Prescription drugs	Network	Out-of-Network
For specialty drugs	After deductible, you pay 20%	Not covered

The specialty drug network is subject to change. Contact pharmacy benefit manager at the telephone number on your ID card to confirm network status of pharmacy and list of specialty drugs.

Specialty prescription drugs that qualify for the Specialty Care Assistance Program will be assigned to Tiers 1 -5, and paid as indicated, after pharmacy deductible:

- o Tier 1 20% coinsurance up to \$100 maximum
- o Tier 2 20% coinsurance up to \$550 maximum; up to \$100 after processing
- o Tier 3 20% coinsurance with no maximum; up to \$100 after processing
- o Tier 4 50% coinsurance; up to \$100 after processing
- o Tier 5 Excluded with Specialty Care Assistance Program available

Prescription Drugs	Network and Out-of-Network
Diabetic Supplies Syringes, test strips, insulin, glucose meters, spacers, peak flow meters, counseling with dietician	After deductible, you pay 20% up to : - \$100 maximum per 30-day supply - \$200 maximum per 60-day supply - \$300 maximum per 90-day supply
Smoking Cessation Up to 84-day supply in 365 calendar days Must be prescribed for use within 12 weeks	Plan pays 100% without deductible or coinsurance
Sexual Dysfunction Drugs Limited to 6 pills per 30 days	Plan pays 80% after deductible

Network: Blue Cross Blue Shield Traditional Network. Go to www.anthem.com, use the “Find a Doctor” tool to search for Network participating providers, selecting Utah for the state, then under “Select plan/network,” choose “Traditional” or “High Deductible Health Plan” under “Medical Employer-Sponsored.”

You may receive care from any physician or hospital, including specialists, whether they are Network or Out-of-Network. Network and Out-of-Network covered services apply toward your deductibles and out-of-pocket maximums.

If the provider participates in the Network, then you are protected from balance billing (being charged the difference between what the provider bills and what insurance paid). This could be a very large expense, so it may be significantly cheaper for you to go to a Network provider.

Network providers will normally submit claims on your behalf, but if you seek care from an Out-of-Network provider, you will be responsible for submitting your own claims.

Addendum F BARIATRIC SURGERY

Bariatric Surgery and Other Treatments for Clinically Severe Obesity

Description

This document addresses surgical and other treatments for clinically severe obesity. Clinically severe obesity is a result of persistent and uncontrollable weight gain that constitutes a present or potential threat to life. There are a variety of surgical procedures and other treatment modalities intended for the treatment of clinically severe obesity.

Note: For additional information, please see:

CG-SURG-92 Paraesophageal Hernia Repair

Clinical Indications

Medically Necessary:

Gastric bypass and gastric restrictive procedures are considered **medically necessary** when **all** of the following criteria are met:

- A. Individual is age 18 years or older; **and**
- B. The recommended surgery is one of the following procedures:
 - 1. Biliopancreatic bypass with duodenal switch
 - 2. Laparoscopic adjustable gastric banding
 - 3. Roux-en-Y procedure up to 150 cm
 - 4. Sleeve gastrectomy
 - 5. Vertical banded gastroplasty; **and**
- C. A body mass index (BMI) of 40 or greater, or BMI of 35 or greater with an obesity-related co-morbid condition including, but not limited to:
 - 1. Diabetes mellitus
 - 2. Cardiovascular disease
 - 3. Hypertension
 - 4. Life threatening cardio-pulmonary problems, (for example, severe obstructive sleep apnea, Pickwickian syndrome, obesity related cardiomyopathy); **and**
- D. Documentation of **all** of the following:
 - 1. Past participation in a weight loss program. The individual must have actively participated in the program for at least 6 continuous months in the 2 years prior to surgery; **and**
 - 2. Pre-operative medical *and* mental health evaluations and clearances; **and**
 - 3. Pre-operative education which addresses the risks, benefits, realistic expectations and the need for long-term follow-up and adherence to behavioral modifications; **and**
 - 4. A treatment plan which addresses the pre and post-operative needs of an individual undergoing bariatric surgery.

Reoperation

Surgical repair/correction or reversal following gastric bypass and gastric restrictive procedures is considered **medically necessary** when there is documentation of a surgical complication related to the original surgery, such as a fistula, obstruction, erosion, disruption/leakage of a suture/staple line, band herniation, stricture, documented gastroesophageal reflux disease (GERD) or pouch enlargement due to vomiting.

Surgical revision/conversion to another surgical procedure is considered **medically necessary** when *either* criteria A or B are met:

- A. For inadequate weight loss, **all** the following criteria are met:
 1. The individual meets the medically necessary criteria for the repeat bariatric surgery (**Note:** Meeting the criteria for the initial bariatric surgery does not count toward meeting the criteria for the surgical revision/conversion); **and**
 2. Two years following the original surgery, weight loss is less than 50% of pre-operative excess body weight and weight remains at least 30% over ideal body weight; **and**
 3. If inadequate weight loss or regain of initial weight loss following the initial surgery is determined to be due to noncompliance with the postoperative dietary and exercise recommendations, a mental health assessment documenting that the noncompliance issues have been adequately addressed; **or**
- B. There is documentation of a complication related to the initial procedure (including but not limited to, obstruction, stricture or documented GERD).

Not Medically Necessary:

Initial and reoperative bariatric procedures are considered **not medically necessary** when the criteria listed above are not met.

Bariatric surgical procedures including, but not limited to, laparoscopic adjustable gastric banding are considered **not medically necessary** for individuals with a BMI below 35 kg/m.

All other gastric bypass/restrictive procedures and other treatment modalities are considered **not medically necessary** including, but not limited to the following:

- Gastric bypass, using a Billroth II type of anastomosis (also known as a "mini gastric bypass")
- Malabsorptive procedures including, but not limited to, jejunioileal bypass, biliopancreatic bypass without duodenal switch, single anastomosis duodenal switch or very long limb (greater than 150 cm) gastric bypass (other than the biliopancreatic bypass with duodenal switch)
- Minimally invasive endoluminal gastric restrictive surgical techniques, such as use of the EndoGastric StomaphyX™ endoluminal fastener and delivery system or endoscopic sleeve gastropasty;

- Laparoscopic gastric plication (laparoscopic greater curvature plication [LGCP]) with or without gastric banding;
- Balloon systems, (such as the ReShape® Integrated Dual Balloon System or the Orbera Intragastric Balloon System);
- Vagus (or vagal) nerve blocking devices, (such as the MAESTRO® Rechargeable System);
- Endoscopically placed percutaneous aspiration tube (such as AspireAssist®).

Stretching of a stomach pouch formed by a previous gastric bypass/restrictive surgery, due to overeating, does not constitute a surgical complication and the revision of this condition is considered **not medically necessary**.

Further Consideration:

A bariatric surgeon with experience in the pediatric population may request further consideration of a case of an individual under 18 years old with severe morbid obesity and unique circumstances by contacting a Medical Director. *(Further information available in the Rationale section of this document).*

Definitions

Adjustable Gastric Banding (AGB): A gastric restrictive procedure in which a gastric band which holds fluid is placed around the exterior of the stomach. Common complications may include slippage of the external band, band erosion, vomiting and ineffective weight loss.

Biliopancreatic Bypass Procedure (also known as the Scopinaro procedure) BPB: A malabsorptive procedure which consists of a subtotal gastrectomy and diversion of the biliopancreatic juices into the small intestine by a long Roux-en-Y procedure. Potential complications in iron deficiency anemia, protein malnutrition, hypocalcemia, and bone demineralization.

Biliopancreatic Bypass with Duodenal Switch (BPD/DS): A variant of the biliopancreatic bypass in which a sleeve gastrectomy is performed instead of a distal gastrectomy.

Body mass index (BMI): The key index for relating body weight to height. The BMI is a person's weight in kilograms (kg) divided by their height in meters (m) squared. To convert pounds to kilograms, multiply pounds by 0.45; to convert inches to meters, multiply inches by 0.0254. (See the definition below for obesity for further information).

Excess body weight: This term refers to the difference between an individual's actual (measured) and ideal body weight. Ideal body weight ranges are established based on height, body frame, gender and age; an example is available from the National Heart Lung and Blood Institute [NHLBI] at: http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm

Gastric balloon (Gastric bubble): This device is inserted into the stomach to reduce the stomach's capacity and produce early satiety. It was generally considered obsolete and was originally intended for temporary use as an adjunct to diet and behavior modification to assist with weight loss. Recently, new balloon systems have been cleared by the FDA (*see information in the above Background section*).

Gastric banding: This surgical procedure is intended to help a person lose weight. A band is placed around the upper part of the stomach, creating a small pouch that can hold only a small amount of food. The narrowed opening between the stomach pouch and the rest of the stomach controls how quickly food passes from the pouch to the lower part of the stomach. This system helps the person to eat less by limiting the amount of food that can be eaten at one time and increasing the time it takes for food to be digested.

Gastric bypass (RYGB): A restrictive and malabsorptive procedure reduces the stomach capacity and diverts partially digested food from the duodenum to the jejunum (section of the small intestine extending from the duodenum). Often associated with the dumping syndrome in which a large portion of partially digested food is delivered directly to part of the small intestine from the stomach and can cause nausea, weakness, sweating, faintness, abdominal pain and vomiting. This procedure requires that individuals take vitamin and mineral supplements due to decreased ability to absorb nutrients. Complications can include leakage and stomal stricture.

Gastroesophageal Reflux Disease (GERD): Reflux of gastric contents into the upper structures (such as the esophagus, oral cavity, larynx or lung) which causes symptoms or complications. GERD in which there are symptoms without erosions present is further classified as nonerosive disease or NERD. GERD with damage or erosions present on endoscopic exam is classified as erosions present or ERD. The diagnosis of GERD is made using some combination of symptom presentation, objective testing with endoscopy, ambulatory reflux monitoring, and response to antisecretory therapy. Objective documentation of GERD is by confirmed by the presence of erosive reflux disease on endoscopy and or abnormal pH monitoring.

Gastroplasty: A surgical procedure that decreases the size of the stomach.

Laparoscopic gastric plication (laparoscopic greater curvature plication [LGCP]): A gastric restrictive bariatric procedure, which is performed alone or in combination with adjustable gastric banding, where the stomach's volume is reduced by dissecting the greater omentum and short gastric vessels, and the greater curvature is invaginated using multiple rows of non-absorbable sutures performed over a bougie or endoscope to ensure a patent lumen.

Long Limb Gastric Bypass (i.e., greater than 150 cm): A malabsorptive procedure in which the stomach is bypassed, either by resection or stapling along the horizontal or vertical axis, and the jejunum functions as the alimentary limb. Potential complications are similar to other malabsorptive procedures.

Mini Gastric Bypass: A variant of the gastric bypass in which the stomach is divided, similar to a traditional gastric bypass, but instead of creating a Roux-en-Y connection, the jejunum is anastomosed directly to the stomach, similar to a Billroth II procedure to the stomach.

Complications can include biliary reflux gastritis, in which bile flows back into the stomach and causes irritation.

Obesity: The state of being well above one's normal weight which is measured and determined by the Body Mass Index (BMI). Severe obesity is defined by the National Institutes of Health (NIH) as a BMI of 40 kg/m² or greater, or a BMI of 35 kg/m² or greater along with other medical complications. The NIH defines obesity as a BMI of greater than or equal to 30 kg/m² and considers a person overweight with a BMI of 25 to 29.9 kg/m².

Sleep apnea: The temporary stoppage of breathing during sleep, often resulting in daytime sleepiness.

Sleeve Gastrectomy (SG): Surgical alternative to gastrectomy which involves resection of the greater curvature of the stomach resulting in a sleeve or tube shaped stomach remnant. Can be performed alone with followed by a malabsorptive procedure.

Surgical Conversion or Revision: Surgery to switch from the initial procedure to a different procedure.

Surgical Correction or Repair: Surgery to correct problems which are the result of the initial procedure, such as complications or incomplete treatment effect.

Surgical Reversal: Surgery that restores the original anatomy of an individual.

Vertical Banded Gastroplasty (VBG): A gastric restrictive procedure in which the stomach is divided vertically, and a band is stapled around the top portion of the stomach to decrease its size. Common complications of this procedure include esophageal reflux, as well as either widening or blockage of the narrow portion of the stomach, which may require reoperation.